2019 PROCEEDINGS

OF THE

National Association
of Insurance Commissioners

2019 Fall National Meeting

December 7 – 10, 2019

Held at the

JW Marriott Austin
Hyatt Place Austin

Austin, Texas
The NAIC is the authoritative source for insurance industry information. Our expert solutions support the efforts of regulators, insurers and researchers by providing detailed and comprehensive insurance information. The NAIC offers a wide range of publications in the following categories:

**Accounting & Reporting**
Information about statutory accounting principles and the procedures necessary for filing financial annual statements and conducting risk-based capital calculations.

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

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

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NAIC member directories, in-depth reporting of state regulatory activities and official historical records of NAIC national meetings and other activities.

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

I. Name

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

II. Duration

The period of duration of the NAIC is perpetual.

III. Registered Office and Agent

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

IV. Authority to Issue Stock

The NAIC shall have no authority to issue capital stock.

V. Incorporators

The name and address of the incorporator are as follows:

Catherine J. Weatherford
National Association of Insurance Commissioners
120 W. 12th St., Suite 1100
Kansas City, MO 64106

VI. Purpose

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

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

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

(c) Support and improve state regulation of insurance.

VII. Restrictions

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

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

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

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

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

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

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

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VIII. Membership

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

IX. Activities

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

X. Powers

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

XI. Immunity

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

XII. Exculpation and Indemnification

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

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

XIII. Dissolution

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

XIV. Bylaws

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

XV. Amendments

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

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

/signature/
Catherine J. Weatherford, Incorporator

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

ARTICLE I Name, Organization and Location

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

ARTICLE II Membership

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

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

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

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

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

ARTICLE III Officers

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

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

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

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

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

**ARTICLE IV Executive Committee**

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

1. The Executive Committee shall have the authority and responsibility to:
   
   (a) manage the affairs of the NAIC in a manner consistent with the Certificate of Incorporation and Bylaws;
   
   (b) make recommendations to achieve the goals of the NAIC based upon either its own initiative or the recommendations of the Standing Committees or Subcommittees reporting to it, for consideration and action by the members at any NAIC Plenary Session;
   
   (c) create and terminate one or more Task Forces reporting to it to the extent needed and appropriate;
   
   (d) establish and allocate, from time to time, functions and responsibilities to be performed by each Zone;
   
   (e) to the extent needed and appropriate, oversee NAIC Offices to assist the NAIC and the individual members in achieving the goals of the NAIC;
   
   (f) submit to the NAIC at each National Meeting, during which a Plenary Session is held, its report and recommendations concerning the reports of the Standing Committees. All Standing Committee reports shall be included as part of the Executive Committee report;
   
   (g) plan, implement and coordinate communications and activities with other state, federal and local government organizations in order to advance the goals of the NAIC and promote understanding of state insurance regulation.

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2. Duties and Operations of the Executive Committee.

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

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

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

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

(e) NAIC OFFICES

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

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

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

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

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

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

The Internal Administration (EX1) Subcommittee shall:

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

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

4. Audit Committee

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

ARTICLE V Zones

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

ARTICLE VI Standing Committees and Task Forces

1. General

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

2. Specific Duties

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

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

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

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

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

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

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

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

3. Task Forces

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

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

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

1. Regular Meetings.

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

2. Special Meetings.

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

3. Waiver of Notice; Postponement.

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

4. Quorum.

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

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

ARTICLE VIII Elections

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

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

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

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

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

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

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

(b) President-Elect.

(c) Vice President.

(d) Secretary-Treasurer.

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

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

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

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

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

ARTICLE IX Proxies; Waiver of Notice

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

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

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

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

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

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

ARTICLE XI Amendments

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

Adopted October 1999, see 1999 Proc., Third Quarter page 7
Amended November 2002, see 2002 Proc., Fourth Quarter page 25
Amended June 2003, see 2003 Proc., Second Quarter page 28
Amended March 2004, see 2004 Proc., First Quarter page 119
Amended December 2004, see 2004 Proc., Fourth Quarter page 58
Amended March 2009, see 2009 Proc., First Quarter pages 3–67
Amended September 2009, see 2009 Proc., Third Quarter
Amended October 2011, see Proc., Summer 2011
Amended December 2015, see Proc., Spring 2016
NAIC Policy Statement on Open Meetings
Revised: April 1, 2014

The NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories. NAIC members are the elected and appointed state government officials who, along with their departments and staff, regulate the conduct of insurance companies and agents in their respective state or territory. The NAIC is committed to conducting its business openly. This policy statement applies to meetings of NAIC committees, subcommittees, task forces and working groups. It does not apply to Roundtable discussions, zone meetings, commissioners’ conferences, and other like meetings of the members. Applicable meetings will be open unless the discussion or action contemplated will include:

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

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

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

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

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

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

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

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

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

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

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

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

Revisions Adopted by the NAIC Membership, April 1, 2014

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2019 COMMITTEE STRUCTURE

Plenary

Executive Committee

(EX1) Subcommittee

Internal Administration

Information Systems Task Force

(A) Committee

Life Insurance and Annuities

Life Actuarial Task Force

(B) Committee

Health Insurance and Managed Care

Health Actuarial Task Force

Long-Term Care Insurance (E/B) Task Force

(see also Financial Condition (E) Committee)

Regulatory Framework Task Force

Senior Issues Task Force

(C) Committee

Property and Casualty Insurance

Casualty Actuarial and Statistical Task Force

Surplus Lines Task Force

Title Insurance Task Force

Workers’ Compensation Task Force

(D) Committee

Market Regulation and Consumer Affairs

Antifraud Task Force

Market Information Systems Task Force

Producer Licensing Task Force

(E) Committee

Financial Condition

Accounting Practices and Procedures Task Force

Capital Adequacy Task Force

Examination Oversight Task Force

Long-Term Care Insurance (E/B) Task Force

(see also Health Insurance and Managed Care (B) Committee)

Receivership and Insolvency Task Force

Reinsurance Task Force

Risk Retention Group Task Force

Valuation of Securities Task Force

(F) Committee

Financial Regulation Standards and Accreditation

(G) Committee

International Insurance Relations

NAIC/Consumer Liaison Committee

NAIC/American Indian and Alaska Native Liaison Committee

NAIC/Industry Liaison Committee

NAIC/State Government Liaison Committee

Updated August 2, 2019

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<table>
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<tr>
<th>APPOINTED and DISBANDED GROUPS</th>
<th>Effective Date</th>
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<tr>
<td>Accelerated Underwriting (A) Working Group</td>
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<tr>
<td>Climate Risk and Resilience (C) Working Group</td>
<td>2019-04-07</td>
<td>Anne Obersteadt</td>
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<td>Dave Fleming</td>
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<td>Bill Rivers</td>
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<td>Technical Consulting (EX1) Working Group</td>
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<td>Cheryl McGee</td>
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<td>Travel Insurance (C) Working Group</td>
<td>2018-08-05</td>
<td>Denise Matthews</td>
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Updated November 1, 2019

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# MEMBERS BY ZONE

## Northeast Zone

<table>
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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Elizabeth Kelleher Dwyer, Chair</td>
<td>Rhode Island</td>
</tr>
<tr>
<td>Stephen C. Taylor, Vice Chair</td>
<td>District of Columbia</td>
</tr>
<tr>
<td>Jessica Altman, Secretary</td>
<td>Pennsylvania</td>
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<tr>
<td>Andrew N. Mais</td>
<td>Connecticut</td>
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<tr>
<td>Trinidad Navarro</td>
<td>Delaware</td>
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<tr>
<td>Eric A. Cioppa</td>
<td>Maine</td>
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<tr>
<td>Gary Anderson</td>
<td>Massachusetts</td>
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<tr>
<td>Al Redmer Jr.</td>
<td>Maryland</td>
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<tr>
<td>John Elias</td>
<td>New Hampshire</td>
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<tr>
<td>Marlene Caride</td>
<td>New Jersey</td>
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<tr>
<td>Linda A. Lacewell</td>
<td>New York</td>
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<tr>
<td>Michael S. Pieciak</td>
<td>Vermont</td>
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## Southeast Zone

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<tr>
<td>Jim L. Ridling, Chair</td>
<td>Alabama</td>
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<tr>
<td>Mike Chaney, Vice Chair</td>
<td>Mississippi</td>
</tr>
<tr>
<td>Scott A. White, Secretary</td>
<td>Virginia</td>
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<tr>
<td>Allen W. Kerr</td>
<td>Arkansas</td>
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<td>David Altmaier</td>
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<td>John F. King</td>
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<td>James J. Donelon</td>
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<td>Mike Causey</td>
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<td>Javier Rivera Rios</td>
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<td>Raymond G. Farmer</td>
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<td>Hodgen Mainda</td>
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<td>Tregenza A. Roach</td>
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<td>James A. Dodrill</td>
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## Midwest Zone

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<tr>
<td>Chlora Lindley-Myers, Chair</td>
<td>Missouri</td>
</tr>
<tr>
<td>Larry Deiter, Vice Chair</td>
<td>South Dakota</td>
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<tr>
<td>Jillian Froment, Secretary</td>
<td>Ohio</td>
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<tr>
<td>Robert H. Muriel</td>
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<td>Stephen W. Robertson</td>
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<tr>
<td>Doug Ommen</td>
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<td>Vicki Schmidt</td>
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<td>Anita G. Fox</td>
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<td>Steve Kelley</td>
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<td>Bruce R. Ramge</td>
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<td>Jon Godfread</td>
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<tr>
<td>Glen Mulready</td>
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<td>Mark Afable</td>
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## Western Zone

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<tr>
<td>Lori K. Wing-Heier, Chair</td>
<td>Alaska</td>
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<tr>
<td>John G. Franchini, Vice Chair</td>
<td>New Mexico</td>
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<tr>
<td>Andrew Stolfi, Secretary</td>
<td>Oregon</td>
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<tr>
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<td>Jeff Rude</td>
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*Updated November 15, 2019*
# EXECUTIVE (EX) COMMITTEE

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<tbody>
<tr>
<td>Eric A. Cioppa, President</td>
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<tr>
<td>Raymond G. Farmer, President-Elect</td>
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<tr>
<td>David Altmaier, Vice President</td>
<td>Florida</td>
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<tr>
<td>Dean L. Cameron, Secretary-Treasurer</td>
<td>Idaho</td>
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<tr>
<td>Most Recent Past President</td>
<td>Louisiana</td>
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## Northeast Zone

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<tr>
<td>Elizabeth Kelleher Dwyer, Chair</td>
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<tr>
<td>Stephen C. Taylor, Vice Chair</td>
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## Southeast Zone

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<td>Jim L. Ridling, Chair</td>
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<tr>
<td>Mike Chaney, Vice Chair</td>
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## Midwest Zone

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<td>Chlora Lindley-Myers, Chair</td>
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<td>Larry Deiter, Vice Chair</td>
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<td>Jillian Froment, Secretary</td>
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## Western Zone

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<tr>
<td>John G. Franchini, Vice Chair</td>
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<td>Andrew Stolfi, Secretary</td>
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NAIC Support Staff: Andrew J. Beal/Kay Noonan

*Updated July 8, 2019*
FINANCIAL STABILITY (EX) TASK FORCE
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<td>Michael S. Pieciak</td>
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NAIC Support Staff: Scott Morris/Denise Matthews

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Artificial Intelligence (EX) Working Group
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NAIC Support Staff: Denise Matthews
INNOVATION AND TECHNOLOGY (EX) TASK FORCE (Continued)

Big Data (EX) Working Group
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Kendall Buchanan  South Carolina
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INNOVATION AND TECHNOLOGY (EX) TASK FORCE (Continued)

Speed to Market (EX) Working Group
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NAIC Support Staff: Petra Wallace/Leana Massey/Tim Mullen/Randy Helder
NAIC Technical Support: Brandy Woltkamp
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of the Executive (EX) Committee

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Kentucky
James J. Donelon
Louisiana
Eric A. Cioppa
Maine
Gary Anderson
Massachusetts
Anita G. Fox
Michigan
Steve Kelley
Minnesota
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Nebraska
Barbara D. Richardson
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Jessica Altman
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Barbara D. Richardson  Nevada
Jillian Froment  Ohio
Glen Mulready  Oklahoma

NAIC Support Staff: Jim Woody
INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

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NAIC Support Staff: Andrew J. Beal/Kay Noonan/Jim Woody

INFORMATION SYSTEMS (EX1) TASK FORCE
of the Internal Administration (EX1) Subcommittee

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<td>Al Redmer Jr., Chair</td>
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<td>West Virginia</td>
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NAIC Support Staff: Cheryl McGee/Sherry Stevens
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NAIC Support Staff: Greg Welker
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<th>State</th>
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<tbody>
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<td>Florida</td>
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<tr>
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<td>Susan Bernard</td>
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<tr>
<td>Philip Barlow</td>
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<td>Kevin Fry</td>
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<td>Roy Eft</td>
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<td>Kathleen Orth</td>
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<td>John Rehagen/Karen Milster</td>
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<td>Justin Schrader</td>
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<td>Dave Wolf</td>
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<tr>
<td>Trey Hancock/Rachel Jade-Rice</td>
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<tr>
<td>Mike Boerner/Doug Slape</td>
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<td>Doug Stolte/David Smith</td>
<td>Virginia</td>
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<tr>
<td>Amy Malm</td>
<td>Wisconsin</td>
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</tbody>
</table>

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NAIC Support Staff: Jane Barr
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NAIC Support Staff: Eva Yeung/Crystal Brown
Catastrophe Risk (E) Subgroup  
of the Property and Casualty Risk-Based Capital (E) Working Group  
of the Capital Adequacy (E) Task Force

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<tr>
<td>Tom Botsko, Chair</td>
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<td>John G. Franchini</td>
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<td>Mike Causey</td>
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<td>Jon Godfread</td>
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### NAIC MEMBER TENURE LIST

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**ALASKA—Appointed, at the Pleasure of the Commissioner of Commerce, Community and Economic Development**

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**AMERICAN SAMOA—Appointed, at the Pleasure of the Governor**

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#### ARIZONA—Appointed, at the Will of the Governor; 6-Year Term

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**Colorado—Appointed, at the Pleasure of the Governor; 2-Year Term**

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### COLOMBIA—Continued

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### CONNECTICUT—Appointed, at the Pleasure of the Governor; 4-Year Term

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<td>Katharine ‘Katie’ L. Wade</td>
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| DELAWARE—Elected; 4-Year Term         | Trinidad Navarro            | 1/3/2017  | incumbent |
| Insurance Commissioner                | Karen Weldin Stewart        | 1/6/2009  | 1/3/2017  | 8            | 0             |
| Insurance Commissioner                | Matthew Denn                | 1/4/2005  | 1/6/2009  | 4            | 0             |
| Insurance Commissioner                | Donna Lee Williams          | 1/1/1993  | 1/4/2005  | 12           | 0             |
| Insurance Commissioner                | David N. Levinson           | 1/1/1985  | 1/1/1993  | 8            | 0             |
| Insurance Commissioner                | David Elliot                | 1/1/1977  | 1/1/1985  | 8            | 0             |
| Insurance Commissioner                | Robert A. Short             | 1/1/1963  | 1/1/1977  | 14           | 0             |
| Insurance Commissioner                | Harry S. Smith              | 1/1/1955  | 1/1/1963  | 8            | 0             |
| Insurance Commissioner                | William R. Murphy           | 1/1/1953  | 1/1/1955  | 2            | 0             |
| Insurance Commissioner                | William J. Swain            | 1/1/1939  | 1/1/1953  | 14           | 0             |
| Insurance Commissioner                | J. Postles Hammond          | 1/1/1935  | 1/1/1939  | 4            | 0             |
| Insurance Commissioner                | James G. Shaw               | 1/1/1927  | 1/1/1935  | 8            | 0             |
| Insurance Commissioner                | Charles M. Hollis           | 1/1/1923  | 1/1/1927  | 4            | 0             |
| Insurance Commissioner                | William J. Swain            | 7/1/1922  | 1/1/1923  | 0            | 6             |
| Insurance Commissioner                | Horace Sudler               | 1/1/1921  | 7/1/1922  | 1            | 6             |
| Insurance Commissioner                | T.R. Wilson                 | 1/1/1917  | 1/1/1921  | 4            | 0             |
| Insurance Commissioner                | William R. McCabe           | 1/1/1913  | 1/1/1917  | 4            | 0             |
| Insurance Commissioner                | Charles H. Maull            | 1/1/1909  | 1/1/1913  | 4            | 0             |
| Insurance Commissioner                | George W. Marshall          | 1/1/1901  | 1/1/1909  | 8            | 0             |
| Insurance Commissioner                | Edward Fowler               | 1/1/1897  | 1/1/1901  | 4            | 0             |
| Insurance Commissioner                | Peter K. Meredith           | 1/1/1893  | 1/1/1897  | 4            | 0             |
| Insurance Commissioner                | R. M. Fooks                 | 8/1/1890  | 1/1/1893  | 2            | 5             |
| Insurance Commissioner                | Isaac N. Fooks              | 3/23/1889 | 8/1/1890  | 1            | 5             |
| Insurance Commissioner                | Nathan Pratt                | 8/1/1885  | 8/1/1889  | 4            | 0             |
| Insurance Commissioner                | Henry C. Douglas            | 9/1/1884  | 8/1/1885  | 0            | 11            |
| Insurance Commissioner                | John R. McFee               | 7/1/1879  | 9/1/1884  | 5            | 2             |
| Secretary of State                    | Ignatius Cooper Grubb       | 10/18/1871| 7/1/1879  | 7            | 9             |
| Secretary of State                    | John Henry Paynter          | 5/24/1871 | 10/18/1871| 0            | 5             |

| DISTRICT OF COLUMBIA—Appointed, at the Pleasure of the Mayor | | | | | |
| Commissioner of Insurance              | Stephen C. Taylor           | 11/3/2015 | incumbent |
| Acting Commissioner of Insurance       | Stephen C. Taylor           | 6/19/2015 | 11/3/2015  | 0            | 5             |
| Acting Commissioner of Insurance       | Chester A. McPherson        | 5/6/2014  | 6/19/2015  | 1            | 1             |
| Interim Commissioner of Insurance      | Chester A. McPherson        | 11/18/2013| 5/6/2014  | 0            | 6             |
## NAIC MEMBER TENURE LIST

### DISTRICT OF COLUMBIA—Continued

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### FLORIDA—Appointed, at the Pleasure of the Financial Services Commission

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© 2019 National Association of Insurance Commissioners
## NAIC MEMBER TENURE LIST

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### NAIC MEMBER TENURE LIST

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

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© 2019 National Association of Insurance Commissioners
# NAIC MEMBER TENURE LIST

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# Kentucky—Appointed, at the Pleasure of the Governor

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**Louisiana—Elected; 4-Year Term**

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### MARYLAND — Appointed, at the Pleasure of the Governor: 4-Year Term

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### MASSACHUSETTS — Appointed, at the Discretion of the Governor

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## MICHIGAN—Appointed, at the Pleasure of the Governor; 4-Year Term

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© 2019 National Association of Insurance Commissioners
## NAIC Member Tenure List

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**MINNESOTA—Appointed, at the Pleasure of the Governor; Confirmed by the Senate**

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### MISSISSIPPI—Elected: 4-Year Term

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<td>Mike Chaney (Re-elected 11/5/2019)</td>
<td>1/1/2008</td>
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© 2019 National Association of Insurance Commissioners
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<tr>
<td>Superintendent of Insurance</td>
<td>Albert B. Lewis</td>
<td>1/5/1978</td>
<td>3/7/1983</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Thomas A. Harnett</td>
<td>6/24/1975</td>
<td>7/20/1977</td>
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<td>Superintendent of Insurance</td>
<td>Lawrence W. Keepnews</td>
<td>3/18/1975</td>
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<td>Benjamin R. Schenck</td>
<td>1/1/1971</td>
<td>3/10/1975</td>
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<td>Henry Root Stern, Jr.</td>
<td>1/28/1964</td>
<td>12/31/1966</td>
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<tr>
<td>Acting Superintendent of Insurance</td>
<td>Samuel C. Cantor</td>
<td>10/3/1963</td>
<td>1/27/1964</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Thomas Thacher</td>
<td>1/27/1959</td>
<td>10/2/1963</td>
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<td>Superintendent of Insurance</td>
<td>Julius S. Wikler</td>
<td>3/17/1958</td>
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<td>Alfred J. Bohlinger</td>
<td>7/1/1950</td>
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<td>Superintendent of Insurance</td>
<td>Louis H. Pink</td>
<td>5/10/1935</td>
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<td>Superintendent of Insurance</td>
<td>George S. Van Schaick</td>
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<td>Henry A. Thellusson</td>
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<td>Thomas F. Behan</td>
<td>7/1/1930</td>
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<td>Albert Conway</td>
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<td>Superintendent of Insurance</td>
<td>James A. Beha</td>
<td>7/1/1924</td>
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<td>Superintendent of Insurance</td>
<td>Francis R. Stoddard, Jr.</td>
<td>12/1/1921</td>
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<td>Henry D. Appleton</td>
<td>11/1/1921</td>
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<td>Jesse S. Phillips</td>
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<td>William H. Hotchkiss</td>
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<td>Francis Hendricks</td>
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<td>Robert A. Maxwell</td>
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<td>John A. McCall, Jr.</td>
<td>4/23/1883</td>
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<td>Charles G. Fairman</td>
<td>4/27/1880</td>
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<tr>
<td>NORTH CAROLINA—Elected; 4-Year Term</td>
<td>Commissioner of Insurance</td>
<td>Mike Causey</td>
<td>1/1/2017</td>
<td>incumbent</td>
<td>0</td>
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<td></td>
<td>Commissioner of Insurance</td>
<td>Wayne Goodwin</td>
<td>1/1/2017</td>
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<td>Commissioner of Insurance</td>
<td>John P. Ingram</td>
<td>1/1/1977</td>
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<td>Commissioner of Insurance</td>
<td>Waldo C. Cheek</td>
<td>6/1/1949</td>
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<td>Commissioner of Insurance</td>
<td>W. P. Hodges</td>
<td>9/1/1942</td>
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<td>Commissioner of Insurance</td>
<td>Daniel C. Boney</td>
<td>11/1/1927</td>
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<td>Stacey W. Wade</td>
<td>1/1/1921</td>
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<td>James R. Young</td>
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<td>Secretary of State</td>
<td>Cyrus Thompson</td>
<td>1/1/1897</td>
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<td>Secretary of State</td>
<td>C. M. Cooke</td>
<td>8/1/1895</td>
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<td>Octavius Coke</td>
<td>4/1/1891</td>
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<td>Secretary of State</td>
<td>William L. Saunders</td>
<td>1/1/1879</td>
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<td>J. A. Englehard</td>
<td>1/1/1877</td>
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<td>Secretary of State</td>
<td>W. H. Howerton</td>
<td>1/1/1873</td>
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<td>No Record in Proceedings (Represented by Special Delegate William H. Finch)</td>
<td>10/1/1871</td>
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<td>NORTH DAKOTA—Elected; 4-Year Term</td>
<td>Commissioner of Insurance</td>
<td>Jon Godfred</td>
<td>1/3/2017</td>
<td>incumbent</td>
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<td>Commissioner of Insurance</td>
<td>Adam Hamm</td>
<td>10/9/2007</td>
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<td>Acting Commissioner of Insurance</td>
<td>Rebecca Ternes</td>
<td>9/1/2007</td>
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<td>Jim Poolman</td>
<td>1/1/2001</td>
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<td>Commissioner of Insurance</td>
<td>Glenn Pomeroy</td>
<td>1/1/1993</td>
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<td>Earl Pomeroy</td>
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<td>Commissioner of Insurance</td>
<td>Jorris O. Wigen</td>
<td>1/1/1981</td>
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<td>Byron Knutson</td>
<td>1/1/1977</td>
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<td>Karsten O. Nygard</td>
<td>12/1/1965</td>
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<td>Frank Albers</td>
<td>12/1/1963</td>
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<td>Alfred J. Jensen</td>
<td>12/1/1951</td>
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<td>Otto Krueger</td>
<td>8/15/1945</td>
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<td>Oscar E. Erickson</td>
<td>1/1/1937</td>
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<td>1/7/1935</td>
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<td>1/2/1917</td>
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<td>Walter C. Taylor</td>
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<td>Ernest C. Cooper</td>
<td>1/1/1905</td>
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<td>Commissioner of Insurance</td>
<td>Ferdinand Leutz</td>
<td>11/13/1900</td>
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<td>George H. Harrison</td>
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<td>Frederick B. Fouche</td>
<td>2/5/1895</td>
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<td>J. C. McManima</td>
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<td>James A. Ward</td>
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<td>E. L. Cadwell</td>
<td>3/11/1885</td>
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<tr>
<td>NORTHERN MARIANA ISLANDS—Appointed, Concurrent with Current Governor</td>
<td>Secretary of Commerce Mark O. Rabauliman</td>
<td>3/1/2015</td>
<td>incumbent</td>
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<td>Acting Secretary of Commerce Mark O. Rabauliman</td>
<td>9/1/2014</td>
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<td>11/1/2011</td>
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<td>Acting Secretary of Commerce Sixto K. Igisomar</td>
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<td>Secretary of Commerce Michael J. Ada</td>
<td>8/1/2008</td>
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<td>Cmrs. of Banking and Insurance James A. Santos</td>
<td>5/1/2006</td>
<td>8/1/2008</td>
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<td>1/1/2006</td>
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<tr>
<td>OHIO—Appointed, at the Pleasure of the Governor; Confirmed by the Senate</td>
<td>Director of Insurance Jillian E. Froment</td>
<td>3/31/2017</td>
<td>incumbent</td>
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<td>Lt. Governor/Director of Insurance Mary Taylor</td>
<td>1/10/2011</td>
<td>3/31/2017</td>
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<td>Director of Insurance Mary Jo Hudson</td>
<td>1/8/2007</td>
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<td>Director of Insurance Ann Womer Benjamin</td>
<td>1/6/2003</td>
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<td>Interim Director of Insurance Holly Saelens</td>
<td>11/29/2002</td>
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<td>Director of Insurance Lee Covington</td>
<td>5/7/1999</td>
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<td>4/1/1999</td>
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<td>Interim Director of Insurance David Meyer</td>
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<td>9/1/1982</td>
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<td>Director of Insurance Robert L. Ratcliff, Jr.</td>
<td>1/1/1980</td>
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<td>Director of Insurance Kenneth E. DeShetler</td>
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<td>Superintendent of Insurance Robert L. Mullins</td>
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### NAIC MEMBER TENURE LIST

#### OHIO—Continued

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#### OKLAHOMA—Elected; 4-Year Term

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#### OREGON—Appointed, Indefinite

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### PENNSYLVANIA—Appointed, at the Discretion of the Governor

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© 2019 National Association of Insurance Commissioners
### NAIC MEMBER TENURE LIST

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### PUERTO RICO—Appointed, Indefinite

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| **SOUTH CAROLINA**—Appointed, at the Will of the Governor | | | | | |
| Director of Insurance | Raymond G. Farmer | 11/13/2012 | incumbent | | |
| Acting Director of Insurance | Gwendolyn Fuller McGriff | 12/1/2011 | 11/13/2012 | 0 | 11 |
| Director of Insurance | David Black | 2/1/2011 | 12/1/2011 | 0 | 10 |
| Director of Insurance | Scott H. Richardson | 2/15/2007 | 2/1/2011 | 4 | 0 |
| Director of Insurance | Eleanor Kitzman | 2/1/2005 | 2/15/2007 | 2 | 0 |
| Co-Acting Director of Insurance | Gwendolyn Fuller & Tim Baker | 8/1/2004 | 2/1/2005 | 0 | 6 |
| Director of Insurance | Ernst Csiszar | 1/26/1999 | 8/1/2004 | 5 | 7 |
| Director of Insurance | Lee P. Jedziniak | 7/1/1995 | 1/26/1999 | 3 | 6 |
| Director of Insurance | Susanne Murphy | 3/1/1995 | 7/1/1995 | 0 | 4 |
| Director of Insurance | John G. Richards | 2/1/1985 | 3/1/1995 | 10 | 1 |
| Director of Insurance | Rogers T. Smith | 10/1/1981 | 2/1/1985 | 3 | 4 |
| Director of Insurance | John W. Lindsay | 7/1/1975 | 10/1/1981 | 6 | 3 |
| Director of Insurance | Howard B. Clark | 1974 | 7/1/1975 | 1 | |
| Acting Director of Insurance | Howard B. Clark | 1974 | 1975 | 0 | |
| Acting Director of Insurance | Glen E. Craig | 12/1/1973 | 1974 | 1 | |
| Acting Director of Insurance | L. H. Mengedoht | 6/1/1973 | 12/1/1973 | 0 | 6 |
| Commissioner of Insurance | John W. Lindsay | 1970 | 6/1/1973 | 3 | |
| Commissioner of Insurance | Leroy M. Brandt | 1969 | 1970 | 1 | |
| Commissioner of Insurance | Charles W. Gambrell | 1964 | 1969 | 5 | |
| Commissioner of Insurance | William F. Austin | 1960 | 1964 | 4 | |
| Commissioner of Insurance | R. Lee Kelly | 1954 | 1960 | 6 | |
## SOUTH CAROLINA—Continued

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## SOUTH DAKOTA—Appointed, at the Pleasure of the Secretary of the Department of Labor and Regulation

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### TENNESSEE—Appointed, at the Discretion of the Governor

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### TEXAS—Appointed; 2-Year Term

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**VIRGIN ISLANDS—Elected: 4-Year Term**

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## NAIC MEMBER TENURE LIST

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Dated: 12/4/2019

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# NAIC MEETING RECORD

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

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1. Sept. 23, 1886: John K. Tarbox (MA) was elected President for the 1887 Convention; Samuel H. Cross (RI) was elected Vice-President; and Robert B. Brinkerhoff (OH) was elected Secretary. Mr. Tarbox died before the Convention assembled. Mr. Cross and Mr. Brinkerhoff retired as Vice-President and Secretary. Oliver Pillsbury (NH) was chosen to preside over the 1887 Convention. It is unknown who acted as Vice-President. Jacob A. McEwen (OH) was chosen to act as Secretary.

2. Aug. 21, 1890: Charles B. Allan (NE) was elected Secretary for the 1891 Convention; however, he resigned before the Convention assembled. Sept. 30, 1891: J. J. Brinkerhoff (IL) was elected Secretary for the 1891 Convention.

3. Sept. 18, 1895: William M. Hahn (OH) was elected President for the 1896 Convention and James R. Waddill (MO) was elected Vice-President; however, Mr. Hahn became functus Officio before the Convention assembled. Sept. 22, 1896: Mr. Waddill was elected President for the 1896 Convention and Stephen W. Carr (ME) was chosen to act as Vice-President.

4. Sept. 23, 1896: James R. Waddill (MO) was elected President for the 1897 Convention and Stephen W. Carr (ME) was elected Vice-President; however, Mr. Waddill was out of office at the date of the Convention. Sept. 7, 1897: Commissioner Carr was elected President for the 1897 Convention. It is unknown who acted as Vice-President.
5. Sept. 23, 1896: Frederick L. Cutting (MA) was elected Secretary for the 1897 Convention; however, he was out of office at the date of the Convention. Sept. 7, 1897: J. J. Brinkerhoff (IL) was elected Secretary for the 1897 Convention. 
6. Sept. 7, 1897: Frederick L. Cutting (MA) was elected Secretary for the 1898 Convention; however, he declined the offer. Sept. 13, 1898: J. J. Brinkerhoff (IL) was elected Secretary for the 1898 Convention.
7. Sept. 15, 1898: Elmer H. Dearth (MN) was elected President for the 1899 Convention; however, he was out of office at the date of the Convention. Sept. 5, 1899: Edward T. Orear (MO) was elected President for the 1899 Convention.
8. Sept. 20, 1900: J. A. O'Shaughnessy (MN) was elected President for the 1901 Convention; however, he was out of office at the date of the Convention. September 1901: William H. Hart (IN) was elected President for the 1901 Convention.
9. Sept. 29, 1910: Theodore H. Macdonald (CT) was elected Vice-President for the 1911 Convention; however, he was out of office at the date of the Convention. It is unknown who acted as Vice-President.
10. Aug. 25, 1911: Harry R. Cunningham (MT) was elected Secretary for the 1912 Convention; however, he resigned before the Convention assembled. March 1912: Fitz Hugh McMaster (SC) was elected Secretary for the 1912 Convention.
11. Aug. 1, 1913: Willard Done (UT) was elected First Vice-President for the 1914 Convention; however, he resigned before the Convention assembled. It is unknown who acted as First Vice-President.
12. Aug. 31, 1917: Emory H. English (IA) was elected President for the 1918 Convention; Robert J. Merrill (NH) was elected First Vice-President; and Michael J. Cleary (WI) was elected Second Vice-President. November 1917: Mr. Merrill resigned as First Vice-President. Dec. 6, 1917: Mr. Cleary was elected First Vice-President for the 1918 Convention and Walter K. Chorn (MO) was elected Second Vice-President. Jan. 1, 1918: Mr. English resigned as President and Mr. Cleary was elected President for the 1918 Convention by the Executive (EX) Committee. It is unknown who acted as First Vice-President.
13. Aug. 31, 1917: Fitz Hugh McMaster (SC) was elected Secretary for the 1918 Convention; however, he resigned before the Convention assembled. Dec. 6, 1917: Joseph Button (VA) was elected Secretary for the 1918 Convention.
14. Sept. 12, 1919: John B. Sanborn (MN) was elected Second Vice-President for the 1920 Convention; however, he resigned before the Convention assembled. June 1920: Alfred L. Harty (MO) was chosen to act as Second Vice-President for the 1920 Convention.
15. Sept. 3, 1920: Frank H. Ellsworth (MI) was elected President for the 1921 Convention; Alfred L. Harty (MO) was elected First Vice-President; and Thomas B. Donaldson (PA) was elected Second Vice-President. June 27, 1921: Mr. Ellsworth resigned as President; Mr. Harty was elected President for the 1921 Convention by the Executive (EX) Committee; Mr. Donaldson was elected First Vice-President; and Platt Whitman (WI) was elected Second Vice-President.
16. Sept. 8, 1922: Platt Whitman (WI) was elected President for the 1923 Convention; H. O. Fishback (WA) was elected First Vice-President; and John C. Luning (FL) was elected Second Vice-President. July 1, 1923: Commissioner Whitman resigned as President; Commissioner Fishback was elected President for the 1923 Convention by the Executive (EX) Committee; and Mr. Luning was elected First Vice-President by the Executive (EX) Committee. It is unknown who acted as Second Vice-President.
17. Sept. 18, 1925: W. R. C. Kendrick (IA) was elected President for the 1926 Convention. January 1926: Commissioner Kendrick resigned and Harry L. Conn (OH) was elected President for the 1926 Convention.
18. Nov. 19, 1926: Harry L. Conn (OH) was elected President for the 1927 Convention and Albert S. Caldwell (TN) was elected First Vice-President. April 1927: Superintendent Conn resigned as President. May 3, 1927: Commissioner Caldwell was elected President for the 1927 Convention and James A. Beha (NY) was elected First Vice-President.
19. Sept. 26, 1928: Charles R. Detrick (CA) was elected President for the 1929 Convention; James A. Beha (NY) was elected First Vice-President; and Howard P. Dunham (CT) was elected Second Vice-President. Jan. 1, 1929: Superintendent Beha resigned as First Vice-President. Commissioner Dunham was elected First Vice-President for the 1929 Convention. April 1929: Commissioner Detrick resigned as President. Commissioner Dunham was elected President for the 1929 Convention; Clarence C. Wysong (IN) was elected First Vice-President; and Jess G. Read (OK) was elected Second Vice-President.
20. Sept. 19, 1929: Joseph Button (VA) was elected Secretary for the 1930 Convention. Dec. 10, 1929: Commissioner Button resigned and Albert S. Caldwell (TN) was elected Secretary for the 1930 Convention.
21. Sept. 9, 1930: Clarence C. Wysong (IN) was elected President for the 1931 Convention; Jess G. Read (OK) was elected First Vice-President; and Clare A. Lee (OR) was elected Second Vice-President. January 1931: Commissioner Wysong resigned as President; Commissioner Lee was no longer serving as Second Vice-President; and Commissioner Read was elected President by the Executive (EX) Committee for the 1931 Convention. June 17, 1931: Charles D. Livingston (MI) was elected First Vice-President by the Executive (EX) Committee for the 1931 Convention and William A. Tarver (TX) was elected Second Vice-President by the Executive (EX) Committee.

22. Oct. 20, 1932: William A. Tarver (TX) was elected President for the 1933 Convention; Garfield W. Brown (MN) was elected First Vice-President; and Dan C. Boney (NC) was elected Second Vice-President. 1933: Commissioner Tarver was no longer acting as President and Commissioner Brown was elected President for the 1933 Convention. Commissioner Boney was chosen to act as First Vice-President for the 1933 Convention and George S. Van Shaick (NY) was chosen to act as Second Vice-President.

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

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

25. June 6, 1945: Edward L. Scheufler (MO) was elected Vice-President for the 1946 Convention; however, he resigned before the Convention assembled. Dec. 3, 1945: Robert E. Dineen (NY) was elected Vice-President by the Executive (EX) Committee for the 1946 Convention.

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

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

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

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

30. June 1962: Joseph S. Gerber (IL) was elected Vice-President; however, he resigned before the June 1963 Convention assembled. The office of Vice President was vacant for the June 1963 Convention.

31. June 1964: Cyrus E. Magnusson (MN) was elected President; however, he resigned before the June 1965 Convention assembled. William E. Timmons (IA) was elected President by the Executive (EX) Committee to fill the unexpired term.

32. June 1968: Charles R. Howell (NJ) was elected President; however, he resigned effective Feb. 28, 1969. Ned Price (TX) was elected by the Executive (EX) Committee to fill the unexpired term.

33. June 1970: Richard E. Stewart (NY) was elected President; however, he resigned effective December 1970. Lorne R. Worthington (IA) was elected by Plenary to fill the unexpired term.

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

35. Ken E. DeShetler (OH) was elected President; however, he resigned effective January 1975. William H. Huff, III (IA) was elected by the Executive (EX) Committee to fill the unexpired term.

36. H. Peter Hudson (IN) was elected President; however, he resigned effective Nov. 15, 1979. It is unknown who presided over the December 1979 Convention.

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

38. David J. Lyons resigned effective June 17, 1994, as NAIC Vice President and Iowa Commissioner of Insurance. A special interim Plenary election was held June 12, 1994: Arkansas Insurance Commissioner Lee Douglass was elected Vice President to serve June 17, 1994, to Dec. 31, 1994.
39. September 2001: NAIC members unanimously agreed that its 2001 Fall National Meeting should be canceled in the wake of the tragic events that occurred Sept. 11, 2001. The meeting was scheduled for Sept. 22–25, 2001, at the Marriott and Westin Copley Place hotels in Boston, Massachusetts.

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

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

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

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

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


46. Michael F. Consedine resigned effective Jan. 20, 2015, as NAIC President-Elect and Pennsylvania Insurance Commissioner. A special Plenary interim election was held via conference call Feb. 8, 2015: Missouri Insurance Director John M. Huff was elected President-Elect to serve from Feb. 8, 2015, to Dec. 31, 2015.

47. Sharon P. Clark resigned effective Jan. 11, 2016, as NAIC President-Elect and Kentucky Insurance Commissioner. A special Plenary interim election was held in Bonita Springs, Florida, on Feb. 7, 2016: Wisconsin Insurance Commissioner Ted Nickel was elected President-Elect; Tennessee Insurance Commissioner Julie Mix McPeak was elected Vice President; and Maine Insurance Superintendent Eric A. Cioppa was elected Secretary-Treasurer to serve from Feb. 7, 2016, to Dec. 31, 2017.

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

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

The following is a listing of NAIC model laws, regulations and guidelines referenced in the Proceedings of the 2019 Fall National Meeting.

Advertisements of Life Insurance and Annuities Model Regulation (#570)
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Annual Financial Reporting Model Regulation (#205)
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Annuity Disclosure Model Regulation (#245)
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Charitable Gift Annuities Exemption Model Act (#241)
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Charitable Gift Annuities Model Act (#240)
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Coordination of Benefits Model Regulation (#120)
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Corporate Governance Annual Disclosure Model Act (#305)
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Corporate Governance Annual Disclosure Model Regulation (#306)
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Credit for Reinsurance Model Law (#785)
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Guideline: Alternative to Section 712 of Insurer Receivership Model Act (#555) (proposed)
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Health Benefit Plan Network Access and Adequacy Model Act (#74)
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Health Carrier Prescription Drug Benefit Management Model Act (#22)  
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CALL TO ORDER

Welcome to the 228th session of the National Association of Insurance Commissioners (NAIC). The meeting will now come to order.

INTRODUCTION OF HEAD TABLE

Honorable James J. Donelon, NAIC Past President and Louisiana Insurance Commissioner
Honorable Raymond G. Farmer, NAIC President-Elect and South Carolina Insurance Director
Honorable Kent Sullivan, Texas Insurance Commissioner
Honorable Dean L. Cameron, NAIC Secretary-Treasurer and Idaho Insurance Director
Honorable David Altmaier, NAIC Vice President and Florida Insurance Commissioner
Andrew J. Beal, NAIC Chief Operating Officer (COO) and Chief Legal Officer (CLO)
Michael F. Consedine, NAIC Chief Executive Officer (CEO)

WELCOME TO SPECIAL GUESTS

I would like to recognize our new members (video plays).

Next, I would like to take a moment to extend a welcome to special guests of the NAIC.

It is my pleasure to begin with our state legislator colleagues, who represent some of the best elected officials in our states’ capitols.

Each year, we make a special effort to reach out to state government officials. The work they do in our states goes hand in hand with the regulatory framework. Understanding the challenges we all face and getting their unique perspectives is vital to forming solid regulatory policies. Please take a moment to recognize our state official and legislator colleagues. Would our state government officials please stand?

We also have representatives from several federal government agencies, including the Federal Emergency Management Agency (FEMA), the Federal Insurance Office (FIO), the Financial Stability Oversight Council (FSOC), the Federal Reserve, the U.S. Department of the Treasury and the U.S. Department of Labor.

I’d like to also recognize our international colleagues from the International Association of Insurance Supervisors (IAIS), as well as a number of insurance regulators from around the globe.

Please join me in a round of applause to welcome our colleagues from the state and federal government, as well as the international community.

INTRODUCTION OF HOST

It is now my distinct pleasure to invite our Fall National Meeting host to the podium. I’ve asked Texas Insurance Commissioner Kent Sullivan to say a few words as he welcomes us to his home state.

HOST WELCOME

Thank you. Welcome to Austin. Welcome to Texas. They say everything is bigger in Texas, but nothing here is bigger than football. In Texas, this is just your typical $70 million high school football stadium. Well, OK, it’s big too if your “something else” is the big University of Texas (UT)-University of Oklahoma (OU) football rivalry.

Earlier this year, when I was minding my own business, my colleague from Oklahoma, Commissioner Glen Mulready, called and suggested a friendly wager over the UT-OU game. The loser would wear the other team’s jersey at the NAIC Fall National Meeting.
I knew immediately that this was a bad bet. I mean, think about it. If he loses, he wears a UT jersey in Austin, Texas—the home of the University of Texas. That’s no big deal. If I lose, I’m wearing an OU jersey in Austin, Texas. That’s a very big deal. That’s potentially life-threatening. But I felt I needed to uphold my state’s honor and take the bet.

And I had one advantage. I didn’t go to UT. You see, if I’d gone to UT, I’d have been focused on Texas actually winning the football game. Instead, I attended the University of Virginia (UVA), where we were terrible in football—and proud of it. Even our cheerleaders at UVA didn’t think we could win. The primary cheer from the sidelines was “beat the point spread.”

So, I used my UVA skill set and told Glen I’d take the bet, but I needed the line, ten-and-a-half points. He said he’d be good to me and not treat it like a rate increase request. Then he gave me 10. OU won, but only by seven. So, I felt back at home. My team lost, but I’d beat the point spread. So, we have a personalized, custom-fitting Longhorns jersey for Glen to wear. You’ll see it on him soon. He’s a good sport and a good friend.

In all seriousness, welcome to Austin and our Fall National Meeting. We hope you enjoy our fair city and we have a good, productive meeting.

What we do here is important. We regulate an industry that touches the lives of virtually every American. People count on insurance during their toughest times. And that means they count on us. Our task as regulators is constantly growing more difficult. We regulate an industry that is financially complex and technologically sophisticated. The market is growing in scope and speed and that creates a separate and unique set of challenges.

Here’s some of what we’re facing in Texas. You see how issues have grown and resources have stayed the same or even decreased. I suspect your situation isn’t much different. So how do we keep up? Well, we need to work together, and the NAIC can help us do that. It’s an organization that needs to help us share ideas, create coordinated and comprehensive solutions to national issues, and keep pace with potential technological solutions. Our regulated community may think that state agencies create bureaucratic barriers. But try dealing with state procurement rules and legislative appropriation! Sometimes the very nature of government impedes our ability to be nimble and stay ahead of the curve, particularly things like the technological curve. That’s a key area where the NAIC can help us. And it speaks to why our work here is so important.

I’d also like to challenge us to look at the issues we’re facing in a new way. Issues such as narrowing health networks, the use of big data, self-driving cars, artificial intelligence and the sharing economy. In this environment, the old canard “this is the way we’ve always done it” is simply not going to work anymore.

We need meaningful innovation. We need user-friendly solutions to solve practical problems. And we need plain-language communication so that our policyholders can understand how best to purchase and effectively use insurance products.

I look forward to discussing these issues with you over the next few days. And finally, I want to acknowledge a serious problem that I know many of you in the audience have, and that is finding the commissioner you’re looking for when you need to speak with him or her. I think that I can help you in one small way. Starting this afternoon, if you’re looking for the Oklahoma commissioner, he’ll be the guy in the Longhorns jersey.

Thanks to all of you. Thanks to my friend Glen and all of our colleagues in Oklahoma. Welcome to Austin!

**PRESIDENTIAL ADDRESS**

*Eric A. Cioppa, NAIC President*

Thank you, Commissioner Sullivan. Some of you have noticed the theme for our meeting is “Bigger in Texas.” It’s appropriate because the global insurance market is big, with more than $1.2 trillion dollars in net premiums written. Not to mention the size of the NAIC: 56 members strong, backed by nearly 11,000 state insurance regulators and 500 NAIC staff.

It’s a good thing we are so well supported, because our vision is equally ambitious. In Texas fashion, for us it was either “go big or go home.” We chose to “go big” in 2019. Whether it was taking on and achieving critical domestic and international priorities, or the continued progress on our strategic plan, *State Ahead*, we did not shy away from the big, tough issues and challenges. To the contrary, we embraced these challenges and laid out large-scale ideas and overarching objectives to propel us to meet the needs of the insurance markets of the future.

In keeping with the Texas-sized theme, this meeting is sizeable. They say little pieces make up the big picture. With nearly 100 official meetings in five days, it is certainly true here. Looking back to our Spring National Meeting in Orlando, we set out goals for 2019 and made a commitment to achieve real, meaningful progress on each.
I know none of us, myself included, did this for a personal legacy, but because we truly believe each of these areas is critical to the future of insurance regulation, both here in the U.S. and abroad.

This reminds me of my favorite Harry Truman quote: “It is amazing what you can accomplish if you do not care who gets the credit.” That fits for all the members around this table.

I am proud of the work of this body, in both long strides and incremental steps. Let me share with you some of that progress on each of our key initiatives that now form our collective legacy.

Annuities are lifetime protection for many Americans, and it’s important that those products are suitable for those purchasing them. To make sure NAIC guidance reflects changes since the model was first adopted in 2003, we are working through a number of updates.

In 2019 we made significant advancements in revising the NAIC Suitability in Annuity Transactions Model Regulation to evolve into a best interest standard, consistent with market trends and complimentary action at the federal level. The current strategy focuses on alignment, where appropriate, with the U.S. Security and Exchange Commission’s (SEC) regulations to enhance regulatory consistency.

Progress on this important initiative highlighted one of the most enduring qualities of NAIC members—our ability to find consensus in areas where others fall victim to partisanship and politics. It’s often been remarked that regardless of the states we come from, their size, their politics or demographics, we put that all aside when we enter these rooms and are bound by our common duties as regulators and our shared commitment to policyholders.

Related to policyholder protection is the very real issue of solvency and stability in the long-term care insurance market. This year, the NAIC appointed the Long-Term Care Insurance (EX) Task Force, an executive-level task force focused on rate coordination and consistency of long-term care insurance products. Tough topics, and while there is more work to be done, important progress was made this year.

We’ve known for some time there is no “silver bullet” that is going to solve the complex issues surrounding long-term care. If we can tackle individual elements, progress will be made. After all, the best way to eat a Texas-sized plate of barbecue is one bite at a time, and we’re doing just that.

But just as we need to resolve legacy issues, we need to keep an eye to the future. I know many of you joined us yesterday for the Center for Insurance Policy and Research’s (CIPR) fall program, “The State of Long-Term Care Insurance.” There is a need for innovation and fresh thinking in this space, and programs like these should help drive a productive conversation forward.

Health insurance markets remain a focus for insurance regulators. The NAIC supports member efforts to stabilize their markets while advocating for state flexibility and control, especially for the unique challenges faced by the territories. We remain one of the few national organizations not paralyzed on the topic of health care.

That’s not to suggest our members don’t have different points of view on health care; they do. One of our greatest strengths is that the nature of our state-based system can serve as laboratories of innovation, especially when we are united in a common cause for consumers.

An example of our consumer-centric focus on health care was our push for air ambulance balance billing reforms. In September, the U.S. Department of Transportation formed the Air Ambulance and Patient Billing Advisory Committee and appointed 13 members, including a state insurance regulator. This is a great opportunity and huge challenge, so we are lucky to have the world’s tallest politician advocating for us on the committee.

Another record was set this year in our communication collaboration efforts. To help educate consumers about the dangers of flood and wildfire, the NAIC partnered with state insurance departments, the Federal Insurance and Mitigation Administration and FEMA. In partnership, we launched the “Your Risk is Real” integrated consumer campaign. Education leads to preparation, and preparation makes communities more resilient.

For everyone sitting around this table and in this room, this is not just a sector priority; this is a generational priority. I know Director Farmer in his upcoming year as NAIC president is going to take on climate risk and resiliency as his top issue. We are committed to being part of the solution to this global crisis. History will not forgive complacency.
We all know natural disasters are becoming more frequent, costly and Texas-sized. I hope you will join us on Sunday for the “CIPR Policy Workshop: Natural Disaster Resiliency.” Tying together the needs of consumers, businesses large and small, and innovations in mitigation tools, this program promises to open a lively discussion about recovery.

On the federal side, the NAIC continues to support a long-term reauthorization of the National Flood Insurance Program (NFIP). We are hopeful that there will not be another lapse in the program, and all of you can help. Please reach out to your members of Congress and share your support for reauthorization of the NFIP.

Keeping ahead of changes in the insurance sector has always been a challenge this body has faced head-on. Technology-based innovations are no different. In addition to our work on adoption of the NAIC Insurance Data Security Model Law (#668) by the states, we are developing tools and resources to keep this membership informed.

We continue to develop resources for members and for the public, to engage, learn and look forward to upcoming challenges so we can tackle them together.

From a policy perspective, how we balance the regulation of data usage, artificial intelligence and privacy will be a defining moment for this sector. We have taken all that we’ve learned in prior years and are now applying it in the development of informed policymaking in these critical areas.

While innovations are exciting and challenging, the core of what we do is rooted in protecting policyholders through monitoring company solvency. To this end, we have made progress on the development of a group capital calculation. When finalized, this calculation will provide additional analytical information for use in assessing group risks and capital adequacy.

The NAIC finalized group capital calculation specifications for further evaluation and field-testing in 2019. Through our coordination with the Federal Reserve throughout the process, our method largely aligns with their “building block approach,” which, again, will lead to enhanced regulatory consistency in the U.S.

While domestic negotiations are never easy, they are a cakewalk compared to some of the pressures we face internationally. Despite being the world’s largest insurance market—and, for reference, Texas is twice the size of Germany—we are constantly pushing back against other jurisdictions’ approaches to regulation.

In 2019, we saw intense negotiations internationally, regarding the development of an international insurance capital standard by the IAIS.

Despite some extraordinary challenges, the NAIC was ultimately successful in executing our strategy and achieving our objectives for the next stage of development. We took what had only been a beachhead for our aggregation method two years ago and turned it into a global front-line.

While the U.S. does not plan to implement the reference ICS, Team USA remains committed to protecting U.S. consumers and companies that engage globally. I believe we have a clear path forward to that end.

Changes globally will impact companies in the U.S., whether they are international standards or tied to other financial sectors. A global understanding of the factors that impact our insurance markets is imperative. To that end, the NAIC continued to work on the U.S. regulatory framework’s program on liquidity risks, with a focus on life insurers due to their potential for large-scale economic impact. Our Macroprudential Initiative will give regulators more data points to better scope the risks taken on by the insurers they regulate.

In addition to executing on our policy priorities, I’ve been privileged to be president as we have moved forward on many of the objectives laid out in the State Ahead framework. Some highlights include enhanced tools for state insurance departments, better and more training opportunities for state regulators, and improved actuarial modeling resources.

We have enhanced financial analysis tools, improved data modeling capabilities and updated consumer resources. State Ahead is our blueprint for the future of the NAIC. Every person sitting around this table has played a part in helping with the construction of that future. And like so many things with the NAIC, we are not building this just for ourselves, but for the generations of regulators to come. We have a 150-year legacy to protect and we can all be proud of the role we’ve played in adding to the rich tapestry that is the NAIC.
At this point, the outgoing president typically turns to the president-elect to tell him or her about the shoes they have to fill or to offer advice. I’m not going to do that today. I wouldn’t do that do you. Instead, I turn to all of you around the table and in the audience.

I know Ray will do his part. I’m asking that all of you support him and continue to do your part. It is so important that everyone in this room participate, engage, support and—when necessary—push back. Together, we will set our course, adjust and ultimately advance the state-based system of insurance regulation.

Our collective resources and talents are immense. Leveraging these assets can and will position us not only for the next year, but for decades to come.

PERSONAL REMARKS

Eric A. Cioppa, NAIC President

Now I’d like to take a few minutes to offer some thanks. First, to the members around this table.

I’d like to personally thank you for the support, encouragement and, yes, pushback and frank discussions we’ve had. I think we are a better organization for it. I think I’ve made some friendships that will last me a lifetime. I very much appreciate all the support I’ve had this year.

Next, I want to offer my thanks to my staff back at home. The last two years, I think I’ve spent the majority of it on the road. They worked hard to support me. It’s nice to know that at home we didn’t miss a beat. Maybe that says what I’m doing is not necessary, but whatever. I have to thank them.

And next the officers. I can’t tell you how many times every single one of the officers has said to me, “What can I do to help?” And it wasn’t for anything other than they wanted to help. And I know I made life-long friends. I’d personally like to thank each and every officer for their support and a wonderful experience.

And then the NAIC itself. I can’t say enough about the NAIC. Mike and Andy, the faces of the NAIC, do an outstanding job. And the members behind Mike and Andy do an outstanding job. They move heaven and earth to make us succeed. And they work hard with one goal in mind: to enhance state regulation and propel us forward. And I want to thank them for all their work and efforts.

And finally, the most important person in the room, she’s my Mike and Andy rolled into one. My wife, Kathy, who is here somewhere. I think she’s in the row back there. She’s been more than patient in my years as an officer. The last two years, I’ve been on the road. I was sitting in Arizona where it was 80 degrees. I called home three-and-a-half feet of snow on the ground. She didn’t complain.

I was in Kuala Lumpur. In Maine, we have a lot of trees. And where we have a lot of trees and you get a bad storm, you lose power for several days. So, we have a personal generator that we use when we lose power. I usually hook it up, but when I was gone, she had to learn how to hook it up and run the generator. Which is good and I very much appreciate it. But when I got home, my son quipped. “You know, Dad, now that Mom knows how to run the generator, if she learns how to use the chainsaw, you’re pretty much obsolete.” I now hide my chainsaw when I go on the road.

Above all, thanks to my wife, Kathy, of 37 years. Thank you for everything.

AWARDS

Eric A. Cioppa, NAIC President

It is my honor to have the opportunity to recognize a few members who show exceptional dedication to the NAIC and insurance regulation with a special award.

In 1989, the NAIC established the Robert Dineen Award in honor of the founder of the NAIC’s Central Office in Kansas City. Robert Dineen was an attorney, insurance regulator and insurance executive. Throughout his career, he was a strong advocate for the preservation of state-based insurance regulation and played a major role in strengthening state regulation after Congress passed the McCarran-Ferguson Act in the 1930s. He served as superintendent of the New York State Insurance Department from 1943 to 1950. He then joined Northwestern Mutual Life Insurance Company in 1950 as a vice president and, ultimately, became president in 1965. In 1968, he was brought on as a consultant to NAIC.
His impressive career set us on a course of active and significant research and analysis. His work affected insurance legislation and regulation in every state and had a major impact on the structure of the American insurance industry. Each year, we present the Dineen Award to state insurance department staff members who exemplify the best of insurance regulation.

First, from Rhode Island, is Jack Broccoli. Jack, will you and Superintendent Elizabeth Kelleher Dwyer please join me at the podium?

Jack exemplifies in every respect what a regulator should be. He is tough yet balanced and fair, with a work ethic that is truly exceptional. Jack has provided more than 30 years of public service not only to the people of Rhode Island but also to insurance consumers across the country and around the world. He developed his own financial analysis tools that were adopted by many states across the country, including the Comprehensive Annual Analysis (CAA) and the Comprehensive Quarterly Analysis (CQA).

Once again, congratulations to you, Jack, and many thanks for your outstanding work on behalf of state-based insurance regulation.

Next, we would like to recognize Patrick McNaughton. Patrick, will you and Commissioner Mike Kreidler (WA) please join me at the podium?

Patrick has played a significant role in the insurance regulatory system, both at the state and national level, with all he has accomplished in his career with the Washington State Office of the Insurance Commissioner and the NAIC. Given his upcoming retirement at year’s end, Patrick embodies the spirit of the award. He consistently goes the extra mile to further and better the state-based system of insurance regulation.

Again, thank you, Patrick, for your commitment to our efforts. Congratulations!

These two regulators represent what’s greatest about what we do to safeguard consumers and promote a strong insurance regulatory environment. Please join me in congratulating them both.

**ADJOURNMENT**

*Eric A. Cioppa, NAIC President*

With that, I officially conclude this Opening Session of the 228th meeting of the National Association of Insurance Commissioners.
To: Members of the NAIC and Interested Parties
From: The Staff of the NAIC

Committee Action

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

EXECUTIVE (EX) COMMITTEE AND PLENARY (Joint Session)
Dec. 10, 2019

1. Adopted the report of the Executive (EX) Committee, which met Dec. 8 and took the following action:
   a. Adopted the report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which met Dec. 7.
   b. Adopted its Nov. 18 and Oct. 7–8 interim meeting report.
   c. Adopted the reports of its task forces: the Financial Stability (EX) Task Force; the Government Relations (EX) Leadership Council; the Innovation and Technology (EX) Task Force; and the Long-Term Care Insurance (EX) Task Force.
   d. Adopted its 2020 proposed charges.
   e. Adopted Requests for NAIC Model Law Development to amend: 1) the Insurance Holding Company System Regulatory Act (#440); 2) the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450); and 3) the Unfair Trade Practices Act (#880).
   f. Received a status report on the NAIC State Ahead strategic plan implementation.
   g. Received a status report on model law development efforts.
   h. Heard reports from the National Insurance Producer Registry (NIPR) and the Interstate Insurance Product Regulation Commission (Compact).
2. Adopted by consent the committee, subcommittee and task force minutes of the Summer National Meeting.
3. Adopted the NAIC 2020 proposed budget.
4. Adopted the NAIC 2020 proposed committee charges.
5. Received the following committee reports: the Life Insurance and Annuities (A) Committee; the Health Insurance and Managed Care (B) Committee; the Property and Casualty Insurance (C) Committee; the Market Regulation and Consumer Affairs (D) Committee; the Financial Condition (E) Committee; the Financial Regulation Standards and Accreditation (F) Committee; and the International Insurance Relations (G) Committee.
6. Adopted the 2020 Generally Recognized Expense Table (GRET).
7. Adopted Actuarial Guideline LII—Variable Annuity Early Adoption (AG 52).
9. Adopted the Post-Disaster Claims Guide.
10. Adopted amendments to the Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (#1556).
12. Adopted the Re-Evaluation of Qualified Jurisdictions and Summary of Findings and Determinations for Bermuda, France, Germany, Ireland, Japan, Switzerland and the United Kingdom (UK) for the NAIC List of Qualified Jurisdictions.
13. Adopted the Evaluation of Reciprocal Jurisdiction and Summary of Findings and Determinations for Bermuda, Japan and Switzerland for the NAIC List of Reciprocal Jurisdictions.
14. Adopted revisions to Part D: Primary Licensing, Redomestications and Change of Control of the Accreditation Standards.
15. Received a status report on state implementation of NAIC-adopted model laws and regulations.
16. Received the results of the 2020 zone officer elections. Midwest Zone: Director Larry Deiter, Chair (SD); Director Jillian Froment, Vice Chair (OH); and Commissioner Doug Ommen, Secretary (IA). Northeast Zone: Commissioner Stephen C. Taylor, Chair (DC); Commissioner Jessica Altman, Vice Chair (PA); and Commissioner Gary Anderson, Secretary (MA). Southeast Zone: Commissioner Jim L. Ridling, Chair (AL); Commissioner Mike Chaney, Vice Chair (MS); and Commissioner James J. Donelon, Secretary (LA). Western Zone: Director Lori K. Wing-Heier, Chair (AK); Commissioner Michael Conway, Vice Chair (CO); and Commissioner Andrew Stolfi, Secretary (OR).
17. Elected the 2020 NAIC officers: Director Raymond G. Farmer, President (SC); Commissioner David Altmaier, President-Elect (FL); Director Dean L. Cameron, Vice President (ID); and Director Chlora Lindley-Myers, Secretary-Treasurer (MO).

EXECUTIVE (EX) COMMITTEE
Dec. 8, 2019
1. Adopted the report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which met Dec. 7 and took the following action:
   a. Adopted its Nov. 18, Oct. 7–8 and Summer National Meeting minutes.
   b. Adopted the Internal Administration (EX1) Subcommittee’s Nov. 26 and Oct. 18 minutes, which included the following action:
      1. Received an update on the Defined Benefit Plan portfolio as of Sept. 30.
      2. Received an update on the NAIC long-term investment plan portfolio as of Sept. 30.
      3. Ratified the vote to begin restructuring the Defined Benefit Plan portfolio to implement the liability driven investment (LDI) strategy.
      4. Approved the 2020 proposed charges for the Internal Administration (EX1) Subcommittee and the Information Systems (EX1) Task Force.
   c. Adopted the report of the Audit Committee, which met Dec. 3 and took the following action:
      1. Received an overview of the Oct. 31 financial statements.
      2. Received an update on the 2019/2020 Service Organization Control (SOC) 1 and SOC 2 reviews and reports.
      3. Received an update on database filing fee payments.
      4. Received an update on zone financials.
   d. Adopted the report of the Information Systems (EX1) Task Force, which met Dec. 6 and took the following action:
      1. Received an update on three draft 2020 fiscals with a technology component.
      2. Received an operational report for the NAIC’s information technology (IT) activities.
      3. Received a portfolio update, which includes 20 active projects, and a summary of three projects completed since the Summer National Meeting.
      4. Reaffirmed the Audit Committee Charter.
   e. Approved a recommendation on a vendor and funding to conduct a System for Electronic Rate and Form Filing (SERFF) assessment.
   f. Approved the release of a fiscal to conduct a principal-based reserve (PBR) yearly renewable term (YRT) reinsurance study for public review and comment.
   g. Heard a presentation on the NAIC branding project, which includes updating the NAIC logo.
   h. Received the joint chief executive officer (CEO)/chief operating officer (COO) report.
   i. Received a cybersecurity briefing.
2. Adopted the report of the Executive (EX) Committee, which met Nov. 18 and Oct. 7–8 and took the following action:
   a. Approved the NAIC 2020 proposed budget and recommended the budget be adopted by the full NAIC membership at the Fall National Meeting.
   b. Approved recommendations for the NAIC’s Defined Benefit Plan Fund Investments.
   c. Adopted the investment policy statement (IPS) for the NAIC’s long-term funds.
   d. Adopted the IPS for the NAIC’s defined benefit plan and the defined contribution plan.
   e. Adopted the Information Systems (EX1) Task Force’s 2020 proposed charges.
   f. Adopted the Internal Administration (EX1) Subcommittee’s 2020 proposed charges.
   g. Exposed the NAIC 2020 proposed budget, including five fiscals, for a public comment period ending Nov. 7.
3. Adopted its 2020 proposed charges.
4. Adopted Requests for NAIC Model Law Development to amend: 1) the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Regulation with Reporting Forms and Instructions (#450); and 2) the Unfair Trade Practices Act (#880).
5. Received a status report on the NAIC State Ahead strategic plan implementation.
6. Received a status report on model law development efforts for amendments to the: Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); Annuity Disclosure Model Regulation (#245); Suitability in Annuity Transactions Model Regulation (#275); Health Maintenance Organization Model Act (#430); Life Insurance Disclosure Model Regulation (#580); Mortgage Guaranty Insurance Model Act (#630); and the following new models: the Real Property Lender-Placed Insurance Model Act; the Pet Insurance Model Act; and the Pharmacy Benefit Manager (PBM) Model Law.
7. Heard reports from NIPR and the Compact.
10. Adopted the report of the Innovation and Technology (EX) Task Force. See the Task Force listing for details.
11. Adopted the report of the Long-Term Care Insurance (EX) Task Force. See the Task Force listing for details.

Financial Stability (EX) Task Force
Dec. 9, 2019
1. Adopted its Summer National Meeting minutes.
2. Adopted the report of the Liquidity Assessment (EX) Subgroup.
3. Exposed the proposed 2019 NAIC Liquidity Stress Test Framework jointly with the Liquidity Assessment (EX) Subgroup for a 60-day public comment period ending Feb. 7.
4. Heard an update on Financial Stability Oversight Council (FSOC) developments.
5. Received an update from the Receivership and Insolvency (E) Task Force on its work to address the Task Force’s referral letter to undertake analysis relevant to the Macroprudential Surveillance Initiative.
6. Heard an update on collateralized loan obligations (CLO) stress tests.
7. Heard an update on macroprudential surveillance.
8. Received an update from the Valuation Analysis (E) Working Group on the Task Force’s referral to assess a potential concern related to the American Academy of Actuaries’ (Academy) economic scenario generators (ESGs).

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

Innovation and Technology (EX) Task Force
Dec. 9, 2019
1. Adopted its Oct. 18 minutes, which included the following action:
   a. Adopted its Summer National Meeting minutes.
   b. Adopted the Sept. 5 minutes of the Artificial Intelligence (EX) Working Group.
   c. Adopted its 2020 proposed charges, which include a few relatively minor changes from its 2019 charges.
   d. Heard a consumer representative request for an InsurTech bulletin.
   e. Adopted a Request for NAIC Model Law Development to revise the Unfair Trade Practices Act (#880).
   f. Discussed comments related to the North Dakota anti-rebating bulletin.
2. Adopted the report of the Artificial Intelligence (EX) Working Group, which met Dec. 7 and took the following action:
   a. Reviewed a draft principles document from the North Dakota Insurance Department as a “strawman” for moving forward to complete the deliverable.
   b. Discussed comments related to the Organisation for Economic Co-operation and Development (OECD) Artificial Intelligence Principles as a basis for developing artificial intelligence (AI) principles for the insurance industry.
   d. Decided to meet at least once via conference call prior to the 2020 Spring National Meeting to discuss the comments and the draft.
3. Adopted the report of the Big Data (EX) Working Group, which met Dec. 7 and took the following action:
   a. Adopted its Oct. 7 minutes, which included the following action:
      1. Heard a presentation from ISO Claims Solutions regarding the use of big data in fraud detection and claims settlement. The presentation provided information on ISO’s ClaimSearch database.
      2. Discussed the use of big data in fraud detection and claim settlement, which included two presentations from ISO and a presentation from the National Insurance Crime Bureau (NICB), and discussed the Working Group members’ views on whether state insurance regulators have the appropriate regulatory authority under existing unfair trade laws and unfair claims settlement regulations to address marketplace practices.
      3. Received an update on the work of the Casualty Actuarial and Statistical (C) Task Force. The Task Force continues to facilitate training and sharing of expertise on predictive analytics through webinars and conference calls on Nov. 26, Oct. 22, Oct. 8 and Aug. 27. The Task Force continues to work on its draft white paper on best practices for the regulatory review of predictive analytics and is reviewing comments from 11 interested parties.
      4. Discussed an update on the work of the Accelerated Underwriting (A) Working Group, which held an organizing conference call on Oct. 2 to review a work plan for accomplishing its charge. The work plan contemplates three general phases to accomplish its work. The first phase is information gathering. The second phase is to identify issues and the best ways to address them (white paper, model bulletin, model law or something else). The third phase is to develop a work product by the 2020 Fall National Meeting.
      5. Received an update on NAIC technical and non-technical rate review trainings. In addition to “book club” calls, the NAIC is developing technical and non-technical training. The technical training will be conducted by the NAIC’s consultant, Dorothy Andrews (Actuarial & Analytics Consortium LLC), and will focus on training actuaries and statisticians. The non-technical training will target rate filing reviewers and market conduct examiners. This training
will focus on evaluating rate classes for unfair discriminations and understanding when additional actuarial assistance is needed.

f. Received a presentation from Birny Birnbaum (Center for Economic Justice—CEJ) on the role of advisory organizations and the need to create the accountability and regulatory oversight of new vendors of big data algorithms as contemplated in antitrust laws and advisory organization statutes.

4. Adopted the report of the Speed to Market (EX) Working Group, which met Dec. 3 and Sept. 12 and took the following action:
   a. Discussed the System for Electronic Rate and Form Filing (SERFF) enhancements and prioritization of several focus areas, including: submission validations, review tools, workload management, performance and reliability, the Search function, document management, reporting and data export, streamlined correspondence, and user experience.
   b. Heard an update on the survey sent to states about SERFF functionality and received a brief overview of the Request for Proposal (RFP) to conduct a business and technical assessment of SERFF.
   c. Discussed suggestions for 2019 changes to the Life, Accident/Health, Annuity and Credit Uniform Product Coding Matrix (PCM) effective Jan. 1, 2020. Changes related to existing Types of Insurance (TOIs)/sub-TOIs and the addition of new TOIs/sub-TOIs were determined not to be needed, but the Working Group voted to remove references to 2010 dates on Medicare Supplement instructions for all TOIs and sub-TOIs.
   d. Discussed suggestions for 2019 changes to the Property/Casualty (P/C) Uniform PCM effective Jan. 1, 2020, and adopted two description changes and a sub-TOI under 16.0 Workers’ Compensation.

5. Heard a report from NAIC staff on activity of the Innovation and Technology State Contacts group.

6. Discussed options for addressing the anti-rebating issues identified as potentially impeding innovation. Commissioner Jon Godfread (ND) presented an updated version of North Dakota’s draft guideline for addressing the anti-rebating issue in his state. The Task Force decided that work complete and discontinue work on a bulletin to begin work on development of language to amend Model #880 since the Executive (EX) Committee adopted the Request for NAIC Model Law Development to do so. The Task Force asked for volunteers to work on a drafting group to develop this model law language.

7. Heard a report on cybersecurity initiatives. Director Raymond G. Farmer (SC) provided a legislative update on adoption of the Insurance Data Security Model Law (#668) and an update on recent and upcoming cybersecurity tabletop exercises. Cynthia Amman (MO), Privacy Protections (D) Working Group chair, also provided an update on data privacy issues. She said the Working Group is in the process of building the membership list as well as the distribution lists for interested state insurance regulators and interested parties. Additionally, she said that the Working Group met Dec. 8 and took the following action:
   a. Discussed its proposed workplan to meet monthly via conference call to keep on track so it can accomplish its charges by the deadline established.
   b. Received a presentation by Jennifer McAdam (NAIC), during which she reviewed: the NAIC Insurance Information and Privacy Protection Model Act (#670); the Privacy of Consumer Financial and Health Information Regulation (#672); the General Data Protection Regulation (GDPR); the California Consumer Privacy Act (CCPA); and the state data privacy legislation.
   c. Received an update from Kendall Cotton, Montana state auditor, on current legislative activities in the state.
   d. Discussed comments received from the CEJ, the National Association of Mutual Insurance Companies (NAMIC) and the American Property Casualty Association (APCIA).

8. Heard an update on a request from Mr. Birnbaum regarding development of a document that would outline the difference between insurance products and banking and other consumer products for the benefit of startups and other companies new to the insurance industry. The Task Force agreed this should not be a charge to the Task Force but discussed other avenues available to get this information communicated and made available through Center for Insurance Policy and Research (CIPR) products, as well as the NAIC’s Professional Designation Program.

9. Heard an update on the National Conference of Insurance Legislators (NCOIL) insurance modernization activity from U.S. Rep. Matt Lehman (R-IN), vice president of NCOIL.

**Long-Term Care Insurance (EX) Task Force**

**Dec. 9, 2019**

1. Adopted its Oct. 31 and Summer National Meeting minutes, which included adoption of its 2020 proposed charges.

2. Received progress reports on the activities of the Task Force’s workstreams as follows:
   a. The Multi-State Rate Review Practices workstream is refining a set of selection principles and criteria for guiding the development of a recommended rate review methodology.
   b. The Restructuring Techniques workstream is developing its strategic plan.
   c. The Reduced Benefit Options and Consumer Notices workstream conducted a state survey to gather information about states’ practices in reviewing and approving reduced benefit options and the associated consumer notices. The workstream plans to research further and gather more information.
d. The Valuation of Long-Term Care Insurance (LTCI) Reserves workstream continues to focus on work performed at the NAIC on the actuarial review of insurers’ actuarial filings and solvency monitoring.

e. The Non-Actuarial Variance Among States workstream conducted a limited state survey to identify factors affecting rate approvals that are not of an actuarial basis. The workstream plans to gather additional information and begin drafting best practices.

f. The Data Call Design and Oversight workstream issued a request for a proposal to select a consultant to conduct a data call of LTCI insurers in order to accumulate, analyze and describe to NAIC members the current level of rate inequity among the states’ policyholders.

3. Heard comments from interested parties, including Cantilo & Bennett LLP and the American Council of Life Insurers (ACLI).

INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE
See the Executive (EX) Committee and Plenary (joint session) listing for details.

Information Systems (EX1) Task Force
Dec. 6, 2019
1. Adopted its Summer National Meeting minutes.
2. Received an update on three draft 2020 fiscals with a technology component.
3. Received an information technology (IT) operational report on the NAIC’s IT activities, including: a) product highlights; b) innovation and technology; c) service and support; d) data collection metrics; e) team; f) project portfolio summary; and g) technology adoption and system usage. The report provides updates for upcoming improvements, impacts to new state technology offerings from the NAIC and general updates on the activities of the NAIC technology team.
4. Received a project portfolio update, including project status reports for 20 active technical projects and a summary of three projects completed since the Summer National Meeting.
5. Received an update on a new NAIC Technology Products and Services catalog.

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE
Dec. 8, 2019
1. Adopted its Nov. 4 minutes, which included the following action:
   a. Adopted its Summer National Meeting minutes.
   b. Adopted its 2020 proposed charges.
   c. Adopted the Life Actuarial (A) Task Force’s 2020 proposed charges.
   d. Adopted the 2020 Generally Recognized Expense Table (GRET).
   e. Adopted Actuarial Guideline LII—Variable Annuity Early Adoption (AG 52).
2. Discussed comments received on the draft Suitability in Annuity Transactions Model Regulation (#275) and approved the draft as revised during this meeting, with the exception of the draft templates, which were referred back to the Annuity Suitability (A) Working Group for discussion during a conference call to be scheduled before year-end.
3. Adopted the following working group and task force reports: the Annuity Disclosure (A) Working Group, including its Dec. 2, Sept. 19 minutes and an extension of the Request for NAIC Model Law Development; the Life Insurance Illustration Issues (A) Working Group, including its Oct. 21, Sept. 17, Sept. 3, July 30 minutes and an extension of the Request for NAIC Model Law Development; and the Retirement Security (A) Working Group, including its Nov. 13 and Oct. 23 minutes.
4. Adopted the report of the Accelerated Underwriting (A) Working Group, which met Dec. 8 and took the following action:
   a. Adopted its Oct. 2 minutes, which included the following action:
      1. Discussed its draft work plan for completing its charge by the 2020 Fall National Meeting.
   b. Heard a presentation on accelerated underwriting in life insurance from Patrick L. Brockett (The University of Texas at Austin).
   c. Discussed its next steps, which includes additional presentations prior to the 2020 Spring National Meeting.
5. Adopted the report of the Annuity Suitability (A) Working Group, which met Dec. 7 and took the following action:
   a. Adopted its Nov. 5, Oct. 29, Oct. 15, Oct. 8, Sept. 17 and Summer National Meeting minutes, which included the following action:
      1. Reviewed and discussed a draft of proposed revisions to Model #275 developed by the technical drafting group. The draft reflected the framework developed by the Working Group during its discussions at the Summer National Meeting and during its July 29, July 23 and June 20 meetings, which include a best interest standard of conduct in Model #275.
      2. Exposed a draft of proposed revisions to Model #275 for a public comment period ending Sept. 30.
      3. Discussed the comments received by the Sept. 30 public comment period deadline.
      4. Referred the revised draft of Model #275 to the Life Insurance and Annuities (A) Committee for its consideration. As part of that motion, it was noted that in sending the draft to the Committee, it does not mean that each Working
Group member supports every provision in the draft, but that the Working Group has completed its work as directed by the Committee at the Spring National Meeting. The Committee chair exposed the revised draft for a public comment period ending Nov. 26.

6. Adopted the report of the Life Actuarial (A) Task Force, which met Dec. 5–6. See the Task Force listing for details.

**Life Actuarial (A) Task Force**

**Dec. 5–6, 2019**

1. Adopted its Oct. 17, Oct. 3, Sept. 26, Sept. 19 and Sept. 12 minutes, which included the following action:
   a. Adopted its Summer National Meeting minutes.
   b. Adopted its 2020 proposed charges.
   c. Adopted the 2020 Generally Recognized Expense Table (GRET).
   d. Provided direction to the IUL Illustration (A) Subgroup on revising *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest* (AG 49).
   e. Adopted the American Academy of Actuaries (Academy) Life Experience Committee and the Society of Actuaries (SOA) Preferred Mortality Oversight Group Valuation Basic Table Team (Joint Committee) Individual Life Insurance Mortality Improvement Scale Recommendation—for Use with AG 38 and VM-20.
   f. Heard updates on the YRT field test from the Academy YRT Field Test Project Oversight Work Group.

2. Heard an update on the YRT field test from the Academy YRT Field Test Project Oversight Work Group.

3. Heard an update from the Academy Annuity Reserves Work Group on the proposed timeline and approach for the development of a principle-based reserve (PBR) framework for non-variable annuities.

4. Heard an update from the Academy SVL Interest Rate Modernization Work Group on a plan to develop valuation rates for products that pass exclusion tests under the Annuity Reserves Work Group PBR framework for non-variable annuities.

5. Adopted the report of the VM-22 (A) Subgroup.

6. Discussed considerations for changes to the Joint Committee process for developing life mortality improvement factors for use with *Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation* (AG 38) and VM-20, Requirements for Principle-Based Reserves for Life Products.

7. Exposed amendment proposal 2019-33, which applies as appropriate PBR requirements for group insurance contracts with individual risk selection issued under insurance certificates.


9. Exposed amendment proposal 2019-60, which revises the applicability of credibility methods to a company’s business subject to VM-20.

10. Exposed amendment proposal 2019-61, which clarifies that policies with a rider s for universal life with secondary guarantee (ULSG) are excluded from the Life PBR Exemption when the secondary guarantee is material.

11. Heard an update from the SOA on research and education.


13. Submitted a proposal to the Life Insurance and Annuities (A) Committee that it consider forming a guaranteed issue (GI) valuation subgroup.


15. Heard an update on the Request for Proposal (RFP) for the economic scenario generator (ESG).

16. Heard an update on the cessation of the London Interbank Offered Rate (LIBOR) and its possible replacement.


18. Discussed PBR mortality aggregation.

19. Heard an update from the Compact.

20. Adopted the minutes of the IUL Illustration (A) Subgroup, and the Subgroup report, which included directing the Subgroup to revise AG 49 to subject cap buy-ups and index return enhancements to constraints reasonably similar to the constraints to be applied to multipliers.

21. Discussed the Valuation Basic Table (VBT) and Expiring Experience, and comments received on Amendment Proposal Form (APF) 2019-56.

22. Adopted the report of the Experience Reporting (A) Subgroup.


**HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE**

**Dec. 8, 2019**

1. Adopted its Oct. 24 and Summer National Meeting minutes. During its Oct. 24 meeting, the Committee:
   a. Adopted the Health Actuarial (B) Task Force’s 2020 proposed charges, the Regulatory Framework (B) Task Force’s 2020 proposed charges and the Senior Issues (B) Task Force’s 2020 proposed charges.
   b. Adopted its 2020 proposed charges.

2. Adopted the report of the Consumer Information (B) Subgroup, including its Nov. 18, Oct. 21 and Oct. 7 minutes.
3. Adopted the report of the Health Innovations (B) Working Group, which met Dec. 7 and took the following action:
   a. Adopted its Oct. 28 and Summer National Meeting minutes.
   b. Heard two presentations on innovative insurer efforts to contain health care costs. A presentation from UnitedHealth Group (UHG) described the prevalence and causes of wasteful spending, the importance of incentives in driving changed health behaviors, and the benefits of more healthy choices on the part of consumers. A presentation from Medica showed the effects of Medica’s engagement with accountable care organizations (ACOs), which resulted in risk-adjusted cost savings in five of six cases.
   c. Heard a presentation on health care costs from the Health Care Cost Institute (HCCI) on trends in health spending. The HCCI pointed out that due to high prices, costs have increased even as utilization has decreased in recent years. It also noted that value-based care may be having an effect on the margins, but such care has only been rigorously studied in the Medicare context.
   d. Heard a presentation on providers’ reactions to insurer cost containment efforts from the Texas Medical Association (TMA). The presentation described the burden of prior authorization and other utilization management practices, and it recommended greater regulation of prior authorization.
   e. Heard a presentation on consumer priorities for cost containment efforts from Families USA. Families USA shared survey data on the difficulties paying for health care services, discussed state efforts regarding the control of prescription drug costs and recommended surprise billing solutions that do not raise premiums.

4. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on its recent regulatory activities. The CCIIO provided the Committee with a snapshot of current open enrollment, including data on the number of applications submitted and enrollment by subsidized and unsubsidized individuals. The CCIIO also discussed its efforts to provide price transparency in the health care marketplace, which is a top priority for the Trump administration.

5. Heard a presentation from the co-author of the book *Overcharged: Why Americans Pay Too Much for Health Care*. The presentation highlighted the current problems in the health care system leading to high health care costs and solutions to address them.

6. Heard a panel presentation on state surprise billing laws. Representatives from the Texas Department of Insurance (DOI) and the Washington DOI discussed their surprise bill laws highlighting provisions in the laws related to their scope and method of establishing the out-of-network provider payment.

7. Heard an update on legal actions related to the federal Affordable Care Act (ACA), including: 1) a case challenging the constitutionality of the individual mandate and its potential impact on other key ACA provisions; 2) a case challenging the legality of the recent federal association health plan (AHP) regulation; 3) a case challenging the legality of the recent federal short-term, limited-duration plan (STLD) regulation; and 4) a case challenging the legality of the federal government’s refusal to pay participants for full risk corridor amounts.

8. Heard a federal legislative update on congressional legislation and administrative actions of interest to the Committee.

9. Adopted the report of the Health Actuarial (B) Task Force, which met Dec. 6. See the Task Force listing for details.

10. Adopted the report of the Long-Term Care Insurance (E/B) Task Force. See the Task Force listing under the Financial Condition (E) Committee for details.

11. Adopted the report of the Regulatory Framework (B) Task Force. See the Task Force listing for details.

12. Adopted the report of the Senior Issues (B) Task Force. See the Task Force listing for details.

### Health Actuarial (B) Task Force

Dec. 6, 2019

1. Adopted the report of the Health Care Reform Actuarial (B) Working Group, which included the following action:
   a. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on the risk adjustment data validation (RADV) white paper released on Dec. 6.

2. Adopted its Sept. 17, Aug. 27 and Summer National Meeting minutes, which included the following action:
   a. Adopted its 2020 proposed charges.
   b. Received an update from the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) on progress on changes to the 2005 Group Term Life Waiver Mortality and Recovery Table (2005 Table).

3. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which met Dec. 6 and took the following action:
   a. Accepted its Oct. 24, Sept. 24, Aug. 28, Aug. 20 and Summer National Meeting minutes, which included the following action:
      2. Adopted the Long-Term Care Pricing (B) Subgroup’s Sept. 12 minutes, which included the following action:
         a. Discussed group long-term care insurance (LTCI) pricing.
      3. Adopted the report of the Long-Term Care Valuation (B) Subgroup, which included guidance for year-end 2019 *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) filings.
         b. Heard an update from the Academy on LTCI Work Group activities.
c. Heard an update from the Society of Actuaries (SOA) on long-term care insurance (LTCI) research.


5. Heard an update from the SOA on health insurance research.

6. Heard an update from the Academy Health Practice Council.

**Long-Term Care Insurance (E/B) Task Force**

See the Task Force listing under the Financial Condition (E) Committee for details.

**Regulatory Framework (B) Task Force**

Dec. 7, 2019

1. Adopted its Oct. 2 and Summer National Meeting minutes. During its Oct. 2 meeting, the Task Force:
   a. Adopted its 2020 proposed charges.

2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, which included its Nov. 25, Nov. 19, Nov. 4, Oct. 28, Oct. 7 and Sept. 16 minutes. During these meetings, the Subgroup:
   a. Discussed the comments received on Sections 1–5 of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). The Subgroup plans to complete its review of the comments received via conference call after the Fall National Meeting.

3. Adopted the report of the ERISA (B) Working Group, which met Dec. 7 and took the following action:
   a. Adopted its Summer National Meeting minutes.
   b. Discussed association health plans (AHPs), including state legislative and regulatory activity addressing multiple employer welfare arrangements (MEWAs).
   c. Heard from the U.S. Department of Labor (DOL) about its reorganization and continuing willingness to coordinate with the NAIC and the states on issues of mutual interest.
   d. Heard from the Georgetown University Center on Health Insurance Reforms (CHIR) about its Freedom of Information Act (FOIA) request to the DOL for information on MEWA investigations.
   e. Adjourned into regulator-to-regulator session pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

4. Adopted the report of the HMO Issues (B) Subgroup, which included its Nov. 21 and Sept. 16 minutes. During these meetings, the Subgroup:
   a. Exposed the Virginia Insurance Bureau’s recommendations for revising the *Health Maintenance Organization Model Act* (#430) to address inconsistencies and redundancies with the provisions in the *Life and Health Insurance Guaranty Association Model Act* (#520) for public a public comment period ending Oct. 15.
   b. Discussed the Virginia Insurance Bureau’s revised recommendations for revising Model #430 and the Maine Bureau of Insurance’s comments on the revised recommendations.
   c. Adopted a motion to accept Maine’s approach for revising Model #430. The Subgroup plans to review and discuss an initial draft of revisions to Model #430 reflecting Maine’s approach via conference call after the Fall National Meeting.

5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which included its Dec. 2, Oct. 3, Aug. 29, Aug. 22 and Aug. 15 minutes. During these meetings, the Subgroup:
   a. Heard presentations from various stakeholders, including representatives from health insurers, pharmaceutical manufacturers, pharmacy benefit managers (PBMs), academia and consumers. The Subgroup conducted these information-gathering sessions to help inform its discussions on next steps to carry out its 2019 charge to consider developing a new NAIC model to establish a licensing or registration process for PBMs. As part of its 2019 charge, the Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.
   b. Discussed its next steps in making progress on its 2019 charge during a regulator-to-regulator session pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

6. Heard an update from the CHIR’s work related to federal Affordable Care Act (ACA) implementation and other issues of interest to state insurance regulators. The update included a discussion of a forthcoming publication discussing state oversight of health care sharing ministries. There was also discussion of the CHIR’s work related to MEWAs. The CHIR recently published thousands of pages of DOL investigative records regarding MEWAs. The CHIR is continuing to track and analyze state regulatory approaches to MEWAs and short-term, limited-duration plans (STLDPs) in the wake of federal rule changes. The CHIR is also continuing its work to track state reforms affecting the individual market. The presentation also highlighted the CHIR’s future research projects, including projects related to reinsurance and standardized health plans.

7. Heard a presentation on the implementation of the Consumer Purchasing Model in Summit County, CO.
8. Heard a panel presentation from America’s Health Insurance Plans (AHIP) on health care cost trends. The presentation also included affordability recommendations for state insurance regulators to consider.

Senior Issues (B) Task Force
Dec. 7, 2019
1. Adopted its Oct. 16, Sept. 24 and Summer National Meeting minutes, which included the following action:
   a. Adopted a letter to the federal Centers for Medicare & Medicaid Services (CMS).
   b. Adopted its 2020 proposed charges.
2. Heard an update on federal funding for the State Health Insurance Assistance Program (SHIP).
3. Heard about a legislative proposal drafted by U.S. Sen. Pat Toomey (PA), which is based upon one of the long-term care (LTC) policy option recommendations adopted by the Task Force that would allow for retirement account dollars to be used to buy long-term care insurance (LTCI), so families can better plan for long-term services and supports (LTSS) needs.
4. Heard an issue raised by Bonnie Burns (California Health Advocates—CHA) about conflicts between Medicare, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and the Coordination of Benefits Model Regulation (§120).

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE
Dec. 9, 2019
1. Adopted its Nov. 18 minutes, which included the following action:
   a. Adopted its Sept. 10 minutes, which included the following action:
      1. Adopted its Summer National Meeting minutes.
      2. Adopted documents related to the private flood insurance data call.
   b. Adopted additional documents related to the private flood insurance data call, including making the data publicly available.
   c. Discussed proposed blanks changes related to private flood insurance.
   d. Discussed the upcoming Fall National Meeting.
2. Adopted the following working group reports: the Cannabis Insurance (C) Working Group; the Lender-Placed Insurance Model Act (C) Working Group; the Pet Insurance (C) Working Group; and the Transparency and Readability of Consumer Information (C) Working Group.
3. Adopted its 2020 proposed charges.
4. Adopted a blanks request to create a supplement to collect private flood insurance data and to revise the Credit Insurance Experience Exhibit to include private flood coverages.
5. Adopted an extension for revisions to the proposed Real Property Lender-Placed Insurance Model Act.
6. Adopted Considerations for State Insurance Regulators in Building the Private Flood Insurance Market, a document meant to provide state insurance regulators with actions that might be considered to facilitate the growth of the private flood insurance market in their states.
7. Heard a presentation from SBP on work the group does to promote resiliency and mitigation among homeowners pre- and post-disaster.
8. Heard a presentation on underinsurance issues from the American Property Casualty Insurance Association (APCIA) and the National Association of Mutual Insurance Companies (NAMIC).
9. Heard an update on crop insurance from the U.S. Department of Agriculture (USDA) and the National Crop Insurance Services (NCIS).
10. Reported that state insurance regulators are currently reviewing private passenger auto state exhibits created from data collected from statistical agents. The Committee plans to release the private passenger auto report on its website in the near future.
11. Adopted the report of the Catastrophe Insurance (C) Working Group, which met Dec. 7 and took the following action:
   a. Adopted its Summer National Meeting minutes.
   b. Adopted the report of the State Disaster Response Plan drafting group, which included the following action:
      1. Updated the Working Group regarding the status of the State Disaster Response Plan.
      2. Exposed the draft of the State Disaster Response Plan for a 30-day public comment period ending Jan. 6, 2020.
   d. Adopted the NAIC Considerations for State Insurance Regulators in Building the Private Flood Insurance Market. The document will be sent to the Property and Casualty Insurance (C) Committee with comments provided by the Reinsurance Association of America (RAA) and NAMIC.
   e. Heard from FEMA and Milliman on Risk Rating 2.0. The presentation focused on the limitations of the current NFIP rates, as well as the changes FEMA hopes to incorporate in its new risk rating system.
12. Adopted the report of the Climate Risk and Resilience (C) Working Group, which met Dec. 7 and took the following action:
   a. Adopted its Oct. 2 and Summer National Meeting minutes. During its Oct. 2 meeting, the Working Group:
   b. Heard an update on Working Group members’ climate resilience-related activities, which included participation in several key conferences focused on sustainability and resilience.
   c. Discussed the NAIC Climate Risk Disclosure Survey, including climate risk mitigation and resilience measures reported by insurers and the incorporation of the Financial Stability Board (FSB) Task Force on Climate-Related Financial Disclosures (TCFD) guidelines into the response guidelines.
   d. Heard a presentation on the American International Group’s (AIG) newly implemented sustainability strategy and enhanced reporting, including participating in the 2018 TCFD disclosure report.

13. Adopted the report of the Terrorism Insurance Implementation (C) Working Group, which met Dec. 8 and took the following action.
   a. Adopted its Summer National Meeting minutes.
   b. Heard updates on congressional activity related to the federal Terrorism Risk Insurance Act (TRIA), which expires on Dec. 31, 2020. This included a report from NAIC staff on congressional activity related to reauthorization of TRIA, including a summary of testimony from Director Chlora Lindley-Myers (MO) before the House Financial Services Committee. Brooke Stringer (NAIC) also reported the U.S. House of Representatives passed a seven-year TRIA reauthorization bill that does not make substantial changes to the program but requires the Government Accountability Office (GAO) to conduct a study on cyber terrorism risks and calls for further reporting on the affordability and availability of terrorism risk insurance for places of worship.
   d. Heard a presentation from NAIC staff regarding preliminary results from the State Supplement portion of the 2019 terrorism risk insurance data call, including an overview of the quality of the data.

14. Adopted the report of the Casualty Actuarial and Statistical (C) Task Force. See the Task Force listing for details.
15. Adopted the report of the Surplus Lines (C) Task Force. See the Task Force listing for details.
16. Adopted the report of the Title Insurance (C) Task Force. See the Task Force listing for details.
17. Adopted the report of the Workers’ Compensation (C) Task Force. See the Task Force listing for details.

Casualty Actuarial and Statistical (C) Task Force
Dec. 7, 2019
1. Adopted its Summer National Meeting minutes.
2. Adopted its Nov. 12 and Oct. 15 minutes, which included the following action:
   a. Adopted its 2020 proposed charges.
   b. Adopted a revised implementation plan for the Casualty Actuarial Society (CAS)/Society of Actuaries (SOA) Task Force’s Appointed Actuary Continuing Education Verification Process.
   c. Exposed the Best Practices for Regulatory Review of Predictive Analytics white paper for a public comment period ending Nov. 22.
3. Adopted the report of the Actuarial Opinion (C) Working Group, including its Nov. 20 and combined Oct. 4, Oct. 1, Sept. 20, Sept. 12, Sept. 10 and Sept. 6 minutes. During these meetings, the Working Group took the following action:
   e. Discussed Statement of Actuarial Opinion (SAO) statistics.
   f. Discussed the 2019 SAO instructions. The Blanks (E) Working Group issued a correction in October to the version included in the Annual/Quarterly Statement Instructions publication. The revisions are posted on the Blanks (E) Working Group’s web page.
   g. Discussed the 0% intercompany pool and a company’s persistent adverse development.
5. Adopted the oral report of the Statistical Data (C) Working Group. The Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report (Homeowners Report) has been publicly released. The Report on Profitability by Line by State (Profitability Report) and the Competition Database Report are adopted and should be released in December. The Auto Insurance Database Report will be considered for adoption after the Fall National Meeting.
7. Heard a presentation about current pricing practices in the United Kingdom (UK).
9. Discussed the Actuarial Standards Board’s (ASB) request for input on a potential Property/Casualty (P/C) Rate Filing Actuarial Standard of Practice (ASOP). State insurance regulators are asked to submit potential answers to the questions asked by the ASB by Jan. 7, 2020.

10. Heard reports from the American Academy of Actuaries (Academy) regarding the activities of its Committee on Property and Liability Financial Reporting (COPLFR) and its Casualty Practice Council. COPLFR has conducted a webinar and in-person training and is developing a frequently asked questions (FAQ) document on the changes in the 2019 SAO instructions.

11. Heard reports on actuarial professionalism from the Academy, the Actuarial Board for Counseling and Discipline (ABCD), and the ASB.

12. Heard reports on P/C actuarial research from the CAS and the SOA.

Surplus Lines (C) Task Force
Dec. 7, 2019
1. Adopted its Summer National Meeting minutes.
2. Adopted the report of the Surplus Lines (C) Working Group, which met Sept. 26 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings and once during an open session. During the meeting, the Working Group approved four applications for the NAIC Quarterly Listing of Alien Insurers.
3. Discussed comments received regarding a 2020 annual blanks proposal regarding the modification of Schedule T to include a new Part 3 that would add details on “Home State” direct premiums written. The blanks proposal was temporarily tabled, and discussion will continue at the 2020 Spring National Meeting.
4. Received an update on a referral to the Producer Licensing (D) Task Force, including proposed revisions to Standard 37 and Standard 38 of the State Licensing Handbook. Discussion will continue during the Producer Licensing (D) Task Force’s meeting at the Fall National Meeting.
5. Heard details regarding adjustments to exempt commercial purchaser minimum qualifications, which are required every five years.

Title Insurance (C) Task Force
Dec. 8, 2019
1. Adopted its Sept. 25 and Summer National Meeting minutes, which included adoption of its 2020 proposed charges.
2. Heard an update on recent fraudulent activities.
3. Heard a presentation on the title industry, including types of endorsements, market statistics, closing protection letter (CPL) statutes and the effect of mandatory title insurance from Demotech.
4. Heard a presentation on the history of CPLs from Stewart Title and Land Title Guarantee Company of Colorado.
5. Received compiled NAIC information on CPLs.

Workers’ Compensation (C) Task Force
Dec. 9, 2019
1. Adopted its Summer National Meeting minutes.
2. Adopted the report of the NAIC/IAIABC Joint (C) Working Group, which included the following action:
   a. Updated the Task Force regarding the status of the Workers’ Compensation Policy and the Changing Workforce white paper.
   b. Exposed the draft of the Workers’ Compensation Policy and the Changing Workforce white paper for a 30-day public comment period ending Jan. 6, 2020.
3. Heard a presentation regarding official disability guidelines and formularies.

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE
Dec. 9, 2019
1. Adopted its Oct. 1 minutes, which included the following action:
   a. Adopted its Summer National Meeting minutes.
   b. Appointed a new Privacy Protections (D) Working Group to address the charge: “Review state insurance privacy protections regarding the collection, use and disclosure of information gathered in connection with insurance transactions, and make recommended changes, as needed, to certain NAIC models, such as the NAIC Insurance Information and Privacy Protection Model Act (#670) and the Privacy of Consumer Financial and Health Information Regulation (#672), by the 2020 Summer National Meeting.”
2. Adopted its 2020 proposed charges, including the charges of the Antifraud (D) Task Force, the Market Information Systems (D) Task Force and the Producer Licensing (D) Task Force.
3. Adopted a workers’ compensation standardized data request, which will be incorporated into the NAIC Market Regulation
Handbook for the states to voluntarily use to determine if a company follows appropriate procedures with respect to the issuance and/or termination of workers’ compensation policies.

4. Adopted property/casualty (P/C) travel insurance examination standards, which will be incorporated into the NAIC Market Regulation Handbook for the states to voluntarily use for conducting travel insurance company examinations. The standards are based upon the Travel Insurance Model Act (#632).

5. Adopted revisions to the NAIC State Licensing Handbook, which was revised to be consistent with established NAIC policy on producer licensing.

6. Adopted the 2019 Continuing Education Reciprocity (CER) Agreement. This agreement is used to support the use of the CER Form. Continuing education (CE) providers may use the CER Form to streamline the course-approval process in multiple states. Through the reciprocal approval process, the CE provider’s home state conducts a substantive review of the CE course; therefore, non-resident states do not need to perform a similar review for a course previously approved by the home state.

7. Adopted the reports of its working groups: the Advisory Organization Examination Oversight (D) Working Group; the Market Conduct Annual Statement Blanks (D) Working Group; the Market Conduct Examination Standards (D) Working Group; the Market Actions (D) Working Group; and the Market Regulation Certification (D) Working Group. The adoption of the reports included adoption of the following:

8. Heard a presentation on mental health parity examinations from the American Psychiatric Association (APA). The APA provided an overview of existing parity market conduct examination areas of interest and encouraged state insurance regulators to use and expand their parity oversight and enforcement authority.

9. Adopted the report of the Market Analysis Procedures (D) Working Group, which met Dec. 8 and took the following action:
   a. Adopted its Nov. 21, Oct. 31 and Aug. 27 minutes, which included the following action:
      1. Adopted its Summer National Meeting Minutes.
      2. Heard an update on the short-term, limited duration (STLD) data call.
      3. Discussed the analysis of lender-placed Market Conduct Annual Statement (MCAS) data.
      4. Discussed a uniform process for addressing MCAS waiver and extension requests.
      5. Agreed not to include fraternals in the MCAS until a formal proposal is received for their inclusion in the MCAS.
      6. Discussed the addition of “Other Health” as the next line of business in the MCAS.
      7. Heard an update on the STLD data call template.
      8. Adopted “Other Health” as a line of business in MCAS.
      9. Discussed a uniform process for addressing MCAS waiver and extension requests.
   b. Heard an update on the STLD data call. A reminder letter was sent to all companies on Dec. 5 reminding them of the Dec. 13 due date.
   c. Discussed the plan for revising the MCAS Best Practices Guide.
   d. Discussed its 2020 proposed charges.
   e. Discussed the “Other Health” line of business for the MCAS and the process for developing the blank in the Market Conduct Annual Statement Blanks (D) Working Group.

10. Adopted the report of the Privacy Protections (D) Working Group, which met Dec. 8 and took the following action:
    a. Heard a presentation by NAIC legal staff, which included the following:
       1. Reviewed Model #670.
       2. Reviewed Model #672.
       4. Reviewed the California Consumer Privacy Act (CCPA).
       5. Reviewed State Data Privacy Legislation.
    b. Discussed the draft briefing document “Privacy Protection (D) Working Group Workplan” and noted that the Working Group will meet on a regular basis via conference call, perhaps every six weeks beginning in 2020.
    c. Asked for additional Working Group members, interested state insurance regulators and interested parties.
    d. Heard comments from the Center for Economic Justice (CEJ), the National Association of Mutual Insurance Companies (NAMIC), the American Property Casualty Insurance Corporation (APCIC) and the American Council of Life Insurers (ACLI).

11. Adopted the report of the Antifraud (D) Task Force. See the Task Force listing for details.


13. Adopted the report of the Producer Licensing (D) Task Force. See the Task Force listing for details.
Antifraud (D) Task Force
Dec. 8, 2019
1. Adopted its Oct. 31 and Summer National Meeting minutes. During its Oct. 31 meeting, the Task Force took the following action:
   a. Adopted its 2020 proposed charges.
   b. Received updates from the National Insurance Crime Bureau (NICB) and the Coalition Against Insurance Fraud (CAIF).
2. Received an update from the Antifraud Education Enhancement (D) Working Group. The Working Group conducted an investigator safety webinar on Oct. 30. The webinar had more than 300 participants and received a 4.6 out of 5 review.
4. Discussed the fraudulent treatment of consumers. The Task Force was presented with a Buzzfeed article bringing awareness to a potential threat claiming that an alliance between insurers and law enforcement is working against innocent consumers. The Task Force decided to further review and provide an additional update at the 2020 Spring National Meeting.
5. Heard a report from the Healthcare Fraud Prevention Partnership (HFPP) and the resources available to states.
6. Heard reports on antifraud activity from NAIC staff and the CAIF.

Market Information Systems (D) Task Force
Dec. 7, 2019
1. Adopted its Oct. 29 minutes, which included the following action:
   a. Adopted its Summer National Meeting minutes.
   b. Adopted the report of the Market Information Systems Research and Development (D) Working Group, which met Sept. 19 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings, and took the following action: 1) reviewed the outstanding Uniform System Enhancement Request (USER) forms; and 2) reprioritized outstanding projects.
   c. Adopted its 2020 proposed charges.
2. Adopted the report of the Market Information Systems Research and Development (D) Working Group, which met Nov. 19 and Nov. 15 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings. During these meetings, the Working Group took the following action:
   a. Reviewed and prioritized the outstanding USER forms.
   b. Reviewed the Regulatory Information Retrieval System (RIRS) subject matter expert (SME) group’s report and recommendations for changes to the RIRS coding.
   c. Reviewed the Market Information Systems (MIS) data analysis results.
   d. Adopted improvements to address data quality of the Complaints Database System (CDS); the Market Action Tracking System (MATS); RIRS action and effective dates; and provide training on Market Conduct Annual Statement (MCAS) waiver and extension processes.
   e. Adopted the MIS Data Analysis Metric and Recommendations.
   f. Received a report on the outstanding USER forms.
   g. Discussed its new charge to make recommendations for the use of artificial intelligence (AI) in the MIS. The Task Force will receive comments and hear presentations at the 2020 Spring National Meeting.

Producer Licensing (D) Task Force
Dec. 7, 2019
1. Adopted its Oct. 25 minutes, which included the following action:
   a. Adopted its Summer National Meeting minutes.
   b. Adopted its 2020 proposed charges.
   c. Discussed proposed revisions to the NAIC Uniform Licensing Standards (ULS) for surplus lines that would permit a state the flexibility to require both an underlying property/casualty (P/C) license and accident and health (A&H) license, only an underlying P/C license, or only an underlying A&H license prior to the issuance of a resident surplus lines license.
   d. Discussed a draft outline of a white paper to review the role of chatbots in the distribution of insurance.
   e. Discussed NAIC/Financial Industry Regulatory Authority (FINRA) data sharing, which will add new data fields of FINRA’s Central Registration Depository (CRD) number and FINRA active/inactive status to the NAIC’s State Producer Licensing Database (SPLD).
2. Adopted revisions to the NAIC State Licensing Handbook (Handbook), which was revised to be consistent with established NAIC policy on producer licensing.
3. Adopted the 2019 Continuing Education Reciprocity (CER) Agreement. This agreement is used to support the use of the Uniform Continuing Education Reciprocity Course Filing Form (CER Form). Continuing education (CE) providers may use the CER Form to streamline the course-approval process in multiple states. Through the reciprocal approval process, the CE provider’s home state conducts a substantive review of the CE course and, therefore, non-resident states do not need to perform a similar review for a course previously approved by the home state.

4. Discussed the Surplus Lines (C) Task Force request to consider whether the requirement of a resident producer to hold underlying P/C licenses before a surplus lines license is issued should be expanded to permit an A&H license to fulfill this requirement. There continues to be divergent views on what, if any, changes should be made to the ULS for surplus lines. The Task Force decided not to modify the ULS. The Task Force decided it would be better for consumers and industry if each state implements changes to state laws, as needed, as the surplus line market for A&H products develops.

5. Adopted the report of the Producer Licensing Uniformity (D) Working Group, including its Oct. 30, Oct. 10, Sept. 26, Sept. 12, Aug. 29 and Aug. 21 minutes. During these meetings, the Working Group took the following action:
   a. Drafted proposed revisions to the Handbook.
   b. Discussed comments received on the proposed revisions to the Handbook.
   c. Adopted the proposed revisions to the Handbook.

6. Adopted the report of the Uniform Education (D) Working Group, including its Oct. 31 and Aug. 22 minutes. During these meetings, the Working Group took the following action:
   a. Drafted proposed revisions to the CER Agreement.
   b. Discussed comments received on the proposed revisions to the CER Agreement.
   c. Adopted the proposed revisions to the CER Agreement.

7. Heard a report from the NIPR Board of Directors, which met Dec. 6. During this meeting, the Board heard a report from the NIPR Audit Committee, which reported NIPR’s total revenues are $3,555,225 (10.2%) above budget through October, and 13.9% above the prior year. The Board approved NIPR’s 2020 budget, with projected revenues of $46.1 million and projected expenses of $43.3 million. The Board heard an update on the progress of implementing NIPR’s strategic plan, which will be completed in 2020. In addition to the general progress on the plan, two major strategic initiatives have been accomplished this year. NIPR implemented Florida for resident licensing for its individual insurance producers, and it is anticipated Florida’s resident business entities will be available before year-end. Another major accomplishment was a joint NAIC/NIPR security infrastructure initiative, data de-identification. The joint project was part of the NAIC’s State Ahead strategic plan initiative and involved extensive work by the teams to protect personally identifiable information (PII) by masking or de-identifying the PII data in a consistent manner for all NAIC and NIPR non-production technical environments. A third strategic initiative, which is coming in January 2020, is an updated NIPR website design that will provide easier navigation and improve the user experience.

FINANCIAL CONDITION (E) COMMITTEE
Dec. 9, 2019

1. Adopted its Oct. 31, Aug. 29 and Summer National Meeting minutes. During its Oct. 31 and Aug. 29 meetings, the Committee took the following action:
   a. Adopted its 2020 proposed charges.
   b. Adopted a Request for NAIC Model Law Development related to the group capital calculation.
   c. Adopted revisions to the Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (#1556).
   d. Adopted proposed changes to the Annual Statement Instructions – Property/Casualty, specifically related to the Actuarial Opinion, including, among other things, the definition of “qualified actuary.”

2. Adopted the following working group reports: the Group Solvency Issues (E) Working Group; and National Treatment and Coordination (E) Working Group.

3. Adopted the report of the Mortgage Guaranty Insurance (E) Working Group, which met Dec. 8 and took the following action:
   a. Exposed a proposed mortgage guaranty insurance capital model for a 45-day public comment period ending Jan. 22, 2020. The model measures a mortgage insurer’s expected capital based on a portfolio of mortgage loans for which it provides guaranty insurance.
   b. Exposed the revised Mortgage Guaranty Insurance Model Act (#630) for a 45-day public comment period ending Jan. 22, 2020. The model was last updated July 2000, and as a result, the model was substantially overhauled.


5. Adopted the report of the Group Capital Calculation (E) Working Group, which met Dec. 7 and took the following action:
   a. Adopted its Oct. 30, Aug. 29 and Summer National Meeting minutes, which included the following action:
      1. Adopted a revised memorandum on debt.
      2. Adopted a Request for NAIC Model Law Development related to the group capital calculation (GCC).
      3. Discussed needed confidentiality protections.
   b. Heard a summary of data and initial observations from the GCC field test.

6. Adopted the report of the Restructuring Mechanisms (E) Working Group, which met Dec. 8 and took the following action:
   a. Adopted its Oct. 1 and Summer National Meeting minutes, which included the following action:
      1. Asked follow-up questions and heard answers from Enstar Group and Aon Service Corporation on their respective
         views on different restructuring mechanisms.
   b. Discussed plans for drafting a white paper as a deliverable of its charges.
   c. Received final restructuring principles from the American Council of Life Insurers (ACLI) and the American Property
      Casualty Insurance Association (APCIA).
   d. Discussed segregated accounts, protected cells and guaranty fund protection.
   e. Heard from the National Conference of Insurance Guaranty Funds (NCIGF) regarding its adopted position on
      restructuring.
   f. Received a report of the Restructuring Mechanisms (E) Subgroup. The Subgroup has distributed a survey to the states
      regarding the transactions and current activity, including input on the definition of “runoff.”
   g. Discussed the Prudential and Rothesay Life decision and various viewpoints.
   h. Received notification from the Oklahoma Insurance Department that they recently approved their first Insurance
      Business Transfer (IBT).


8. Adopted the report of the Capital Adequacy (E) Task Force. See the Task for listing for details.

9. Adopted the report of the Examination Oversight (E) Task Force. See the Task for listing for details.

10. Adopted the report of the Receivership and Insolvency (E) Task Force. See the Task for listing for details.

11. Adopted the report of the Reinsurance (E) Task Force. See the Task for listing for details.


13. Adopted the report of the Valuation of Securities (E) Task Force. See the Task for listing for details.

Accounting Practices and Procedures (E) Task Force
Dec. 8, 2019

1. Adopted its Aug. 22 and Summer National Meeting minutes.

2. Adopted the report of the Statutory Accounting Principles (E) Working Group, which met Dec. 7 and took the following
   action:
   a. Adopted its Sept. 9 and Summer National Meeting minutes.
   b. Adopted the following nonsubstantive revisions to statutory accounting guidance:
      1. Revisions adopt: a) Statement of Statutory Accounting Principles (SSAP) No. 61R—Life, Deposit-Type and
         Accident and Health Reinsurance disclosures with an effective date of Dec. 31, 2020; b) A-791 Q&A updates
         regarding contracts with medical loss ratios (MLRs); and c) updates to the 2c. Q&A regarding risk transfer and
         group term life yearly renewable term (YRT) reinsurance with an effective date of Jan. 1, 2021. The proposed
         revisions to the A-791 Q&A regarding the scope of nonproportional contracts subject to Appendix A-791 were
         referred to the informal life and health reinsurance drafting group to address informal application questions. The
         Working Group directed notification to the Life Actuarial (A) Task Force.
      2. Revisions clarify that goodwill resulting from the acquisition of a subsidiary, controlled or affiliated (SCA) entity
         by an insurance reporting entity that is reported on the SCA financial statements (resulting from the application
         of pushdown) is subject to the 10% admittance limit based on the acquiring entity’s capital and surplus. The
         remainder of the agenda item was re-exposed.
      3. Revisions clarify the recognition and measurement guidance for derivatives that do not qualify as hedging, income
         generation or replication transactions.
      4. Revisions clarify that nonadmittance is required when there is an unalleviated substantial doubt about an SCA’s
         ability to continue as an ongoing concern identified in any part of the audit report.
   5. Revisions reject:
      i. ASU 2019-05, Targeted Transition Relief
      ii. ASU 2019-06, Extending the Private Company Accounting Alternatives on Goodwill and Certain Identifiable
         Intangible Assets to Not-for-Profit Entities
      iii. ASU 2019-03, Updating the Definition of Collections
      iv. ASU 2018-08, Clarifying the Scope and the Accounting Guidance for Contributions Received and
         Contributions Made
6. Revisions clarify that only wash sales that cross reporting period end-dates are subject to the wash sale disclosure.
8. Revisions incorporate the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (U.K. Covered Agreement), into Appendix A-785—Credit for Reinsurance.
9. Adopted the following editorial revisions to statutory accounting:
   i. Clarify wording in an existing SSAP No. 62R—Property and Casualty Reinsurance disclosure.
   ii. Reference the definition of a structured note.
   iii. Add two new suffixes for Securities Valuation Office (SVO) filings carried over from the prior year.

6. Exposed the following substantive revisions to statutory accounting guidance:
   1. A revised issue paper and a substantively-revised SSAP No. 32—Preferred Stock.
   2. SSAP No. 105—Working Capital Finance Investments incorporating industry revisions to program requirements, as directed by the Working Group, and directed NAIC staff to draft an issue paper.

7. Exposed the following nonsubstantive revisions to statutory accounting guidance:
   1. Revisions specify that cash pooling structures that meet specified criteria qualify as cash equivalents.
   2. Revisions incorporate additional concepts to prevent the “rolling” of certain investments as cash equivalents or short-term investments. Revisions exclude qualifying cash pools from rolling requirements.
   4. Revisions reject ASU 2017-11, Accounting for Certain Financial Instruments with Down Round Features; Replacement of the Indefinite Deferral for Mandatory Redeemable Financial Instruments of Certain Noncontrolling Interests with a Scope Exception and incorporate guidance for when certain freestanding instruments shall be recognized as liabilities, not equity.
   5. Revisions expand guidance regarding financial guarantees and the use of the equity method for when losses exceed the equity value. The “Illustration of the Application of INT 00-24” will be inserted as an exhibit.
   6. SSAP No. 25—Affiliates and Other Related Parties:
      i. Revisions data-capture existing disclosures, which are currently completed in a narrative format. A blanks proposal to expose the data-captured template was proposed to be concurrently exposed.
      ii. Revisions clarify the types of entities that are included as related parties and that a non-controlling ownership interest greater than 10% is a related party and subject to the related party disclosures, the guidance for disclaimers of affiliation, and control for statutory accounting. The revisions also reject seven Financial Accounting Standards Board (FASB) ASUs for statutory accounting. The exposure includes an intent to dispose agenda item 2011-16, which is a historical item drafted to consider the SSAP No. 25 definition. With exposure, directed notification to the Group Solvency Issues (E) Working Group.
   7. Revisions provide enhanced disclosures to identify when an issued surplus note’s anticipated or typical cash flows have been partially or fully offset by a held asset.
   8. Revisions eliminate the multi-step financial modeling designation guidance in determining final NAIC designations for residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) securities. This exposure is contingent on a related action by the Valuation of Securities (E) Task Force.
   9. Revisions include footnote excerpts in the reporting exhibits to aggregate deposit-type contracts captured in Exhibit 5 – Life Contracts and an inquiry as to whether a similar footnote would be beneficial for Exhibit 6 – Accident and Health Contracts. Comments regarding instruction clarifications for Exhibit 7 – Deposit-Type Contracts were requested. With exposure, directed notification to the Financial Stability (EX) Task Force.
   10. Revisions propose minor edits to the liquidity disclosures regarding withdrawal characteristics for life and deposit-type contracts to match noted reporting clarifications.
   11. Revisions expand managing general agent (MGA) and third-party administrator (TPA) disclosures.
   12. Revisions clarify that the installment fee guidance should be narrowly applied. Comments are requested on how related installment fee expenses should be reported, whether guidance to separately identify and reclassify installment fee expenses to other expenses should be provided, and whether diversity should be permitted in reporting installment fee expenses. The Casualty Actuarial and Statistical (C) Task Force and the Property and Casualty Risk-Based Capital (E) Working Group will be notified of the exposure.
   13. Revisions incorporate interested parties’ recommendations to separate the guidance by product type and emphasize guidance that loss and loss adjusting expense liabilities are established regardless of payments to third parties (except for capitated health claim payments). The revisions emphasize existing guidance that claims that related liabilities are not recognized as paid until the losses are paid to claimants or claims are adjusted.
   14. Revisions incorporate disclosure updates for reinsurers from reciprocal jurisdictions.
15. Requested comments on preferred approaches for reporting retroactive contracts that meet the exception for prospective accounting and the characteristics of the approaches. Requested industry and state insurance regulator volunteers, and directed notification to the Casualty Actuarial and Statistical (C) Task Force.

16. Revisions include additional NAIC staff modifications regarding persistency commission and levelized commission arrangements to address certain comments received to allow for further discussion. With exposure, directed a referral to the Life Actuarial (A) Task Force.

17. Revisions clarify the reporting of derivatives with financing premiums, and requested comments on whether guidance allowing offset should be considered for derivatives and related financing provisions.

18. Revisions clarify that the fair value of collateral received or held for derivative disclosure purposes shall be reported net of collateral paid/pledged if a counterparty has the legal right to offset. Updates to applicable annual statement instructions are proposed to be concurrently exposed.

19. Revisions clarify that the “assignment” of goodwill is a disclosure element. Also directed revisions to the Sub-1 Acquisition Overview filing template to capture this information for new SCA acquisitions.

20. Revisions clarify that a look-through of a more-than-one holding company structure is permitted if each of the holding companies within the structure complies with the requirements.


22. Revisions reject ASU 2016-14, Presentation of Financial Statements of Not-for-Profit Entities.

23. Exposed the following editorial revisions to statutory accounting:
   i. Update references in SSAP No. 62R Exhibit A – Implementation Questions and Answers, which provides a retroactive reinsurance illustration and update, and paragraph 85 to match the current format of property/casualty (P/C) annual statement Schedule F – Reinsurance.
   ii. Revise references to the annual statement instructions and combine the life and fraternal references.

e. Received an update on the following projects and referrals:
   2. Responses for the data call on “linked” surplus notes to address the Surplus Note Accounting – Referral from the Reinsurance (E) Task Force are requested by Dec. 31, 2019.
   3. FASB delayed implementation of ASU 2016-13: Credit Losses until 2023 for everyone except large U.S. Securities and Exchange Commission (SEC) filers, which are required to follow the ASU in 2020.
   5. No comments by the Working Group are planned regarding U.S. generally accepted accounting principles (GAAP) exposures. Received information from industry on recent FASB discussions. NAIC staff will address the expected Reference Rate Reform FASB project to ensure that it will be promptly reviewed.
   f. The comment deadline for new and exposed items is Jan. 31, 2020, except for the editorial agenda item (Ref #2019-44EP), which has a Dec. 20, 2019, comment deadline.

13. Adopted the report of the Blanks (E) Working Group, which met Oct. 22 and took the following action:
   a. Adopted its Sept. 5 and Aug. 20 minutes, which included the following action:
      1. Exposed blanks proposal 2019-24BWG. The proposal adds a life experience data contact to the electronic Jurat page for life/fraternal company filers only to allow NAIC staff and state insurance regulators to locate a contact person more easily from each legal entity life insurance company to facilitate communication regarding data studies and submissions to the NAIC.
      b. Adopted four blanks proposals:
         1. 2019-21BWG – Modify the Illustrations for Note 33 to disclose individually the Separate Account with Guarantees Products and Separate Account Nonguaranteed Products.
         2. 2019-22BWG – Add a question regarding the Executive Summary of the PBR Actuarial Opinion to the Supplemental Exhibits and Schedules Interrogatories.
         3. 2019-23BWG – Modify the instructions and illustration for Note 8 – Derivatives for disclosures adopted by SSAP No. 108. Add instructions and a blanks page for Schedule DB, Part E, to the quarterly statement.
         4. 2019-24BWG – Add a Life Experience Data Contact to the electronic Jurat page for life/fraternal companies.
   c. Exposed its revised procedures.
   d. Exposed three proposals for a public comment period ending Nov. 22.
   e. Approved the editorial listing.

**Capital Adequacy (E) Task Force**

Dec. 8, 2019
1. Adopted its Oct. 8 minutes, which included the following action:
a. Adopted its Sept. 18 minutes, which included the following action:
   1. Adopted its 2020 proposed charges.

b. Exposed its referrals:
   1. NAIC Designations for Schedule D, Part 2 – Section 2.
   2. Mutual Funds.
   3. Comprehensive Funds.

2. Adopted the report of the Health Risk-Based Capital (E) Working Group, which met Dec. 8 and took the following action:
   a. Adopted its Oct. 21 and Sept. 9 minutes, which included the following action:
      1. Reported that the Working Group met Oct. 10 in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
      3. Discussed field testing of the Health Test and agreed to move forward.
      4. Referred the Long-Term Care HMO Guaranty Fund Memorandum to the Capital Adequacy (E) Task Force.
      5. Received comments and rejected proposal 2019-04-H (Health Care Receivables).
      6. Received comments on the excessive growth charge.
      7. Received comments on the Health Bond Structure.
      8. Discussed the managed care credit.
      9. Received an update from the Health Test Ad Hoc Group.
   b. Discussed the Health Bond Structure draft.
   c. Received comments on the Health Test Language Proposal.
   e. Adopted updates to the 2020 working agenda.
   f. Received an update from the Excessive Growth Charge Ad Hoc Group.

3. Adopted the report of the Life Risk-Based Capital (E) Working Group, which met Dec. 7 and took the following action:
   a. Adopted its Oct. 23 and Summer National Meeting minutes. During its Oct. 23 meeting, the Working Group:
      1. Rejected the proposal to update the risk-based capital (RBC) charge for unaffiliated common stock supporting long-horizon contractual commitments.
      2. Exposed the memorandum on potential further work on life growth operational risk for public comment.
      3. Adopted its July 22, June 24, June 17, June 6, May 13, April 26 and Spring National Meeting minutes.
   b. Adopted the report of the Longevity Risk (A/E) Subgroup, including adoption of its Nov. 25, Nov. 4, Oct. 7, Sept. 30 and Sept. 18 minutes, which included the following action:
      1. Discussed the Academy Longevity Risk Task Force’s proposal for incorporating a risk charge for longevity in the life and fraternal RBC formula.
      2. Adopted the Subgroup’s recommendation to the Life Risk-Based Capital (E) Working Group for a longevity risk charge.
   c. Exposed the Longevity Risk (A/E) Subgroup’s recommendation for a longevity risk charge along with the Academy’s alternative that includes covariance for a 60-day public comment period. The Working Group also agreed to scope out longevity reinsurance transactions for now with direction to the Subgroup to continue to work on this aspect.
   d. Heard an update from the Academy C2 Work Group.
   e. Heard an update from NAIC staff on the work being done on economic scenario generators (ESGs).
   f. Discussed comments received on life growth risk.
   g. Discussed an issue related to phase-in and spreading of variable annuity reserves and capital. The Working Group will review and identify any needed guidance.

4. Adopted the report of the Property and Casualty Risk-Based Capital (E) Working Group, which met Dec. 8 and took the following action:
   a. Adopted its Nov. 8 minutes, which included the following action:
      1. Adopted the Catastrophe Risk (E) Subgroup’s Summer National Meeting minutes.
      2. Adopted its Summer National Meeting minutes.
      3. Adopted proposal 2019-11-P (Clarification to Instructions Regarding Lloyd’s of London) and the 2019 reporting guideline.
      5. Exposed the 2019 catastrophe event list.
      6. Heard updates from the Academy on reviewing the underwriting risk components.
      7. Discussed the appropriate factor of unrated uncollateralized recoverables.
8. Discussed the factor of using the aggregate exceedance probability (AEP) and occurrence exceedance probability (OEP) basis.

b. Adopted the report of the Catastrophe Risk (E) Subgroup, which met Dec. 6 and took the following action:
1. Adopted its Nov. 8 minutes, which included the following action:
   a. Adopted its Summer National Meeting minutes.
   b. Adopted the Property and Casualty Risk-Based Capital (E) Working Group’s Summer National Meeting minutes.
   c. Adopted proposal 2019-11-P (Clarification to Instructions Regarding Lloyd’s of London) and the 2019 reporting guideline.
   d. Adopted proposal 2019-12-P (Remove PR038 Adjustment for Reinsurance Penalty).
   e. Exposed the 2019 catastrophe event lists.
   f. Heard updates from the American Academy of Actuaries (Academy) on reviewing the underwriting risk components.
   g. Discussed the appropriate factor of unrated uncollateralized recoverables.
   h. Discussed the factor of using the aggregate exceedance probability (AEP) and occurrence exceedance probability (OEP) basis.
3. Heard a presentation from the Academy on “Wildfire: Lessons Learned.” The presentation included topics on wildfire risk, mitigation, and modeling.
4. Heard a presentation from the Academy on “Actuaries Climate Index (ACI).” The presentation included topics on ACI components, and ACI recent index findings.
5. Discussed the factor of using AEP basis versus OEP basis.
6. Discussed the possibility of allowing additional third-party commercial vendor models.
c. Exposed proposal 2018-19-P (Vulnerable 6 or Unrated Risk Charge) for a 45-day public comment period ending Jan. 21, 2020.
d. Discussed 2020 property/casualty (P/C) RBC working agenda.
e. Discussed the possibility of using the NAIC as a centralized location for reinsurer designations.
f. Discussed the possible treatment of the R3 related to the runoff companies and captive companies.
g. Discussed the monoline mortgage guaranty insurers. The Working Group will closely monitor the development of the risk-based mortgage guaranty capital model from the Mortgage Guaranty Insurance (E) Working Group.
h. Discussed the Restructuring Mechanisms (E) Subgroup charge related to the Property and Casualty Risk-Based Capital formula.

5. Adopted its working agenda.
6. Received a Long-Term Care HMO Guaranty Fund Memorandum.
10. Adopted the RBC Preamble.
11. Received comments on referrals for:
   a. NAIC Designations for Schedule D, Part 2, Section 2 – Common Stocks.
   b. RBC Charges for Funds and Comprehensive Funds.
   c. Structured Notes.

**Examination Oversight (E) Task Force**
**Dec. 8, 2019**
1. Adopted its Sept. 13 and Summer National Meeting minutes.
2. Adopted the report of the Electronic Workpaper (E) Working Group, which met Dec. 3 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.
3. Adopted the report of the Financial Examiners Coordination (E) Working Group, which met Aug. 5 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
4. Adopted the report of the Financial Analysis Solvency Tools (E) Working Group, which met Sept. 4 to discuss proposed revisions to the Financial Analysis Handbook (Handbook) and the Insurance Regulatory Information System (IRIS) for 2019 annual statement filings. The proposals included:
   a. Combined two quantitative procedures under property/casualty (P/C) reserving, where the materiality procedure and the related quantitative benchmark procedure were combined under one procedure.
   b. Exposed enhanced regulatory guidance to the Handbook related to parental guarantees and troubled insurance companies that resulted from referrals from the Financial Analysis (E) Working Group.
c. Adopted Handbook guidance on salary compensation that was drafted by the Risk-Focused Surveillance (E) Working Group and exposed at the 2018 Fall National Meeting.
d. Adopted previously exposed guidance updates to the Handbook related to intercompany pooling, which was referred by the Group Solvency Issues (E) Working Group.
e. Adopted previously exposed changes to the Life IRIS for 2020 annual statement filings due to blank changes.

At the close of the open meeting, the Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. The Working Group adopted the proposed revisions via e-vote on Oct. 15.

5. Adopted the report of the IT Examination (E) Working Group, which met Sept. 26 to adopt revisions on the following:
   a. Information technology (IT) review conclusions – Revisions are intended to clarify the scope of the IT review and the way examiners should respond to IT review findings.
   b. Use of third-party work – Revisions are intended to clarify the ways that third-party work can be evaluated and used during an exam’s IT review.
   c. Cybersecurity self-assessment tools – Revisions allow state insurance regulators to incorporate the results of a company’s completed self-assessment. Additionally, a drafting group developed a mapping between IT exam guidance and the cybersecurity self-assessment tool developed by the Financial Services Sector Coordinating Council (FSSCC) to facilitate state insurance regulator use of the information contained within the tool.

6. Adopted the report of the Financial Examiners Handbook (E) Technical Group as amended during the Task Force meeting, which met Nov. 14 and Sept. 12 to adopt revisions on the following topics:
   a. Troubled companies – Revisions incorporate insights from the Troubled Company Handbook on the following topics: priority ratings guidance, communication expectations for companies that are troubled or potentially troubled and pre-receivership considerations.
   b. Management letters – Revisions clarify which level of the management letter should be addressed and the level of information that should be included therein. During the Task Force meeting, the Task Force received a proposal from industry to amend the guidance to clarify that the discretion by the state insurance regulators to issue management letters should consider the guidance that immediately follows.
   c. Exhibit V (Prospective Risk Assessment) – Revisions encourage enhanced testing of overarching prospective risks and to better facilitate the communication of examination results with the financial analysts.
   d. Exhibit AA (Summary Review Memorandum) – Revisions address the order in which C-level interviews should be conducted, as well as provide a new interview template for interviewing a chief marketing officer.
   e. Compensation study – Revisions include a description of commonly held roles and responsibilities for commonly held regulatory positions and suggest salary ranges for examiners and analysts based on the results of a state insurance regulator compensation study.

7. Received a report from the NAIC’s Capital Markets Bureau regarding a transition within U.S. financial markets away from using LIBOR as a reference benchmark. The Capital Markets Bureau will provide further state insurance regulator-only educational materials to help state insurance regulators better understand how insurance companies will be affected.

8. Received an update from NAIC staff regarding work performed to update the state insurance regulator-only Jumpstart reports.

Long-Term Care Insurance (E/B) Task Force
The Long-Term Care Insurance (E/B) Task Force did not meet at the Fall National Meeting.

Receivership and Insolvency (E) Task Force
Dec. 8, 2019
1. Adopted its Summer National Meeting minutes.
3. Adopted the report of the Receivership Financial Analysis (E) Working Group, which met Dec. 8 in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. During this meeting, the Working Group discussed the status of individual receiverships.
4. Adopted the report of the Receivership Large Deductible Workers’ Compensation (E) Working Group, which met Dec. 2 and Oct. 24 and took the following action:
6. Discussed next steps for addressing recommendations from the Macroprudential Initiative (MPI). The Task Force plans to:
   a. Continue discussions during a future conference call regarding possible remedies for ensuring the continuity of essential services and functions to an insurer in receivership.
   b. Delegate to its Receivership Model Law (E) Working Group the development of recommendations for methods to encourage the states to adopt key areas in receivership law to enhance the efficiency and effectiveness of the receivership process across the states.
8. Heard an international resolution update that highlighted activities of the International Association of Insurance Supervisors (IAIS). The IAIS Resolution Working Group met in September to:
   a. Finalize the Application Paper on Recovery Planning.
   b. Continue development of the Application Paper on Resolution Planning.

Reinsurance (E) Task Force
Dec. 8, 2019
1. Adopted its Oct. 22 minutes, which included the adoption of the proposed revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions, adopted the re-evaluations of France, Germany, Ireland and the United Kingdom as Qualified Jurisdictions, and adopted revisions to the Reinsurance Ceded section of the Accreditation Program Manual, and its Summer National Meeting minutes.
2. Adopted the report of the Reinsurance Financial Analysis (E) Working Group. The Working Group met Nov. 26 and Oct. 10 in regulator-to-regulator sessions, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss actions taken with respect to the passporting of certified reinsurers by the states.
3. Adopted the report of the Qualified Jurisdiction (E) Working Group. The Working Group met Nov. 5, Oct. 7 and Aug. 22 via conference call in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings. The Working Group has adopted re-evaluations of Bermuda, France, Germany, Ireland, Japan, Switzerland and the United Kingdom as Qualified Jurisdictions and evaluations of Bermuda, Japan and Switzerland as Reciprocal Jurisdictions.
4. Adopted the re-evaluations of Bermuda, Japan and Switzerland as Qualified Jurisdictions and their evaluations as Reciprocal Jurisdictions.
5. Exposed a Blanks Proposal that incorporates the 2019 revisions from the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) into the Annual Reporting Blanks and Instructions.

Risk Retention Group (E) Task Force
Dec. 7, 2019
1. Adopted its Oct. 7 minutes.
2. Adopted Frequently Asked Questions (FAQ) and Best Practices documents for risk retention groups (RRGs) to further assist the states with the registration of RRGs.
3. Adopted a referral to the Property and Casualty Insurance (C) Committee to consider proposed revisions to the NAIC Uniform Risk Retention Group – Notice and Registration form. The revisions are intended to clarify expectations for RRGs registering in non-domiciliary states and facilitate compliance with the federal Liability Risk Retention Act (LRRA).
4. Discussed next steps for the Task Force, including informing industry and regulators about the new resources and registration form; monitoring the impact of the above adoptions; providing training, such as a webinar; and considering revisions to the Risk Retention and Purchasing Group Handbook or the Company Licensing Best Practices Handbook.

Valuation of Securities (E) Task Force
Dec. 8, 2019
1. Adopted its Sept. 5, Oct. 31; and Summer National Meeting minutes, which included the following action:
   a. Adopted an updated amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to add instructions for the new administrative fields “RTS” and “RT” that was exposed for a 14-day comment period that ended Aug. 30.
   b. Adopted its 2020 proposed charges.
   c. Adopted a P&P Manual amendment updating the interim instructions for Mortgage Reference Securities that was exposed for a 30-day comment period that ended Sept. 4.
   d. Discussed a proposed P&P Manual amendment to add instructions for Exchange Traded Funds (ETF) that contain a combination of preferred stocks and bonds and directed Securities Valuation Office (SVO) staff to prepare a memo summarizing issues related to ETFs.
e. Received a proposed P&P Manual amendment to rename the U.S. Direct Obligations/Full Faith and Credit Exempt List and to the NAIC U.S. Government Money Market Fund List and discontinue the Bond Fund List and migrate these funds to the new NAIC Fixed Income-Like SEC (U.S. Securities and Exchange Commission) Registered Funds List in 2020. The amendment was exposed for 45-day comment period ending on Dec. 16.

f. Receive a proposed P&P Manual amendment to add instructions to limit NAIC Designations to the NAIC Assigned Sovereign Rating. The amendment was exposed for 45-day comment period ending on Dec. 16.

g. Received a proposed P&P Manual amendment to add instructions for Ground Lease Transactions. The amendment was exposed for 22-day comment period ending on Nov. 22.

h. Discussed a proposed P&P Manual amendment for Principal Protected Securities.

2. Received an update from NAIC staff on projects before the Statutory Accounting Principles (E) Working Group, including:

- Items Adopted by the Working Group: 1) Other Derivatives – revisions to clarify that other derivatives – which are derivatives that are not used in hedging, income generation or replication transactions – shall be reported at fair value and nonadmitted; 2) Goodwill – for subsidiary, controlled and affiliated investments (SCAs), the Working Group adopted minor revisions to clarify that goodwill from an insurance entity acquisition of an SCA is subject to the 10% adjusted capital and surplus limit, regardless if the goodwill had been “pushed down;” and 3). Wash Sales – revisions to clarify that the wash sale disclosure shall only include wash sale transactions that cross reporting periods. Items Exposed by the SAPWG: 1) Preferred Stock – revised issue paper and proposed substantively revised SSAP No. 32R as part of the investment classification project; 2) Related Party Transactions – proposed to data-capture existing SSAP No. 25 disclosures and exposure to clarify the types of entities that are included as related parties, clarification that non-controlling ownership interest greater than 10% is a related party; 3) Working Capital Finance Investments – substantive revisions to SSAP No. 105 as directed by the Working Group to reflect 6 of the recommendations provided by industry and referred from the Task Force; 4) Rolling Short-Term Investments – revisions to SSAP No. 2R to incorporate principle concepts in classifying investments as cash equivalents or short-term investments; 5) Qualifying Cash Pools – revisions to SSAP No. 2R to incorporate concepts to allow cash pools to be reported as cash equivalents; 6) Financial Modeling – 43R – revisions to eliminate the financial modeling guidance from SSAP No. 43R, noting that this exposure was contingent on the Task Force taking a similar action at the National Meeting; and 7) Financing Derivatives – revisions for the reporting of derivatives with financing premiums.

3. Received a proposed Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) amendment to reflect the U.S. SEC’s adoption of a new Rule 6c-11 under the Investment Company Act of 1940, to modernize regulation of exchange traded funds to operate without first obtaining an exemptive order under from the SEC under the Act and exposed the amendment for a 45-day comment period ending Jan. 23, 2020.

4. Adopted a proposed P&P Manual amendment and refer it to the Statutory Accounting Principles (E) Working Group instructions for Ground Lease Financing (GLF) transaction following a decision tree analysis approach: 1) the SVO would analyze it to see it if meets the credit tenant loan criteria and the SVO could analyze the sub-leases; 2) assess if the Structured Security Group can model the GLF; and 3) if a ratings agency rating was assigned, authorize the SVO to use that analysis in its assessment. The amendment that was exposed for a 22-day comment period that ended on Nov. 22.

5. Received a proposed P&P Manual amendment to remove the financial modeling instructions for RMBS/CMBS securities and direct Investment Analysis Office (IAO) staff to instead produce NAIC designations and NAIC designation categories for these securities and exposed the amendment for a 60-day comment ending Feb. 7, 2020.

6. Received an SVO staff report on their work defining principal protected notes. Staff reported being working iteratively with industry on a general framework to describe repackaged securities that may possess Other Non-Payment Risks that the SVO must assess under its Subscript S authority.

7. Received a CIPR staff report on their infrastructure project. CIPR staff, with assistance from the Capital Markets Bureau, is researching the state of infrastructure investing as it pertains to US insurance companies and has solicited a great deal of information from interested parties. A great deal of progress has been made, including finalizing a definition of economic infrastructure.

8. Received an SVO staff report on various technology projects: integration of security identifiers in the filing exempt process (BECRS/GICRS) has been deferred; inclusion of ratings data the Japan Credit Rating Agency, Ltd. has been deferred; implementation of additional CRP data feeds for securities subject to private rating letters component of filing exemption has been deferred; implementation of the carry-over procedure in 2019 for the administrative symbols “YE” and “IF” completed; and implementation of NAIC designation categories was on schedule for early 2020.

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE
Dec. 6 – 7, 2019

The Financial Regulation Standards and Accreditation (F) Committee met Dec. 6, in regulator-to-regulator session pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; 2) vote to award continued accreditation to the insurance departments of Connecticut, Massachusetts and New York; and 3) vote to award accreditation for the first time to the insurance department of the U.S. Virgin Islands. The Committee also met Dec. 7, in open session, and
took the following action:
1. Adopted its Summer National Meeting minutes.
3. Adopted revisions to the Review Team Guidelines for troubled companies effective Jan. 1, 2020. The revisions incorporate updated guidance on timely and effective communication of a troubled or potentially troubled company between the domiciliary and non-domiciliary states.
4. Adopted the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) as revisions to the Reinsurance Ceded accreditation standard. These revisions address the reinsurance collateral requirements necessary for U.S. ceding companies to take credit for certain reinsurance transactions. The adoption includes a waiver of procedure to expeditiously adopt the accreditation standard. The adopted effective date is Sept. 1, 2022.
5. Adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) as a new accreditation standard effective Sept. 1, 2022. This model establishes uniform, national standards governing reserve financing arrangements pertaining to term life and universal life insurance policies with secondary guarantees.

INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE
Dec. 7, 2019
1. Adopted its Nov. 6, Oct. 15, Aug. 13, and 2019 Summer National Meeting minutes. During its Nov. 6, Oct. 15 and Aug. 13 meetings, the Committee took the following action:
   a. Heard an update on upcoming International Association of Insurance Supervisors (IAIS) committee meetings.
   b. Approved submission of NAIC comments on the IAIS draft Issues Paper on the Use of Big Data Analytics in Insurance and heard updates on IAIS activities and the Financial Sector Assessment Program (FSAP).
   c. Approved submission of NAIC comments on IAIS revised supervisory material and material related to the holistic framework for systemic risk in the insurance sector.
2. Adopted the report of the ComFrame Development and Analysis (G) Working Group, which met Dec. 7 in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss next steps for implementation of the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) and the monitoring period and to hear an update on the aggregation method process.
3. Adopted its 2020 proposed charges.
4. Heard an update on key 2019 projects of the IAIS, including revised Insurance Core Principles (ICPs) and ComFrame, the holistic framework for systemic risk in the insurance sector, and the insurance capital standard (ICS) and monitoring period.
5. Heard an update on international activities, focusing on regional supervisory cooperation and the Organisation for Economic Co-operation and Development (OECD). Regional supervisory cooperation activities include ongoing engagement with regulators in Europe, the Asia-Pacific region and Latin America, as well as the NAIC International Fellows Program.
6. Heard an update on the FSAP. The 2019–2020 International Monetary Fund (IMF) FSAP of the U.S. financial regulatory system is currently underway. The FSAP is comprised of Mission 1 and Mission 2, with much of the work for the FSAP exercise for insurance concentrated in Mission 1, which took place this fall. Mission 2 will take place in early 2020, with meetings both with the NAIC and several states. The IMF is expected to publish a technical note on insurance by the summer of 2020.

NAIC/CONSUMER LIAISON COMMITTEE
Dec. 9, 2019
1. Adopted its Summer National Meeting minutes.
2. Observed the presentation of the Excellence in Consumer Advocacy award from the NAIC consumer representatives to Commissioner Michael Conway (CO).
3. Heard a presentation from the Center for Economic Justice on what state insurance regulators can do to promote retirement security. This presentation focused on the health (long-term care) and non-health (life and annuity) gaps in consumer education and consumer protection, current NAIC committee activities, and a consumer-focused strategy to fill the gaps.
4. Heard a presentation from United Policyholders (UP) on using residual markets. This presentation explained California's current situation; recapped what UP, the California Department of Insurance, California’s FAIR Plan and partners are doing; and briefly reviewed Florida's experience.
5. Heard a presentation from the Automotive Education and Policy Institute on consumers filing complaints or reporting improper insurer behavior in the automobile repair context. This presentation shed light on the fact that critical problems for consumers filing complaints or reporting improper insurer behavior in the automobile repair context is that consumers have no idea why it may be important for them to have particular repair procedures or parts used in the repair of their vehicles.
6. Heard a presentation from Claire McAndrew (Families, USA) and Sarah Lueck (Center on Budget and Policy Priorities—CBPP) on protecting patients from surprise medical bills and the impact of other Federal policy changes on consumers. This presentation discussed the importance of federal protections against surprise medical bills, provided an update on the status of surprise medical bill legislation in Congress, and highlighted implications for state insurance regulators. It also discussed other federal policy changes - including changes made by the federal government, Congress, or the courts - that would impact coverage and care for consumers and the work of state insurance regulators.

7. Heard a presentation from Deborah Darcy (American Kidney Fund-AKF) on clarifying insurance coverage of living donors. This presentation provided recommendations to state insurance regulators on the need for clear guidance in health insurance documentation and how complaints to commissioners should be resolved by the health insurance of the recipient paying the medical bills.

8. Heard a presentation from Katie Keith (Out2Enroll) and Silvia Yee (Disability Rights Education and Defense Fund—DREDF) on raising consumer concerns about wellness programs. In light of a recently announced federal opportunity for states to expand wellness programs to the individual market, this presentation highlighted the latest data on wellness programs, recent legal challenges, consumer concerns, and recommendations for state regulators.

9. Heard a presentation from Matthew Smith (Coalition Against Insurance Fraud—CAIF) and Dan Kreitman (Healthcare Fraud Prevention Partnership—HFPP) on how HFPP is protecting Americans from insurance fraud. This presentation acquainted commissioners and the consumer representatives with the HFPP, its history, purpose and how it could assist regulators in protecting their citizens.

NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE
Dec. 8, 2019
1. Adopted its Summer National Meeting minutes.
3. Heard an update from NAIC legal staff on the removal of health insurance resources from the U.S. Health and Human Services (HHS) website.

NAIC/INDUSTRY LIAISON COMMITTEE
The NAIC/Industry Liaison Committee did not meet at the Fall National Meeting.

NAIC/STATE GOVERNMENT LIAISON COMMITTEE
Dec. 7, 2019
1. Heard welcome remarks from NAIC president, Superintendent Eric A. Cioppa (ME). Superintendent Cioppa discussed how the NAIC has made progress on a number of important initiatives, including the recent amendments to the Credit for Reinsurance Model Law (#785).
2. Adopted its 2018 Summer National Meeting minutes.
4. Discussed health insurance developments. Director Raymond G. Farmer (SC) noted how state insurance regulators are waiting for the draft Notice of Benefit and Payment Parameters for 2021, which sets the rules for federal Affordable Care Act (ACA)-compliant plans. He also discussed how regulators are tracking congressional activity on surprise bills, and how the U.S. Department of Transportation has appointed an Air Ambulance Advisory Committee, to which Commissioner Jon Godfread (ND) was appointed.
5. Discussed long-term care insurance (LTCI). Commissioner Scott A. White (VA) discussed how the NAIC is focused on developing a consistent national approach for reviewing LTCI rates that result in actuarily appropriate increases being granted by the states in a timely manner. He also said state insurance regulators are focused on ensuring consumers are provided with meaningful options to reduce their benefits in situations where the premiums are no longer affordable. He discussed the creation of the Long-Term Care Insurance (EX) Task Force and gave an update on the various workstreams.
6. Discussed big data and data privacy. Commissioner Godfread discussed how big data is reshaping the insurance marketplace, and how state insurance regulators are responding. He also noted how the NAIC has appointed a new Privacy Protections (D) Working Group to review state insurance privacy protections and determine if changes are needed.
7. Discussed the group capital calculation (GCC) and Macroprudential Initiative. Superintendent Cioppa discussed how the GCC will be a tool that state insurance regulators can use in their solvency-monitoring activities. He discussed macroprudential monitoring and how it provides state insurance regulators with a better understanding of how the insurance sector is impacted by various risk exposures in the broader financial markets and economy.

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Executive (EX) Committee and Plenary
Austin, Texas
December 10, 2019

The Executive (EX) Committee and Plenary met in joint session in Austin, TX, Dec. 10, 2019. The following members participated: Eric A. Cioppa, Chair (ME); Raymond G. Farmer, Vice Chair (SC); David Altmairer, Vice President (FL); Dean L. Cameron, Secretary-Treasurer (ID); James J. Donelon, Most Recent Past President represented by Nick Lorusso (LA); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Jerry Workman (AL); Allen W. Kerr (AR); Elizabeth Perri (AS); Keith Schraad (AZ); Michael Conway represented by Peg Brown (CO); Andrew N. Mais (CT); Stephen C. Taylor (DC); Trinidad Navarro (DE); John F. King (GA); Dafne M. Shimizu represented by Michele Santos (GU); Colin M. Hayashida represented by Paul Yuen (HI); Doug Ommen (IA); Robert H. Muriel represented by Kevin Fry (IL); Stephen W. Robertson represented by Amy Beard (IN); Vicki Schmidt (KS); Nancy G. Atkins (KY); Gary Anderson (MA); Al Redmer Jr. (MD); Anita G. Fox (MI); Steve Kelley (MN); Chlora Lindley-Myers (MO); Mike Chaney represented by Mark Haire (MS); Matthew Rosendale represented by Kendall Cotton (MT); Mike Causey (NC); Jon Godfread (ND); Bruce R. Ramge (NE); John Elias represented by Christie Rice (NH); Marlene Caride (NJ); John G. Franchini (NM); Barbara D. Richardson (NV); Linda A. Lacewell represented by Stephen Doody (NY); Jillian Froment (OH); Glen Mulready (OK); Andrew Stolfi (OR); Jessica Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry Deiter (SD); Hodgen Mainda (TN); Kent Sullivan (TX); Todd E. Kiser (UT); Scott A. White (VA); Tregenza A. Roach represented by Cheryl Charleswell (VI); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler (WA); Mark Afable represented by Nathan Houdek (WI); James A. Dodrill (WV); and Jeff Rude (WY).

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

Superintendent Cioppa reported the Executive (EX) Committee met Dec. 8 and adopted the Dec. 7 report from the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

The Executive (EX) Committee adopted its interim meeting report from Nov. 18, Oct. 8 and Oct. 7, which included the following action: 1) approved the NAIC 2020 proposed budget and recommended the budget be adopted by the full NAIC membership at the Fall National Meeting; 2) approved recommendations for the NAIC’s Defined Benefit Plan Fund Investments; 3) adopted the investment policy statement (IPS) for the NAIC’s long-term funds; 4) adopted the IPS for the NAIC’s defined benefit plan and the defined contribution plan; 5) adopted the Information Systems (EX1) Task Force’s 2020 proposed charges; 6) adopted the Internal Administration (EX1) Subcommittee’s 2020 proposed charges; and 7) exposed the NAIC 2020 proposed budget, including five fiscals, for a public comment period ending Nov. 7.

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

The Executive (EX) Committee adopted its 2020 proposed charges.

The Executive (EX) Committee adopted Requests for NAIC Model Law Development to amend: 1) the Insurance Holding Company System Regulatory Act (#440); 2) the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450); and 3) the Unfair Trade Practices Act (#880).

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

The Executive (EX) Committee received a status report on model law development efforts for amendments to: 1) the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); 2) the Annuity Disclosure Model Regulation (#245); 3) the Suitability in Annuity Transactions Model Regulation (#275); 4) the Health Maintenance Organization Model Act (#430); 5) the Life Insurance Disclosure Model Regulation (#580); 6) the Mortgage Guaranty Insurance Model Act (#630); and 7) the following new models: a) the Real Property Lender-Placed Insurance Model Act; b) the Pet Insurance Model Act; and c) the Pharmacy Benefit Manager (PBM) Model Law.

The Executive (EX) Committee heard reports from the National Insurance Producer Registry (NIPR) and the Interstate Insurance Product Regulation Commission (Compact).
Commissioner Kerr made a motion, seconded by Commissioner Altmaier, to adopt the Dec. 8 report of the Executive (EX) Committee. The motion passed.

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

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

3. **Adopted the NAIC 2020 Proposed Budget**

Director Farmer reported that the 2020 proposed budget was approved for exposure to the public on Oct. 7 and was posted on the NAIC website on Oct. 8. A public briefing for interested parties was held on Oct. 14. A public hearing was held on Nov. 18, and one comment letter received was addressed. The Executive (EX) Committee approved the 2020 proposed budget during the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee meeting held on Nov. 18.

Director Farmer provided an overview of the budget. The proposed budget is based on $114.5 million in operating revenues and operating expenses of $124.5 million and includes five fiscals. In addition, total funding of $324,500 was approved by the Executive (EX) Committee on Dec. 7 to hire a firm to conduct a System for Electronic Rate and Form Filing (SERFF) assessment during the first half of 2020, which increases 2020 operating expenses to $124.8 million.

After including nearly $3.2 million of investment income, the NAIC’s proposed budget reflects a reduction in net assets of $7.2 million. The liquid operating reserve ratio would be approximately 90.8% at the end of 2020.

Director Farmer made a motion, seconded by Commissioner Kerr, to adopt the NAIC 2020 proposed budget, including $324,500 in funding for the SERFF assessment (Attachment One). The motion passed.

4. **Adopted the NAIC 2020 Proposed Committee Charges**

Director Farmer reported that the 2020 proposed committee charges cover the work for the working groups, task forces and committees that operate through the NAIC. These charges have been exposed, discussed and adopted at the letter committees. The charges document is a dynamic document that may change as the work for 2020 proceeds.

Director Farmer made a motion, seconded by Commissioner Kerr, to adopt the NAIC 2020 proposed committee charges (Attachment Two). The motion passed.

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

Commissioner Ommen reported the Life Insurance and Annuities (A) Committee met Dec. 8 and adopted its Nov. 4 minutes, which included the following action: 1) adopted its Summer National Meeting minutes; 2) adopted its 2020 proposed charges; 3) adopted the Life Actuarial (A) Task Force’s 2020 proposed charges; 4) adopted the 2020 Generally Recognized Expense Table (GRET); and 5) adopted Actuarial Guideline LII—Variable Annuity Early Adoption (AG 52).

The Committee adopted the report of the Annuity Suitability (A) Working Group, which met Dec. 7 and adopted its Sept. 17 and Summer National Meeting minutes.

The Committee discussed comments received on the draft Suitability in Annuity Transactions Model Regulation (#275) and approved the draft as revised during this meeting, with the exception of the draft templates, which were referred back to the Annuity Suitability (A) Working Group for discussion during a conference call on Dec. 19.

The Committee adopted the following working group and task force reports: the Annuity Disclosure (A) Working Group, including its Dec. 2 and Sept. 19 minutes, as well as an extension of the Request for NAIC Model Law Development; the Accelerated Underwriting (A) Working Group, including its Oct. 2 minutes; the Life Insurance Illustration Issues (A) Working Group, including its Oct. 21, Sept. 17, Sept. 3 and July 30 minutes, as well as an extension of the Request for NAIC Model Law Development; the Life Actuarial (A) Task Force, including the creation of a new Guaranteed Issue Life Valuation (A) Subgroup; and the Retirement Security (A) Working Group, including its Nov. 13 and Oct. 23 minutes.
6. **Adopted the 2020 Generally Recognized Expense Table (GRET)**

Commissioner Ommen reported that as in previous years, the Society of Actuaries (SOA) Committee on Life Insurance Company Expenses submitted its GRET analysis to the Life Actuarial (A) Task Force for the upcoming year. The SOA followed the same methodology in developing the 2020 GRET as last year for the 2019 GRET. The 2020 GRET was adopted by the Life Insurance and Annuities (A) Committee during its Nov. 4 conference call.

Commissioner Ommen made a motion, seconded by Director Farmer, to adopt the 2020 GRET (Attachment Three). The motion passed.

7. **Adopted Actuarial Guideline LII—Variable Annuity Early Adoption (AG 52)**

Commissioner Ommen reported that AG 52 is informational-only and explains that a company is permitted to adopt the new variable annuity framework early for values used for the Dec. 31, 2019, financial statements.

Commissioner Ommen made a motion, seconded by Commissioner Altmaier, to adopt AG 52 (Attachment Four). The motion passed.

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

Commissioner Altman reported the Health Insurance and Managed Care (B) Committee met Dec. 8. During this meeting, the Committee adopted its Oct. 24 and Summer National Meeting minutes. During its Oct. 24 meeting, the Committee took the following action: 1) adopted the Health Actuarial (B) Task Force’s 2020 proposed charges, the Regulatory Framework (B) Task Force’s 2020 proposed charges, and the Senior Issues (B) Task Force’s 2020 proposed charges; and 2) adopted its 2020 proposed charges.

The Committee adopted the following subgroup, working group and task force reports: the Consumer Information (B) Subgroup, including its Nov. 18, Oct. 21 and Oct. 7 minutes; the Health Innovations (B) Working Group, including its Oct. 28 minutes; the Health Actuarial (B) Task Force; the Long-Term Care Insurance (E/B) Task Force; the Regulatory Framework (B) Task Force; and the Senior Issues (B) Task Force.

The Committee heard an update from Randy Pate, from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on its recent regulatory activities. Mr. Pate provided the Committee with a snapshot of current open enrollment, including data on the number of applications submitted and enrollment by subsidized and unsubsidized individuals and highlighted the effects of Section 1332 waivers in reducing premium costs. Mr. Pate also discussed its efforts to provide price transparency in the health care marketplace.

The Committee heard a presentation from Charles Silver, the co-author of the book “Overcharged: Why Americans Pay Too Much for Health Care.” The presentation highlighted the current problems in the health care system leading to high health care costs and solutions to address them. The problems discussed include fraud, waste and abuse, opaque prices, surprise bills and high prescription drug costs. Mr. Silver proposed solutions, including letting the insurance-driven spending cycle burn itself out and letting the market resolve the problems through the retail health sector.

The Committee heard a panel presentation on state surprise billing laws. Representatives from the Texas Department of Insurance (DOI) and the Washington DOI discussed their surprise billing laws highlighting provisions in the laws related to their scope and method of establishing the out-of-network provider payment.

The Committee heard an update on legal actions related to the federal Affordable Care Act (ACA), including: 1) a case challenging the constitutionality of the individual mandate and its potential impact on other key ACA provisions; 2) a case challenging the legality of the recent federal association health plan (AHP) regulation; 3) a case challenging the legality of the recent federal short-term, limited-duration plan (STLDP) regulation; and 4) a case challenging the legality of the federal government’s refusal to pay participants for full risk corridor amounts.

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

Superintendent Dwyer reported the Property and Casualty Insurance (C) Committee met Dec. 9 and took the following action: 1) adopted its Nov. 18 minutes, which included the following action: a) adopted its Sept. 10 minutes, which included adoption of its Summer National Meeting minutes and documents related to the private flood insurance data call; b) adopted additional
documents related to the private flood insurance data call, including making the data publicly available; c) discussed proposed blanks changes related to private flood insurance; and d) discussed the upcoming Fall National Meeting.

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

The Committee adopted its 2020 proposed charges.

The Committee adopted a Blanks’ request to create a supplement to collect private flood insurance data and revise the Credit Insurance Experience Exhibit to include private flood coverages. The proposed Annual Statement changes will split residential from commercial private flood coverages as well as standalone from endorsements and first dollar from excess. This information, along with the data call, will allow regulators and others to better understand the growth of the private flood insurance market.

The Committee adopted an extension for revisions to the proposed Real Property Lender-Placed Insurance Model Act.

The Committee adopted Considerations for State Insurance Regulators in Building the Private Flood Insurance Market, a document meant to provide state insurance regulators with actions that might facilitate the growth of the private flood insurance market.

The Committee also: 1) heard a presentation from SBP on work the group does to promote resiliency and mitigation among homeowners pre- and post-disasters; 2) heard a presentation from the American Property Casualty Insurance Association (APCIA) and the National Association of Mutual Insurance Companies (NAMIC) regarding underinsurance and steps the industry is taking to work on the issue; 3) heard an update from the U.S. Department of Agriculture (USDA) and the National Crop Insurance Services (NCIS) regarding crop insurance and private crop-hail insurance and how the entities continue to work with regulators; and 4) reported that state insurance regulators are currently reviewing private passenger auto state exhibits created from data collected from statistical agents. The Committee plans to release the private passenger auto report on its website in the near future.


Superintendent Dwyer reported the Cannabis Insurance (C) Working Group was appointed in August 2018 with a charge of studying insurance issues related to legal cannabis business and drafting a white paper describing insurance regulatory issues, including coverage gaps. The Working Group drafted the white paper with assistance from cannabis industry groups and other interested parties and adopted the paper in July 2019. The Property and Casualty Insurance (C) Committee adopted the white paper during the Summer National Meeting.

As more states continue to legalize cannabis, the need and demand for cannabis insurance will only continue to increase. The white paper findings show that there are substantial gaps in insurance coverage for the cannabis industry, exposing those who engage with the cannabis industry. The white paper also explores other regulatory issues related to insurance issues in the cannabis industry, including how insurance rates are set; legal and regulatory authority at the federal, state and local levels; and cannabis operations and best practices.

Superintendent Dwyer stated that the white paper provides an excellent overview to the states, and it will assist the states in understanding potential insurance coverage gaps and what regulatory or other considerations might be taken to ensure that legal businesses are properly protected through insurance products.

Superintendent Dwyer made a motion, seconded by Commissioner Richardson, to adopt the white paper Regulatory Guide: Understanding the Market for Cannabis Insurance (Attachment Five). The motion passed.

11. Adopted the Post-Disaster Claims Guide

Superintendent Dwyer reported the Transparency and Readability of Consumer Information (C) Working Group received a referral from the Catastrophe Insurance (C) Working Group to create a claims guide for DOIs to provide to consumers following
a disaster. The claims guide provides information on steps to take following a disaster, including how to report an insurance claim, information on additional living expenses, types of adjusters, depreciation, ordinance and law coverage, assignment of benefits; insurance fraud, and several other topics. The document also includes logs for consumers to record claim information, adjuster information, contractor information, claim communication and emergency repairs.

The Transparency and Readability of Consumer Information (C) Working Group will consider how to put this information onto a website that is readable for consumers.

Superintendent Dwyer made a motion, seconded by Commissioner Altmaier, to adopt the Post-Disaster Claims Guide (Attachment Six). The motion passed.

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

Director Lindley-Myers reported the Market Regulation and Consumer Affairs (D) Committee met Dec. 9 and took the following action: 1) adopted its Oct. 1 minutes, which included the following action: a) adopted its Summer National Meeting minutes; and b) appointed a new Privacy Protections (D) Working Group to address the charge to “[r]eview state insurance privacy protections regarding the collection, use and disclosure of information gathered in connection with insurance transactions, and make recommended changes, as needed, to certain NAIC models, such as the NAIC Insurance Information and Privacy Protection Model Act (#670) and the Privacy of Consumer Financial and Health Information Regulation (#672), by the 2020 Summer National Meeting.”

The Committee adopted its 2020 proposed charges, including the charges of the Antifraud (D) Task Force, the Market Information Systems (D) Task Force, and the Producer Licensing (D) Task Force.

The Committee adopted a Workers’ Compensation Standardized Data Request, which will be incorporated into the NAIC Market Regulation Handbook for the states to voluntarily use to determine if a company follows appropriate procedures with respect to the issuance and/or termination of worker compensation policies.

The Committee adopted Property/Casualty (P/C) Travel Insurance Examination Standards, which will be incorporated into the NAIC Market Regulation Handbook for the states to voluntarily use to conduct travel insurance company examinations. The standards are based upon the Travel Insurance Model Act (#632).

The Committee adopted revisions to the NAIC State Licensing Handbook, which was revised to be consistent with established NAIC policy on producer licensing.

The Committee adopted the 2019 Continuing Education Reciprocity (CER) Agreement used to support the use of the CER Form to streamline the course-approval process in multiple states. Through the reciprocal approval process, the continuing education (CE) provider’s home state conducts a substantive review of the CE course; therefore, non-resident states do not need to perform a similar review for a course previously approved by the home state.

The Committee adopted the reports of its task forces and working groups: the Antifraud (D) Task Force; the Market Information Systems (D) Task Force; the Producer Licensing (D) Task Force; the Advisory Organization Examination Oversight (D) Working Group; the Market Conduct Annual Statement Blanks (D) Working Group; the Market Conduct Examination Standards (D) Working Group; the Market Actions (D) Working Group; the Market Analysis Procedures (D) Working Group; the Market Regulation Certification (D) Working Group; and the Privacy Protections (D) Working Group. The adoption of the reports included the adoption of the following: 1) a recommendation from the Market Analysis (D) Working Group for the Market Conduct Annual Statement Blanks (D) Working Group to begin the development of an “Other Health” Market Conduct Annual Statement (MCAS) blank; and 2) a recommendation of the Market Conduct Annual Statement Blanks (D) Working Group to extend the health MCAS filing deadline to June 30 for 2020, 2021 and 2022.

The Committee heard a presentation from the American Psychiatric Association (APA) on mental health parity examinations, which provided an overview of existing parity market conduct examination areas of interest and encouraged state insurance regulators to use and expand their parity oversight and enforcement authority.

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

Commissioner Altmaier reported the Financial Condition (E) Committee met Dec. 9 and adopted its Oct. 31, Aug. 29 and Summer National Meeting minutes. During its Oct. 31 and Aug. 29 meetings, the Committee took the following action:
The Committee adopted the following: 1) adopted its 2020 proposed charges; 2) adopted a Request for NAIC Model Law Development related to the group capital calculation (GCC); 3) adopted revisions to the Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (#1556); and 4) adopted proposed changes to the Annual Statement Instructions – Property/Casualty, specifically related to the actuarial opinion, including, among other things, the definition of “qualified actuary.”

The Committee adopted the reports of the following task forces and working groups: the Accounting Practices and Procedures (E) Task Force; the Capital Adequacy (E) Task Force; the Examination Oversight (E) Task Force; the Receivership and Insolvency (E) Task Force; the Reinsurance (E) Task Force; the Risk Retention Group (E) Task Force; the Valuation of Securities (E) Task Force; the Group Capital Calculation (E) Working Group; the Group Solvency Issues (E) Working Group; the Mortgage Guaranty Insurance (E) Working Group; the National Treatment and Coordination (E) Working Group; and the Restructuring Mechanisms (E) Working Group.

The Committee also: 1) adopted proposed salary updates to the Financial Condition Examiners Handbook, which retains the current methodology in the handbook and also creates a new methodology that is based on ranges derived from a survey completed last year; and 2) adopted revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions.

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

14. **Adopted Amendments to the Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (#1556)**

Commissioner Altmaier reported on the changes to Guideline #1556. The proposed changes are intended to eliminate any misalignments between federal and state laws that could be an obstacle to achieving effective and orderly recovery and resolutions for U.S. insurance groups.

Commissioner Altmaier made a motion, seconded by Director Farmer, to adopt Guideline #1556 (Attachment Seven). The motion passed.

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

Director Lindley-Myers reported that the NAIC adopted revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) in June. These revisions are intended to conform the models to the reinsurance collateral provisions of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement), known collectively as the Covered Agreements. Not only are jurisdictions that are subject to the Covered Agreements treated as Reciprocal Jurisdictions for reinsurance collateral purposes, but other Qualified Jurisdictions can also qualify for collateral elimination as Reciprocal Jurisdictions. The states that meet the requirements of the NAIC Financial Standards and Accreditation Program are also considered to be Reciprocal Jurisdictions.

The Process for Evaluating Qualified and Reciprocal Jurisdictions was amended to reflect the revisions to Model #785 and Model #786 and add a new section on the review of Qualified Jurisdictions as Reciprocal Jurisdictions. Both the Reinsurance (E) Task Force and Financial Condition (E) Committee have adopted these revisions.

Director Lindley-Myers made a motion, seconded by Commissioner Altmaier, to adopt the revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions (Attachment Eight). The motion passed.

16. **Adopted the Re-Evaluation of Qualified Jurisdictions and Summary of Findings and Determinations for Bermuda, France, Germany, Ireland, Japan, Switzerland and the United Kingdom for the NAIC List of Qualified Jurisdictions**

Director Lindley-Myers reported that the initial five year evaluation periods for the current NAIC List of Qualified Jurisdictions (Bermuda, France, Germany, Ireland, Japan, Switzerland and the United Kingdom [UK]) are set to expire on Dec. 31, and it is necessary to approve their re-evaluations effective for Jan. 1, 2020. Several improvements were added to the revised process.
with respect to the evaluation of Qualified Jurisdictions, the most important being the elimination of the five-year re-evaluation requirement. Now, Qualified and Reciprocal Jurisdictions will remain on the lists until such time as there is a reason identified to remove them from the lists.

Director Lindley-Myers made a motion, seconded by Commissioner Altmaier, to adopt the Re-Evaluation of Qualified Jurisdictions and Summary of Findings and Determinations for Bermuda, France, Germany, Ireland, Japan, Switzerland and the UK for the NAIC List of Qualified Jurisdictions (Attachment Nine). The motion passed.

17. Adopted the Evaluation of Reciprocal Jurisdiction and Summary of Findings and Determinations for Bermuda, Japan and Switzerland for the NAIC List of Reciprocal Jurisdictions

Director Lindley-Myers made a motion, seconded by Commissioner Altmaier, to adopt the Evaluation of Reciprocal Jurisdiction and Summary of Findings and Determinations for Bermuda, Japan and Switzerland for the NAIC List of Reciprocal Jurisdictions (Attachment Ten) and add them to the NAIC List of Reciprocal Jurisdictions effective Jan. 1, 2020. They will join European Union (EU) member countries that are subject to an in-force Covered Agreement, eliminating reinsurance collateral requirements as automatically included on the NAIC List of Reciprocal Jurisdictions, as well as U.S. jurisdictions meeting requirements for accreditation under the NAIC Financial Standards and Accreditation Program. The motion passed.

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

Commissioner Kiser reported the Financial Regulation Standards and Accreditation (F) Committee met Dec. 6 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; 2) vote to award continued accreditation to the insurance departments of Connecticut, Massachusetts and New York; and 3) vote to award accreditation for the first time to the insurance department of the U.S. Virgin Islands.

The Committee met in open session Dec. 7 and adopted its Summer National Meeting minutes.

The Committee adopted revisions to Part D: Primary Licensing, Redomestication and Change of Control of the Self-Evaluation Guide (SEG)/Interim Annual Review effective Jan. 1, 2020. The revisions are consistent with updates to the Part D Review Team Guidelines adopted by the Committee at the Summer National Meeting.

The Committee adopted revisions to the Review Team Guidelines for troubled companies effective Jan. 1, 2020. The revisions incorporate updated guidance on timely and effective communication of a troubled or potentially troubled company between the domiciliary and non-domiciliary states.

The Committee adopted the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) as revisions to the Reinsurance Ceded accreditation standard. These revisions address the reinsurance collateral requirements necessary for U.S. ceding companies to take credit for certain reinsurance transactions and are designed to incorporate the relevant provisions of the Covered Agreements. The adoption included a waiver of procedure to expeditiously adopt the accreditation standard. The adopted effective date is Sept. 1, 2022, the end of the 60-month period when federal preemption mechanisms must be completed. Enforcement of the standard will commence Jan. 1, 2023. This standard will be considered by the Plenary at the 2020 NAIC Spring National Meeting.

The Committee adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) as a new accreditation standard effective Sept. 1, 2022. This model establishes uniform, national standards governing reserve financing arrangements pertaining to term life and universal life insurance policies with secondary guarantees. This standard will be considered by the Plenary at the 2020 NAIC Spring National Meeting.

19. Adopted Revisions to Part D: Primary Licensing, Re-Domestications and Change of Control of the Accreditation Standards

Commissioner Kiser reported at the Summer National Meeting, the Financial Regulations Standards and Accreditation (F) Committee adopted significant revisions to Part D: Primary Licensing, Redomestications and Change of Control of the Accreditation Standards. These revisions will serve to enhance each state’s ability to rely on the work of other accredited states and emphasize the importance of the functions covered by Part D. Those functions encompass a review of primary licensure for new companies; Form A filings for mergers and acquisitions; and with the revisions, redomestications.
The Committee also took the step of subjecting Part D to a formal recommendation from the Review Team with the result that the outcome could affect a state’s accredited status. Previously, these standards were subject to management comments or improvement suggestions but were not given the same weight as the analysis and examination standards. This element of the proposal appropriately elevates the Part D standards with the goal to achieve more effective regulation.

Commissioner Kiser made a motion, seconded by Commissioner Altmaier, to adopt revisions to Part D: Primary Licensing, Redomestications and Change of Control of the Accreditation Standards, which include the addition of redomestications within the standards, with an effective date of Jan. 1, 2020, and subject all of the Part D standards to Recommendation A or B, with the result that the outcome can affect a state’s accredited status, with an effective date of Jan. 1, 2022 (Attachment Eleven). The motion passed.

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

Commissioner Anderson reported the International Insurance Relations (G) Committee met Dec. 7 and adopted its Nov. 6, Oct. 15, Aug. 13, and Summer National Meeting minutes. During its Nov. 6, Oct. 15 and Aug. 13 meetings, the Committee took the following action: 1) heard an update on upcoming International Association of Insurance Supervisors (IAIS) committee meetings; 2) approved submission of NAIC comments on the IAIS draft Issues Paper on the Use of Big Data Analytics in Insurance; 3) heard updates on IAIS activities and the Financial Sector Assessment Program (FSAP); and 4) approved submission of NAIC comments on IAIS revised supervisory material and material related to the holistic framework for systemic risk in the insurance sector.

The Committee adopted the report of the ComFrame Development and Analysis (G) Working Group. The Working Group met Dec. 7 in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to: 1) discuss next steps for implementation of the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) and the monitoring period; and 2) hear an update on the aggregation method (AM) process. The Working Group has fulfilled its mandate and will be disbanded with all ongoing work to be absorbed under the existing groups within the Financial Condition (E) Committee.

The Committee also adopted its 2020 proposed charges.

The Committee heard updates on key 2019 projects of the IAIS, including revised Insurance Core Principles (ICPs) and ComFrame, the holistic framework for systemic risk in the insurance sector, and the insurance capital standard (ICS) and monitoring period. While these key IAIS projects were finalized this year, work on implementation and further development will continue into 2020 and the Committee will remain engaged on these projects.

The Committee heard updates on international activities, focusing on regional supervisory cooperation and the Organisation for Economic Co-operation and Development (OECD). Regional supervisory cooperation activities include ongoing engagement with regulators in Europe, the Asia-Pacific region, and Latin America, as well as the NAIC International Fellows Program.

The Committee heard an update on the FSAP. The 2019–2020 International Monetary Fund (IMF) FSAP of the U.S. financial regulatory system is currently underway. The FSAP comprises Mission 1 and Mission 2, with much of the work for the FSAP exercise for insurance concentrated in Mission 1, which took place this fall. Mission 2 will take place in early 2020, with meetings with the NAIC and several states. The IMF is expected to publish a technical note on insurance by the summer of 2020.

21. Received a Status Report on State Implementation of NAIC-Adopted Model Laws and Regulations

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

22. Heard the Results of the 2020 NAIC Zone Officer Election

The Executive (EX) Committee and Plenary received the results of the 2020 NAIC zone officer elections: Midwest Zone: Director Larry Deiter, Chair (SD); Director Jillian Froment, Vice Chair (OH); and Commissioner Doug Ommen, Secretary (IA). Northeast Zone: Commissioner Stephen C. Taylor, Chair (DC); Commissioner Jessica Altman, Vice Chair (PA); and Commissioner Gary Anderson, Secretary (MA). Southeast Zone: Commissioner Jim L. Ridling, Chair (AL); Commissioner
Mike Chaney, Vice Chair (MS); and Commissioner James J. Donelon, Secretary (LA). Western Zone: Director Lori K. Wing-Heier, Chair (AK); Commissioner Michael Conway, Vice Chair (CO); and Commissioner Andrew Stolfi, Secretary (OR).

23. **Elected the 2020 NAIC Officers**

The NAIC membership elected the 2020 NAIC officers: Director Raymond G. Farmer, President (SC); Commissioner David Altmaier, President-Elect (FL); Director Dean L. Cameron, Vice President (ID); and Director Chlora Lindley-Myers, Secretary-Treasurer (MO).

Having no further business, the Executive (EX) Committee and Plenary adjourned.
NAIC 2020 Budget
Reconciliation of Revenue/Expense Changes to the 2020 Budget

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Investment Income</th>
<th>Expense</th>
<th>Revenues Over/ (Under) Expenses</th>
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<td>$3,153,072</td>
<td>$124,499,330</td>
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Amendments:
1. SERFF Business and Technical Assessment
   - 324,500
   - (324,500)

Revised NAIC 2020 Budget as presented for adoption at the NAIC 2019 Fall National Meeting

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Investment Income</th>
<th>Expense</th>
<th>Revenues Over/ (Under) Expenses</th>
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Notes:
1. On October 7, 2019 the NAIC Executive (EX) Committee approved the release of a request for proposal (RFP) to identify a firm to conduct a business and technical assessment of the NAIC’s System for Electronic Rate and Form Filing (SERFF). The selection of the firm and cost of the assessment was approved on December 7, 2019.
Executive Summary
NAIC 2020 Budget

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

The 2020 budget incorporates funding for the final year of the NAIC’s three-year strategic plan, State Ahead. The plan articulates a comprehensive vision for the future of state insurance regulation and how the NAIC can help the membership stay ahead of the curve in a rapidly evolving marketplace. The budget demonstrates a firm commitment to the initiatives outlined in State Ahead, with its support of technology advancements and the continuing modernization of insurance regulation in areas such as innovation, cybersecurity, and international standard-setting.

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

For many years, the NAIC has collected data on behalf of the states for statutory financial statements, complaints data, and Market Conduct Annual Statements (MCAS). In recent years, the NAIC has expanded its services to include regulatory ad-hoc data collection efforts, such as the short-term limited duration data call. With the expansion of services, the NAIC is utilizing new technologies to develop and expand systems for collecting various regulatory data sets in a timely and cost-effective manner.

Identified in State Ahead as a significant element to achieving the plan’s goals, the NAIC has committed to moving its technology platform to the Cloud. Through mid-2019, the NAIC has nine applications in the Cloud, including the Professional Designation program and MCAS. Cloud solutions will streamline data intake processes, expand the tools offered to the membership and the insurance industry, increase the level and timeliness of analysis, and allow for experimentation of new products and services without a significant financial investment.
Support of the Membership

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

A Focus on Consumers

The NAIC provides a multi-channel approach to reach and assist consumers in making informed decisions on insurance matters. These multi-pronged public relations campaigns include items like consumer insights and alerts, a consumer section on naic.org, mobile apps, and targeted social campaigns. The NAIC also hosts a consumer hotline to help consumers contact their state insurance departments for assistance.

Valuable Products and Services

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

The NAIC is committed to maintaining and enhancing these systems to provide high-quality service to all stakeholders. The 2020 budget includes five technology-based fisals, which represent initiatives to automate manual processes, enhance security, streamline billing processes, take advantage of cloud-based solutions, and improve delivery of products and services.

By the Numbers

NAIC products and services make life easier on a number of fronts.

- **Life Policy Locator** – 100,006 requests received in 2018, with 31,385 located life insurance policies for a total claims amount of more than $454 million
- **System for Electronic Rates & Forms Filing (SERFF)** – 557,089 transactions processed in 2018
- **Online Premium Tax for Insurance (OPTins)** – 142,616 transactions processed in 2018
- **State Based Systems (SBS)** – provides back-office services for 30 jurisdictions in 2019
- **Professional Designation Program** – 1,211 designations awarded since the program’s inception in October 2006
- **Center for Insurance Policy and Research (CIPR) Key Research Issues** – 150 briefs currently available online including NAIC key initiatives and topics ranging from cybersecurity and innovation to natural catastrophe risk and resiliency
Building the Budget

The NAIC strives for transparency in its budget process as well as in its operations. The budget process gets underway in the spring each year, when department managers evaluate current-year revenues and expenses in order to assess the year-end picture, then propose a budget for the following year based on their operational objectives and member initiatives. Managers carefully focus on variances between the current year’s budget and projected results and anticipated business needs for the coming year. This process includes a review of all projects, products, programs, services, committee charges, and technology initiatives in light of the NAIC’s mission and the membership’s strategic priorities, particularly those outlined in State Ahead. NAIC senior management reviews each department budget in detail with its division director to make adjustments according to the strategic and financial needs of the association and ultimately consolidates all requests into a single, comprehensive budget.

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

2019: The Halfway Point of State Ahead

State Ahead outlined 94 initiatives to be accomplished over three years. The NAIC is at the halfway mark with the completion of 35 of these initiatives, while 40 are being actively worked and 19 more are slated to start in 2020.

2019: Building Full Speed Ahead

The NAIC continued to focus on building an infrastructure for data, technology, and talent to implement State Ahead.

Expected Results for 2019

Based on actual operating results (before adding investment income) through June 30, 2019, the NAIC projects a net negative operating margin of $8.8 million compared to a budgeted net negative operating margin of $11 million, an improvement of nearly $2.3 million. Investment income is projected to be $13.7 million, resulting in a net asset increase of $4.9 million.

Several initiatives outlined in the State Ahead blueprint resulted in fiscal impact statements for 2019. These fiscals were made available for public comment in advance of membership consideration, approval, and incorporation into the 2019 budget.

Additional information regarding 2019 projected variances is included throughout the detailed footnotes of the budget.

Year Three of the Plan

2020: Transforming

By the end of 2020, the NAIC will be positioned to provide its members with new analytics, technology, and tools to more effectively regulate their markets.

2020 Budget

The 2020 budget demonstrates NAIC’s continued strong focus on prudent financial management.

The 2020 NAIC operating budget (before adding investment income) reflects revenues of $114.5 million and expenses of $124.5 million, which represent a 6.5% and a 5.1% increase, respectively, from the 2019 budget, resulting in $10.0 million in projected expenses over revenues. Viewed in relation...
to the 2019 projected totals, the 2020 budget represents operating revenue increase of 3.8% and operating expense increase of 4.6%. Additional information about the 2020 budget is included throughout the detailed footnotes of the budget.

A fiscal impact statement (fiscal) is prepared for new or existing NAIC initiatives with revenue, expense, or capital impacts of $100,000 or more either in the current budget or within the following few years’ budgets or requires more than 1,150 internal technical resources to accomplish. Each fiscal includes a detailed description of the initiative; the impact on key stakeholders; the financial and operational impact of the initiative; and an assessment of the risks. The total financial impact of the five fiscal included in the 2020 budget is a net of $4.3 million in expenses over revenues. Additional information about each initiative is included in the various Fiscal tabs of the budget.

The 2020 budget includes $3.2 million in investment income from the NAIC’s Long-Term Investment Portfolio. Investment income is composed of interest and dividends earned reduced by investment management fees – investment gains and losses are not projected nor included in the budget.

Combining budgeted results from operations with budgeted investment income, the 2020 budget has a reduction in net assets of $6.9 million.

Preparing for the Unknown

The budget proposal includes all known activities anticipated to occur in 2020. However, situations may arise during the course of the year that require additional funding. In such an event, a funding request is prepared and presented to the Executive (EX) Committee and Internal Administration (EX1) Subcommittee for consideration. Funding for any approved project comes from the Regulatory Modernization and Initiatives Fund, established in 2005 to manage requests for funding for specific projects.

2020 Fiscal Impact Statements

- **Cloud Transition Phase IV (Cloud Migration)** – This fourth phase of the project focuses on minimal change to most of the targeted systems to be migrated, in order to do so quickly and at a minimal cost. This phase continues the culture transformation designed to make the organization nimbler, thus enabling more frequent and faster delivery of products, and provides technical support for cloud projects already in progress.
  - Net 2020 expense of $3.2M after NIPR cost-sharing

- **Enhanced Regulatory Data Collection (RDC)** – This project expands the current system into an enterprise solution that can integrate with other applications, improve data quality, and speed up the review process. This project will enable business owners to be more self-reliant and independent. This project will provide functionality that will be used by the Uniform Certificate of Authority Application (UCAA) redesign.
  - Expense in 2020 of $239K

- **Financial Data Delivery Platform Enhancement** – This initiative moves financial statement data order fulfillment to the Cloud, thereby eliminating outdated platforms and improving the NAIC’s security profile. This project will allow customers to access their data in a more timely manner without manual intervention and support from NAIC staff.
  - Expense in 2020 of $397K

- **SERFF Billing Enhancements** – will simplify the SERFF transaction pricing structure by eliminating SERFF prepaid blocks and instead charging a fee based on prior-period usage. The NAIC will also collect the transaction fee at the time of filing, thereby reducing payment and collection efforts.
  - Expense in 2020 of $86K

- **Uniform Certificate of Authority Application (UCAA) Redesign and Biographical Affidavit Database** – moves the UCAA platform to the Cloud and expands the number of company licensing-related forms and applications, including Biographical Affidavits, by 2022.
  - Expense in 2020 of $390K, with $760K in 2021 and $295K in 2022
that arise following the adoption and implementation of an annual budget. The Fund is based on 1.5% of the NAIC’s projected consolidated net assets as of December 31, 2020, or $1.9 million with the inclusion of fiscals.

**Ensuring Financial Stability**

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

In July 2015, the Executive (EX) Committee and Internal Administration (EX1) Subcommittee approved a report from an independent financial advisory firm which established the NAIC’s liquid operating reserve target range of 83.4% to 108.2%. This range was the result of a comprehensive review of current and future identified risks and an evaluation of comparable organizations. This report recognized the increased level of uncertainty facing the NAIC and anticipated future investments which would be required to enhance the association’s information technology and technical infrastructure, which is represented by many elements of the 2020 budget.

**Contact Information**

The NAIC appreciates the opportunity to present this 2020 budget and believes it provides a comprehensive review of the NAIC’s business and financial operations for the current and upcoming fiscal year. A summary of the 2020 budget’s key components is included in the budget overview.

Please feel free to contact Jim Woody, Chief Financial Officer, at (816) 783-8015, or Carol Thompson, Senior Controller, at (816) 783-8038, should you have any questions or need additional information.

---

**Operating Reserve**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018 Audited</td>
<td>93.0%</td>
</tr>
<tr>
<td>2019 Projected</td>
<td>94.7%</td>
</tr>
<tr>
<td>2020 Proposed</td>
<td>91.3%</td>
</tr>
</tbody>
</table>

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## 2020 Budget with Fiscal Impact Statements

### Revenue and Expense by Line

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Assessments</td>
<td>R1</td>
<td>$2,108,679</td>
<td>$1,054,205</td>
<td>$2,090,460</td>
<td>$2,109,460</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Database Fees</td>
<td>R2</td>
<td>$29,750,827</td>
<td>$30,958,559</td>
<td>$30,906,867</td>
<td>$30,334,777</td>
<td>$625,090</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Publications and Insurance Data Products</td>
<td>R3</td>
<td>$16,059,955</td>
<td>$7,259,383</td>
<td>$16,156,765</td>
<td>$15,912,690</td>
<td>$244,075</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valuation Services</td>
<td>R4</td>
<td>$26,918,340</td>
<td>$9,324,749</td>
<td>$27,449,436</td>
<td>$26,942,918</td>
<td>$506,518</td>
<td></td>
<td></td>
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<tr>
<td>Transaction Filing Fees</td>
<td>R5</td>
<td>$10,752,404</td>
<td>$6,229,960</td>
<td>$11,454,121</td>
<td>$11,117,289</td>
<td>$336,892</td>
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<td></td>
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<tr>
<td>National Meetings, NAIC Events, and Interim Meetings</td>
<td>R6</td>
<td>$2,549,365</td>
<td>$1,147,500</td>
<td>$2,811,000</td>
<td>$2,807,531</td>
<td>$23,469</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education and Training</td>
<td>R7</td>
<td>$391,930</td>
<td>$124,365</td>
<td>$376,666</td>
<td>$414,398</td>
<td>$(37,732)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative Services and License Fees</td>
<td>R8</td>
<td>$17,166,364</td>
<td>$9,733,962</td>
<td>$18,860,249</td>
<td>$17,730,395</td>
<td>$1,138,819</td>
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<td></td>
</tr>
<tr>
<td><strong>Total Operating Revenues</strong></td>
<td>R9</td>
<td>$43,601</td>
<td>$21,623</td>
<td>$30,000</td>
<td>$61,500</td>
<td>$39,493</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Salary Income**

<table>
<thead>
<tr>
<th>Description</th>
<th>2018 Actual</th>
<th>2019 Actual</th>
<th>2019 Projected</th>
<th>Increase (Decrease) from 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Salary Income</td>
<td>50,241,678</td>
<td>51,971,330</td>
<td>220,741</td>
<td>$1,729,662 ($1,301,187)</td>
</tr>
</tbody>
</table>

**Other Income**

<table>
<thead>
<tr>
<th>Description</th>
<th>2018 Actual</th>
<th>2019 Actual</th>
<th>2019 Projected</th>
<th>Increase (Decrease) from 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Operating Expenses</td>
<td>$105,454,967</td>
<td>$124,899,360</td>
<td>5,431,953</td>
<td>4,687,393 (7,865)</td>
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</tbody>
</table>

**Revenues Over/(Under) Expenses before Investment Income**

<table>
<thead>
<tr>
<th>Description</th>
<th>2018 Actual</th>
<th>2019 Actual</th>
<th>2019 Projected</th>
<th>Increase (Decrease) from 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Revenues</td>
<td>$286,498</td>
<td>$286,498</td>
<td>$286,498</td>
<td>$286,498</td>
</tr>
</tbody>
</table>

**Investment Income**

<table>
<thead>
<tr>
<th>Description</th>
<th>2018 Actual</th>
<th>2019 Actual</th>
<th>2019 Projected</th>
<th>Increase (Decrease) from 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Investment Income</td>
<td>$(3,183,385)</td>
<td>$(3,183,385)</td>
<td>$(3,183,385)</td>
<td>$(3,183,385)</td>
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</tbody>
</table>

**Revenues Over/(Under) Expenses**

<table>
<thead>
<tr>
<th>Description</th>
<th>2018 Actual</th>
<th>2019 Actual</th>
<th>2019 Projected</th>
<th>Increase (Decrease) from 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Revenues</td>
<td>$(2,896,887)</td>
<td>$(2,896,887)</td>
<td>$(2,896,887)</td>
<td>$(2,896,887)</td>
</tr>
</tbody>
</table>

A detailed analysis of each line item is included in the Revenue Detail, Expense Detail, and Investment Income Detail tabs.
## 2020 Fiscal Impact Statements
(dollars in thousands)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cloud Transition Phase IV (Cloud Migration)</td>
<td>$133.1</td>
<td>$3,341.7</td>
<td>(3,208.6)</td>
<td></td>
</tr>
<tr>
<td>Enhanced Regulatory Data Collection (RDC)</td>
<td></td>
<td>238.7</td>
<td>(238.7)</td>
<td></td>
</tr>
<tr>
<td>Financial Data Delivery Platform Enhancement</td>
<td></td>
<td>396.8</td>
<td>(396.8)</td>
<td></td>
</tr>
<tr>
<td>SERFF Billing Improvements</td>
<td></td>
<td>86.4</td>
<td>(86.4)</td>
<td></td>
</tr>
<tr>
<td>Uniform Certificate of Authority Application (UCAA) Redesign and Biographical Affidavit Database</td>
<td></td>
<td>390.4</td>
<td>(390.4)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Fiscal Impact Statements</strong></td>
<td><strong>133.1</strong></td>
<td><strong>4,453.9</strong></td>
<td><strong>(4,320.8)</strong></td>
<td><strong>$0.0</strong></td>
</tr>
<tr>
<td><strong>2020 Budget Before Fiscals</strong></td>
<td><strong>114,330.0</strong></td>
<td><strong>120,045.4</strong></td>
<td><strong>(5,715.5)</strong></td>
<td><strong>1,419.6</strong></td>
</tr>
<tr>
<td><strong>2020 Budget After Fiscals and Before Investment Income</strong></td>
<td><strong>114,463.1</strong></td>
<td><strong>124,499.3</strong></td>
<td><strong>(10,036.2)</strong></td>
<td><strong>1,419.6</strong></td>
</tr>
<tr>
<td><strong>Investment Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2020 Budget After Fiscals and Investment Income</strong></td>
<td><strong>$117,616.2</strong></td>
<td><strong>$124,499.3</strong></td>
<td><strong>($6,883.3)</strong></td>
<td><strong>$1,419.6</strong></td>
</tr>
</tbody>
</table>
Date: November 14, 2019

To: All NAIC Members and Interested Parties

From: Director Raymond G. Farmer, NAIC President-Elect
     Michael Consedine, NAIC Chief Executive Officer
     Andy Beal, NAIC Chief Operating Officer and Chief Legal Officer
     Jim Woody, NAIC Chief Financial Officer

Re: Summary of Comments on the Proposed 2020 NAIC Budget

The NAIC received one comment letter from the National Association of Mutual Insurance Companies (NAMIC) on the proposed 2020 budget after it was released for public comment on October 8, 2019. This document summarizes NAMIC’s comments and includes the NAIC’s response to each comment.

A Public Hearing will be held November 18, 2019, to discuss these comments. Participation instructions for the public hearing can be accessed at http://www.naic.org/about_budget.htm.

Contributions to Regulator Efficiency

- NAMIC noted the NAIC 2020 budget includes several programs and services that contribute to efficiencies in state-based insurance regulation and enable regulators to become more proficient in their roles. NAMIC cited the continued upgrade of financial analysis solvency tools through the FASTR project; the investments in the NAIC Professional Designation Program; the migration to and development of new programs within a cloud computing environment, and the steps taken to strengthen the NAIC’s data security environment. NAMIC went on to provide detailed statements of support for each of these initiatives. NAMIC did caution NAIC “to not inject any regulatory biases or other ill-defined, aspirational goals that do not further state-based insurance regulation but do cause unnecessary compliance costs that are ultimately borne by policyholders.”

NAIC Response: The NAIC appreciates NAMIC’s support of these initiatives. The NAIC’s goal is to ensure state-based insurance regulation keeps pace with a rapidly changing marketplace. The initiatives cited by NAMIC as well as numerous others outlined on the NAIC State Ahead website demonstrate that commitment. NAIC senior leadership developed an internal project review process several years ago, which requires all key initiatives be vetted before starting, to ensure the project is aligned with State Ahead and Member priorities and will provide benefits to state-based regulation. Any project meeting certain thresholds requires a fiscal impact statement, or fiscal. These thresholds are expenses exceeding $100,000, technology resources exceeding 1,150 hours, or any new revenue stream. Fiscals are posted on the NAIC’s website prior to
membership consideration in order to allow for the public to comment. Both the internal vetting and the fiscal process are designed to ensure that all initiatives undertaken by NAIC staff will enhance or improve state-based insurance regulation and will not result in unnecessary costs.

**Internal Data Protection and Security**

- NAMIC noted the NAIC is spending time and financial resources to increase the level of data protection and security around the data and data repositories the NAIC maintains by conducting independent third-party audits. While supporting the direction the NAIC is taking to ensure data and systems are protected, NAMIC also stated it does not necessarily mean the insurance industry is comfortable providing additional data to the NAIC without justification.

**NAIC Response:** As NAMIC noted, the 2020 budget reflects NAIC’s commitment to data protection and security, especially in light of the transition to the Cloud. The NAIC collects a wide variety of data from various sources, primarily from the insurance industry. It does so, however, based on a regulatory business need. There is no intent to collect data simply because of any technology expansion efforts. Data collection has been and will continue to be at the request of the NAIC membership for the purpose of regulating the insurance industry.

**Cloud Development Tools Modernization**

- One of the four initiatives specifically supported by NAMIC was the migration of the NAIC’s applications to the Cloud, which is a significant element to the State Ahead strategic plan. NAMIC pointed out the investments associated with each of the four phases, noting the initiative has the capability to reduce maintenance costs, improve efficiencies, and strengthen security. NAMIC said its members are interested in reviewing a comprehensive cost/benefit analysis of the NAIC’s migration to the Cloud and asked for the costs to develop and maintain the Cloud on an ongoing basis, the benefits and costs savings to operating in a Cloud environment, and the overall security enhancements that go along with managing and housing applications that contain sensitive and proprietary company information on the Cloud.

**NAIC Response:** The NAIC appreciates NAMIC’s support of this critical initiative. Although the NAIC will be entering its fourth phase of the initiative in 2020, the work to complete migrations will continue past year-end 2020. A number of significant systems are scheduled to begin migrations in 2020, such as SERFF, State Based Systems, and I-SITE; however, given the size of these systems, it is not expected that all systems will be fully migrated to the Cloud by year-end 2020. The NAIC does, however, expect to complete the project utilizing internal resources, thereby not requesting additional fiscal funding.

As noted in the 2020 fiscal, the primary benefits of investing in the cloud platform are increased efficiencies including improved system availability; enhanced customer support; predictable costs and flexibility; and greater innovation opportunities. Cost savings are expected long term, but while the migration is in progress, the NAIC recognizes it must continue to invest in the on-premise systems as well as the cloud migrations in order to continue its operations. Having said that, the NAIC has taken steps to reduce costs where feasible. First, the NAIC has engaged an
industry-leading firm to provide consulting expertise as to how best to design and deploy cloud-based solutions. In addition, the NAIC has also implemented a cost management program managed by another industry-leading firm which pinpoints potential cost savings in the Cloud by taking certain actions. The NAIC will continue to investigate opportunities to reduce the cost of maintaining its Cloud infrastructure while taking advantages of the Cloud’s technical capabilities.

IAIS Dues

- NAMIC noted that the NAIC dues paid to the International Association of Insurance Supervisors (IAIS) continue to increase at a significant rate and questioned the value proposition. NAMIC members asked whether the NAIC is one of the highest paying members and/or if they are assessed based on the number of jurisdictions in the United States.

NAIC Response: The IAIS annual dues paid by the NAIC cover the memberships of the NAIC itself and the individual 56 NAIC members. IAIS annual dues are calculated based on two parameters: the written premium within the jurisdiction and the jurisdiction’s GDP per capita. The size of the US insurance market relative to the rest of the world and the US GDP, result in the NAIC’s annual dues level. While the NAIC’s IAIS dues increased 12.5% in 2020 compared to 2019, a 10% increase is expected in 2021 and annual fee increases will continue to decline in subsequent years. Additionally, the NAIC is continuing to work with IAIS Secretariat to control the level of spending and identify further operational improvements that can be reflected in annual budgets. Since the dues are billed in Swiss Francs, the actual rate the NAIC pays in US dollars may be higher or lower depending on the currency exchange rate when the payment is made.

Concluding Comments

The NAIC takes a holistic approach to the development of its annual budget. With the goal of transparency in mind, NAIC leadership welcomes the opportunity to publicly present the proposed 2020 NAIC budget and respond to questions and/or comments raised by interested parties. State insurance regulators, supported by the NAIC, are committed to protecting policyholders as well as ensuring the financial solvency of the insurance industry in a cost-effective and financially prudent manner. The NAIC continuously seeks opportunities to reduce operating costs while providing world-class support to its members, regulators, insurance customers, and interested parties. In addition, the NAIC will continue to utilize a portion of its Net Assets to ensure the products and services required by state insurance departments are delivered with minimal price changes.
November 7, 2019

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

VIA Email Transmission: jwoody@naic.org

RE: NAMIC Comments – NAIC Proposed 2020 Budget

Dear Mr. Woody:

The following comments are submitted on behalf of the members of the National Association of Mutual Insurance Companies1 regarding the NAIC’s proposed 2020 budget.

NAMIC members have long been supporters of the state-based regulatory system and are mindful of the many challenges facing state insurance departments, such as working with limited or dwindling resources or attracting and retaining talent. We therefore believe it is incumbent upon the NAIC to assure streamlined and efficient regulatory standards and guidance so as not to unduly burden states in carrying out their respective duties and responsibilities.

Regarding the 2020 budget, there are several programs and services that NAMIC believes will go a long way to helping state regulators become more efficient and proficient in their critical role as state regulators. Such programs and services include: the continued upgrade of financial analysis solvency tools (FASTR), the new investments made to the NAIC Professional Designation Program, the migration to and development of new programs within a cloud computing environment, and the enhancements made to the NAIC’s own data security environment. These programs and others demonstrate that the NAIC is becoming a more important resource to the states in a society becoming more dependent on the use of new and innovative technology. However, as the NAIC continues to incorporate data analytics and other artificial intelligence into its internal analysis and workstream, caution should be taken not to inject any regulatory biases or other ill-defined, aspirational

1 NAMIC membership includes more than 1,400 member companies. The association supports regional and local mutual insurance companies on main streets across America and many of the country’s largest national insurers. NAMIC member companies write $268 billion in annual premiums. Our members account for 59 percent of homeowners, 46 percent of automobile, and 29 percent of the business insurance markets. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.
goals that do not further state-based insurance regulation but do cause unnecessary compliance costs that are ultimately borne by policyholders.

The remainder of our comments will focus on these areas of interest but also include some commentary on the overall direction of the NAIC.

Financial Analysis Solvency Tools
The NAIC 2020 budget includes $135,000 in professional services for the continued work on the Financial Analysis Tool Redesign (FASTR). This program, which included dedicated Fiscal Statements in both the 2018 and 2019 budgets, is a long-term program designed to help the state financial analyst become more efficient and to make their jobs easier. As part of the State Ahead strategy, the first phase of FASTR included a redesign of the Financial Profile Report, an automated analysis tool that allows regulators to better identify issues and trends and to navigate financial data more efficiently. The second phase when fully implemented will include an update to the financial risk repositories, a massive database of insurer financial data that allows regulators to monitor the performance of the industry and identify concerns for further investigation. NAMIC members support the upgrades of these tools and are hopeful they will lead to more valuable insurer/regulator interactions.

NAIC Professional Designation Program
In addition to helping the states with new tools and enhanced ways to access and analyze data, another initiative that has potential to help state insurance regulators is the NAIC Professional Designation Program and specifically the increased investment into the program for the 2020 fiscal year. In conjunction with this program, the NAIC budget proposes an increase of $91,400 in professional fees. NAMIC supports this increase in spending and supports the overall program which started in 2006 and has awarded over 1,200 professional designations in that time. As communicated in the State Ahead Initiative, the NAIC wishes to increase regulator enrollment into the program and NAMIC also encourages more states to participate. Given the current state of demographics in the U.S. economy, a program like this is critical if states and the NAIC want to address the issue of the high rate of retiring baby-boomers. Continued investments into programs like this will help train the future regulators of tomorrow to deal with the complex and ever-changing insurance regulatory landscape.

Cloud Development Tools Modernization
A significant element in the State Ahead Initiative includes the migration of all the NAIC’s applications to a Cloud environment. Since 2017, the NAIC has dedicated funds to developing a Cloud strategy and included minimal investments into Cloud programs and services. As the State Ahead Initiative was formalized, so too were increased investments into the NAIC’s Cloud Strategy, starting in 2018 with an investment of $238,000. These initial investments were the start of migrating existing NAIC applications to the Cloud. Last year, according to the 2019 Fiscal Statement regarding the third phase of cloud transition, budgeted spending increased dramatically to $3.5 million; however, this represented the first full year of system migrations. Included in the 2020 budget is an additional request of $3.3 million in expenses. The aggregated
amount of spending for cloud migration projects totals just over $7 million over the last four budget cycles. The sheer volume of these figures speaks to the NAIC’s dedication to running programs and systems in a safer and more secure environment, such as the Cloud, and its’ importance to the overall strength of the organization.

The migration to the Cloud has the opportunity to reduce IT maintenance costs and according to the commentary provided during the Open Hearing for the budget, some of those savings have started to emerge. Further, outdated and obsolete systems are being retired and the systems replacing them that are being hosted on the Cloud are more efficient. In addition, the new applications that are being initially developed on the Cloud have the benefit of being developed utilizing the latest technologies and security enhancements. With these potential benefits and the high development costs, NAMIC members are interested in reviewing a comprehensive cost/benefit analysis of the NAIC’s migration to the Cloud. Included in this analysis would be the costs to develop and maintain the Cloud on an ongoing basis, the benefits and costs savings to operating in a Cloud environment, and the overall security enhancements that go along with managing and housing applications that contain sensitive and proprietary company information on the Cloud.

Internal Data Protection and Security
Data protection and security is another area where NAMIC supports the direction NAIC operations is taking, particularly as it pertains to the increasing amount of company information being shared between the NAIC and the states. Whether that includes financial data included as part of the risk repositories or the nearly 170 systems that will ultimately be run on the Cloud, NAMIC applauds the NAIC for taking steps to enhance the organizations information systems through conducting independent third-party audits to certify each of their systems against industry (SOC 2) standards. A note in the 2020 budgets on professional fees: audits, includes a line item of $180,000 for a SOC 2 gap assessment for cloud computing, $148,400 for a cybersecurity audit, and $90,000 for security testing related to cloud computing. This demonstrates the NAIC’s recognition of how important it is to provide a safe and secure environment for their members (states) to work within. NAMIC strongly encourages the NAIC to continue its commitment the important area of data protection and security.

Simple technology upgrades and security measures, however, do not mean that the industry supports or is comfortable with any enhanced data requirements it may be asked to submit to the NAIC for regulatory approval. Requests should not be inordinate, excessive, or in any way justified simply because the NAIC has engaged in technology expansion. Further, as additional, critical, proprietary, and confidential information is submitted per regulatory requirements, the NAIC as the data hub for this information should continue to implement and explore extremely robust protections from external sources.

General Comments
Each of the last several years, revenues and expenses combined have outperformed the budget. Factoring in investment gains during those years has allowed the NAIC to operate at a deficit yet continue to grow its’ net asset base. For the 2020 budget the NAIC is targeting a slight decrease to its’ liquid operating reserve ratio; however, it remains in the necessary
range for adequate funding. Continued growth and expansion should be in proportion to expected needs and tempered by continued review for efficiencies and removal of redundancies that provide excessive costs to all stakeholders, thereby continuing to be good stewards of public and private funds.

For instance, dues paid to the International Association of Insurance Supervisors continue to increase at a significant rate with no apparent end in sight – and for an increasingly questionable value proposition based on the direction of many of their workstreams. The increase from 2018 to 2019 was just over $50,000 and budgeted 2020 dues includes an additional $91,000 bringing total dues to be paid in 2020 to the IAIS to just over $671,000. NAMIC members inquire whether the NAIC is one of the highest paying members and/or if they are assessed based on the number of jurisdictions in the United States.

Closing
NAMIC members appreciate the opportunity to provide input on the NAIC 2020 annual budget. We believe the association is managing the significant finances of the organization and has invested in several projects that may benefit the states and ultimately the insurers and policyholders they serve.

Thank you for your consideration of these comments on this matter of importance to NAMIC, its member companies, and their policyholders.

Sincerely,

Jon Bergner
Assistant Vice President – Public Policy and Federal Affairs
National Association of Mutual Insurance Companies
Executive (EX) Committee and Plenary, 12/10/19

2020 Committee Charges

EXECUTIVE (EX) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Executive (EX) Committee will:
   A. Identify the goals and priorities of the organization and make recommendations to achieve such goals and priorities based on input of the membership. Make recommendations by the 2020 Commissioners Conference.
   B. Create/terminate task force(s) and/or Executive (EX) Committee-level working groups to address special issues and monitor the work of these groups. Create necessary task force(s) and/or Executive (EX) Committee-level working groups throughout 2020 as necessary.
   C. Submit reports and recommendations to NAIC members concerning the activities of its subcommittee and the standing committees. Submit a report at each national meeting.
   D. Consider requests from NAIC members for friend-of-the-court briefs.
   E. Establish and allocate functions and responsibilities to be performed by each NAIC zone.
   F. Pursuant to the Bylaws, oversee the NAIC offices to assist the organization and the individual members in achieving the goals of the organization.
   G. Conduct strategic planning on an ongoing basis.
   H. Plan, implement and coordinate communications and activities with the Federal Insurance Office (FIO).
   I. Plan, implement and coordinate communications and activities with other state, federal, local and international government organizations to advance the goals of the NAIC and promote understanding of state insurance regulation.
   J. Review and approve requests for the development of model laws and/or regulations. Coordinate the review of existing model laws and/or regulations.
   K. Select NAIC national meeting sites five and six years in advance of the meeting date to ensure efficient and economical locations and facilities.
   L. Review and revise, as necessary and appropriate, the criteria and categories for registrants at NAIC national meetings.

NAIC Support Staff: Andrew J. Beal/Kay Noonan
FINANCIAL STABILITY (EX) TASK FORCE

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

Ongoing Support of NAIC Program, Products or Services

1. The Financial Stability (EX) Task Force will:

   A. Consider issues concerning domestic and global financial stability as they pertain to the role of state insurance regulators and make recommendations to the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council, and/or the Executive (EX) Committee, as appropriate.

   1. Analyze existing post-financial crisis regulatory reforms for their application in identifying macroeconomic trends, including identifying possible areas of improvement or gaps, and propose to the Financial Condition (E) Committee or other relevant committee enhancements and/or additions to further improve the ability of state insurance regulators and the industry to address macroprudential impacts; consult with such committees on implementation, as needed.

   B. Consider state insurance regulators’ input to national and international discussions on macroeconomic vulnerabilities affecting the insurance sector.

   1. Monitor international macroprudential activities at forums like the International Association of Insurance Supervisors (IAIS).

   2. Implement the Macroprudential Initiative (MPI) domestically, which includes enhancements to the U.S. regulatory toolkit as part of the State Ahead initiative.

   C. Serve as a forum to coordinate state insurance regulators’ perspectives on a wide variety of issues arising from the designation of a U.S. insurance group as “systemically important” and “internationally active” both pre- and post-designation, including:

   1. Where appropriate, develop policy recommendations and/or guidance regarding the role, responsibilities and activities of state insurance regulators in the context of consolidated supervision resulting from designation.

   2. Analyze proposed rules by the federal agencies that relate to financial stability.

   3. Analyze proposed policy measures regarding supervisory standards for global systemically important insurers and internationally active insurance groups.

   4. Develop comment letters on such analysis for further consideration by the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council, and/or the Executive (EX) Committee, as appropriate.

NAIC Support Staff: Elise Liebers/John Hopman/Mark Sagat/Todd Sells/Tim Nauheimer
GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

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

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Ethan Sonnichsen/Mark Sagat/Brian R. Webb
INNOVATION AND TECHNOLOGY (EX) TASK FORCE

The mission of the Innovation and Technology (EX) Task Force is to provide a forum for regulator education and discussion of innovation and technology in the insurance sector, to monitor technology developments that affect the state insurance regulatory framework, and to develop regulatory guidance, as appropriate.

Ongoing Support of NAIC Programs, Products or Services

1. The Innovation and Technology (EX) Task Force will:
   A. Provide forums, resources and materials for the discussion of innovation and technology developments in the insurance sector, including the collection and use of data by insurers and state insurance regulators—as well as new products, services and distribution platforms—in order to educate state insurance regulators on how these developments affect consumer protection, privacy, insurer and producer oversight, marketplace dynamics and the state-based insurance regulatory framework.
   B. Develop regulatory guidance, model laws or model law revisions, and white papers or make other recommendations to the Executive (EX) Committee, as appropriate.
   C. Monitor and discuss regulatory issues that arise with the development of autonomous vehicles. Study and, if necessary, develop recommendations for changes needed to the state-based insurance regulatory framework.
   D. Discuss emerging issues related to companies or licensees leveraging new technologies to develop products for on-demand insurance purposes—in addition to potential implications on the state-based insurance regulatory structure—including, but not limited to, reviewing new products and technologies affecting the insurance space and the associated regulatory implications.
   E. Monitor developments in the area of cybersecurity, including the implementation of the Insurance Data Security Model Law (#668) and representing the NAIC and communicating with other entities/groups, including sharing information as may be appropriate.
   F. Coordinate with other NAIC committees and task forces, as appropriate, on technology, innovation, cybersecurity issues and data privacy.

2. The Big Data (EX) Working Group will:
   A. Review current regulatory frameworks used to oversee insurers’ use of consumer and non-insurance data. If appropriate, recommend modifications to model laws and/or regulations regarding marketing, rating, underwriting and claims, regulation of data vendors and brokers, regulatory reporting requirements, and consumer disclosure requirements.
   B. Propose a mechanism to provide resources and allow the states to share resources to facilitate their ability to conduct technical analysis of, and data collection related to, the review of complex models used by insurers for underwriting, rating and claims. Such a mechanism shall respect and in no way limit the states’ regulatory authority.
   C. Assess data needs and required tools for state insurance regulators to appropriately monitor the marketplace and evaluate underwriting, rating, claims and marketing practices. This assessment shall include gaining a better understanding of currently available data and tools, as well as recommendations for additional data and tools, as appropriate. Based on this assessment, propose a means to collect, house and analyze needed data.
3. The **Speed to Market (EX) Working Group** will:
   A. Consider proposed System for Electronic Rate and Form Filing (SERFF) features or functionality presented to the Working Group by the SERFF Advisory Board, likely originating from the SERFF Product Steering Committee. Upon approval and acquisition of any needed funding, direct the SERFF Advisory Board to implement the project. Receive periodic reports from the SERFF Advisory Board, as needed.
   B. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed to market operational efficiencies related to product filing needs, efficiencies and effective consumer protection. This includes the following activities:
      1. Provide a forum to gather information from the states and the industry regarding tools, policies and resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency issues for state insurance regulators and the industry, particularly with regard to uniformity. In 2020, evaluate the state survey results compiled in 2019 regarding the usefulness of existing tools and potential new tools and propose a plan to make improvements.
      2. Use SERFF data to develop, refine, implement, collect and distribute common filing metrics that provide a tool to measure the success of the speed to market modernization efforts as measured by nationwide and individual state speed to market compliance, with an emphasis on monitoring state regulatory and insurer responsibilities for speed to market for insurance products.
      3. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal document (UTD) on an annual basis, including the review, approval and notification of changes. Monitor, assist with and report on state implementation of any PCM changes.
      4. Facilitate the review and revision of the *Product Filing Review Handbook*, which contains an overview of all of the operational efficiency tools and describes best practices for industry filers and state reviewers with regard to the rate and form filing and review process. In 2020, develop and implement a communication plan to inform states about the *Product Filing Review Handbook*.
   C. Provide direction to NAIC staff regarding SERFF functionality, implementation, development and enhancements. Direct NAIC staff to provide individual state speed to market reports to each commissioner at each national meeting. Receive periodic reports from NAIC staff, as needed.
   D. Conduct the following activities as desired by the Interstate Insurance Product Regulation Commission:
      1. Provide support to the Compact as the speed to market vehicle for asset-based insurance products, encouraging the states’ participation in, and the industry’s usage of the Compact.
      2. Receive periodic reports from the Compact, as needed.

4. The **Artificial Intelligence (EX) Working Group** will:
   A. Study the development of artificial intelligence (AI), its use in the insurance sector, and its impact on consumer protection and privacy, marketplace dynamics, and the state-based insurance regulatory framework. The Working Group will develop regulatory guidance, beginning with guiding principles, and make other recommendations to the Innovation and Technology (EX) Task Force as appropriate by the 2020 Summer National Meeting.

NAIC Support Staff: Scott Morris/Denise Matthews
The Long-Term Care Insurance (EX) Task Force will:
1. Recognizing the gravity of the threat posed by the current long-term care insurance (LTCI) environment both to consumers and our state-based system of insurance regulation, this Task Force is charged to:
   A. Develop a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.
   B. Identify options to provide consumers with choices regarding modifications to LTCI contract benefits where policies are no longer affordable due to rate increases.
   C. Deliver such a proposal to the Executive (EX) Committee by the 2020 Fall National Meeting.
2. Provide periodic reporting to the Long-Term Care Insurance (E/B) Task Force to help ensure coordination between the two task forces on LTCI issues.

Unless otherwise affirmatively extended or modified by the Executive (EX) Committee, the Task Force and its charges will expire Jan. 31, 2021.

NAIC Support Staff: Jeffrey C. Johnston
INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Cheryl McGee/Sherry Stevens
LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

3. The Annuity Disclosure (A) Working Group will:
   A. Review and revise, as necessary, Section 6—Standards for Annuity Illustrations in the Annuity Disclosure Model Regulation (#245) to take into account the disclosures necessary to inform consumers in light of the product innovations currently in the marketplace.

4. The Annuity Suitability (A) Working Group will:
   A. Review and revise, as necessary, the Suitability in Annuity Transactions Model Regulation (#275).
   B. Consider how to promote greater uniformity across NAIC-member jurisdictions.

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

6. The Life Insurance Illustration Issues (A) Working Group will:
   A. Explore how the narrative summary required by Section 7B of the Life Insurance Illustrations Model Regulation (#582) and the policy summary required by Section 5A(2) of the Life Insurance Disclosure Model Regulation (#580) can be enhanced to promote consumer readability and understandability of these life insurance policy summaries, including how they are designed, formatted and accessed by consumers.

7. The Retirement Security (A) Working Group will:
   A. Explore ways to promote retirement security consistent with the NAIC’s continuing “Retirement Security Initiative.”

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

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

Ongoing Support of NAIC Programs, Products and Services

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

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

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

4. The IUL Illustration (A) Subgroup will:
   A. Consider enhancements to Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49). Provide recommendations for modifications to AG 49 to the Life Actuarial (A) Task Force.

5. The Longevity Risk (A/E) Subgroup of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group will:
   A. Provide recommendations for recognizing longevity risk in statutory reserves and/or risk-based capital (RBC), as appropriate. Complete by the 2020 Spring National Meeting.
6. The VM-22 (A) Subgroup will:
   A. Recommend requirements, as appropriate, for non-variable (fixed) annuities in the accumulation and payout phases for consideration by the Life Actuarial (A) Task Force. A PBR methodology will be considered, as appropriate.

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

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

Ongoing Support of NAIC Programs, Products or Services

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

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

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

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

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

Ongoing Support of NAIC Programs, Products or Services

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

2. The Health Care Reform Actuarial (B) Working Group will:
   A. Assist the Health Actuarial (B) Task Force in completing its charge to provide support for issues related to implementation of, and/or changes to, the federal Affordable Care Act (ACA).

3. The Long-Term Care Actuarial (B) Working Group will:
   A. Assist the Health Actuarial (B) Task Force in completing the following charges:
      1. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices and rate changes.
      2. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.

4. The Health Reserves (B) Subgroup will:
   A. Assist the Health Actuarial (B) Task Force in completing its charge to continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.

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

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

Ongoing Support of NAIC Programs, Products and Services

1. The Regulatory Framework (B) Task Force will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2020.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the ERISA (B) Working Group, monitor, analyze and report developments related to association health plans (AHPs).
   F. Monitor, analyze and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.

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

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

4. The HMO Issues (B) Subgroup will:
   A. Revise provisions in the Health Maintenance Organization Model Act (#430) to address conflicts and redundancies with provisions in the Life and Health Insurance Guaranty Association Model Act (#520).

5. The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will:
   A. Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.

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

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

Ongoing Support of NAIC Programs, Products or Services

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

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

Ongoing Support of NAIC Programs, Products or Services

1. The Property and Casualty Insurance (C) Committee will:
   A. Discuss issues arising and make recommendations with respect to advisory organization and insurer filings for personal and commercial lines, as needed. Report yearly.
   B. Monitor the activities of the Casualty Actuarial and Statistical (C) Task Force.
   C. Monitor the activities of the Surplus Lines (C) Task Force.
   D. Monitor the activities of the Title Insurance (C) Task Force.
   E. Monitor the activities of the Workers’ Compensation (C) Task Force.
   F. Provide an impartial forum for considering appeals of adverse decisions involving alien insurers delisted or rejected for listing to the Quarterly Listing of Alien Insurers. Appeal procedures are described in the International Insurers Department (IID) Plan of Operation.
   G. Monitor and review developments in case law and rehabilitation proceedings related to risk-retention groups (RRGs). If warranted, make appropriate changes to the Risk Retention and Purchasing Group Handbook.
   H. Monitor the activities of the Federal Crop Insurance Corporation (FCIC) that affect state insurance regulators:
      1. Serve as a forum for discussing issues related to the interaction of federal crop insurance programs with state insurance regulation.
      3. Monitor the regulatory information exchanges between the FCIC and state insurance regulators, as well as the FCIC and the NAIC, and make recommendations for improvement or revisions, as needed.
   I. Report on the private flood insurance market using data obtained from the state insurance regulator private flood insurance data call.

2. The Cannabis Insurance (C) Working Group will:
   A. Assess and periodically report on the status of federal legislation that would protect financial institutions from liability associated with providing services to cannabis businesses operating legally under state law.
   B. Encourage admitted insurers to ensure coverage adequacy in states where cannabis, including hemp, is legal.
   C. Provide insurance resources to stakeholders and keep up with new products and innovative ideas that may shape insurance in this space.
   D. Collect aggregated insurance availability and coverage gap information, as well as other cannabis and hemp insurance-related data, to then publicly share in a released report by the end of 2021.

3. The Catastrophe Insurance (C) Working Group will:
   A. Monitor and recommend measures to improve the availability and affordability of insurance and reinsurance related to catastrophe perils for personal and commercial lines.
   B. Evaluate potential state, regional and national programs to increase capacity for insurance and reinsurance related to catastrophe perils.
   C. Monitor and assess proposals that address disaster insurance issues at the federal and state levels. Assess concentration-of-risk issues and whether a regulatory solution is needed.
   D. Provide a forum for discussing issues and recommending solutions related to insuring for catastrophe risk, including terrorism, war and natural disasters.
   E. Provide a forum for discussing various issues related to catastrophe modeling, and monitor issues that will result in changes to the Catastrophe Computer Modeling Handbook.
   F. Investigate and recommend ways the NAIC can assist states in responding to disasters, and discuss issues surrounding loss mitigation. Update the State Disaster Response Plan, as needed, so that it provides a blueprint for action by the states to respond to catastrophic events.
PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE (continued)

G. Continue to examine ways to help state insurance regulators facilitate the private flood insurance market.
H. Study, in coordination with other NAIC task forces and working groups, earthquake matters of concern to state insurance regulators. Consider various innovative earthquake insurance coverage options aimed at improving take-up rates.

4. The Climate Risk and Resilience (C) Working Group will:
   A. Engage with industry and stakeholders in the U.S. and abroad on climate related risk and resiliency issues.
   B. Investigate and recommend measures to reduce risks of climate change related to catastrophic events.
   C. Identify insurance and other financial mechanisms to protect infrastructure and reduce exposure to the public.
   D. Identify sustainability, resilience and mitigation issues and solutions related to the insurance industry.
   E. Evaluate private-public partnerships to improve insurance market capacity related to catastrophe perils.
   F. Investigate and receive information regarding the use of modeling by carriers and their reinsurers concerning climate risk.
   G. Review the impact of climate change on insurers through presentations by interested parties.
   H. Review innovative insurer solutions to climate risk, including new insurance products through presentations by interested parties.

5. The Lender-Placed Insurance Model Act (C) Working Group will:
   A. Complete the drafting and adoption of a new model law concerning lender-placed insurance as it relates to mortgages.

6. The Pet Insurance (C) Working Group will:
   A. Complete the development of a model law or guideline to establish appropriate regulatory standards for the pet insurance industry.

7. The Terrorism Insurance Implementation (C) Working Group will:
   A. Coordinate the NAIC’s efforts to address insurance coverage for acts of terrorism. Work with the U.S. Department of the Treasury’s Terrorism Risk Insurance Program (TRIP) Office on matters of mutual concern. Discuss long-term solutions to address the risk of loss from acts of terrorism.
   B. Review and report on data collection related to insurance coverage for acts of terrorism.

8. The Transparency and Readability of Consumer Information (C) Working Group will:
   A. Study and evaluate actions that will improve the capacity of consumers to comparison shop on the basis of differences in coverage provided by different insurance carriers offering personal lines products.
   B. Systematize and improve presale disclosures of coverage.
   C. Facilitate consumers’ capacity to understand the content of insurance policies and assess differences in insurers’ policy forms.
   D. Assist other groups with drafting language included within consumer-facing documents.
   E. Study and discuss whether there is a need for consumer disclosures regarding significant premium increases on property/casualty (P/C) insurance products.
   F. Update and develop webpage and mobile content for A Shopping Tool for Homeowners Insurance and A Shopping Tool for Automobile Insurance.
   G. Discuss and draft a disclosure for state insurance regulators to consider requiring to be added to homeowners’ policies regarding the fact that homeowners policies do not cover losses from flood, earthquake or other specified disasters.

NAIC Support Staff: Aaron Brandenburg/Kris DeFrain
**CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE**

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

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

1. **The Casualty Actuarial and Statistical (C) Task Force** will:
   
   **A.** Provide reserving, pricing, ratemaking, statistical and other actuarial support to NAIC committees, task forces and/or working groups. Propose changes to the appropriate work products (with the most common work products noted below) and present comments on proposals submitted by others regarding casualty actuarial and statistical matters. Monitor the activities, including the development of financial services regulations and statistical (including disaster) reporting, regarding casualty actuarial issues.
   
   1. Property and Casualty Insurance (C) Committee – ratemaking, reserving or data issues.
   2. Blanks (E) Working Group – P/C annual financial statement, including Schedule P; P/C quarterly financial statement; P/C quarterly and annual financial statement instructions, including Statement of Actuarial Opinion (SAO) and Actuarial Opinion Summary Supplement.

   **B.** Monitor national casualty actuarial developments and consider regulatory implications.
   
   1. Casualty Actuarial Society (CAS) – Statements of Principles and Syllabus of Basic Education.
   3. Society of Actuaries (SOA) – general insurance track’s basic education.

   **C.** Facilitate discussion among state insurance regulators regarding rate filing issues of common interest across the states through the scheduling of regulator-only conference calls.

   **D.** Work with the CAS and SOA to identify: 1) whether the P/C Appointed Actuaries’ logs of continuing education (CE) should contain any particular categorization to assist regulatory review; 2) what types of learning P/C Appointed Actuaries are using to meet CE requirements for “Specific Qualification Standards” today; and 3) whether more specificity should be added to the P/C Appointed Actuaries’ CE requirements to ensure that CE is aligned with the educational needs for a P/C Appointed Actuary.

   **E.** In coordination with the Big Data (EX) Working Group:
   
   1. Draft and propose changes to the Product Filing Review Handbook to include best practices for the review of predictive models and analytics filed by insurers to justify rates.
   2. Draft and propose state guidance (e.g., information, data) for rate filings that are based on complex predictive models.
   3. Facilitate training and the sharing of expertise through predictive analytics webinars (Book Club).

2. **The Actuarial Opinion (C) Working Group** will:

   **A.** Propose revisions to the following, as needed, especially to improve actuarial opinions, actuarial opinion summaries, and actuarial reports, as well as the regulatory analysis of these actuarial documents and loss and premium reserves:

   1. **Financial Analysis Handbook.**
   2. **Financial Condition Examiners Handbook.**
   3. **Annual Statement Instructions—Property/Casualty.**
   4. Regulatory guidance to appointed actuaries and companies.
   5. Other financial blanks and instructions, as needed.
3. The **Statistical Data (C) Working Group** will:
   A. Consider updates and changes to the *Statistical Handbook of Data Available to Insurance Regulators*.
   B. Consider updates and developments, provide technical assistance, and oversee the production of the following reports and databases. Periodically evaluate the demand and utility versus the costs of production of each product.
   1. *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance*.
   2. *Auto Insurance Database*.

NAIC Support Staff: Kris DeFrain/Jennifer Gardner/Libby Crews
SURPLUS LINES (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Surplus Lines (C) Task Force** will:
   A. Provide a forum for discussion of current and emerging surplus lines-related issues and topics of public policy and determine appropriate regulatory response and action.
   B. Review and analyze quantitative and qualitative data on U.S. domestic and alien surplus lines industry results and trends.
   C. Monitor federal legislation related to the surplus lines market and ensure that all interested parties remain apprised.
   D. Develop or amend relevant NAIC model laws, regulations and/or guidelines.
   E. Oversee the activities of the Surplus Lines (C) Working Group.

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

NAIC Support Staff: Andy Daleo/Bob Schump
TITLE INSURANCE (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Title Insurance (C) Task Force will:
   A. Monitor issues and developments occurring in the title insurance industry, and provide support and expertise to other NAIC committees, task forces and/or working groups, or outside entities, as appropriate.
   B. Review and assist various regulatory bodies in combating fraudulent and/or unfair real estate settlement activities. Such efforts could include working with the Antifraud (D) Task Force and other NAIC committees, task forces and/or working groups to combat mortgage fraud and mitigating title agent defalcations through the promotion of closing protection letters and other remedies. Report results at each national meeting.
   C. Consult with the Consumer Financial Protection Bureau (CFPB) and other agencies responsible for information, education and disclosure for mortgage lending, closing and settlement services about the role of title insurance in the real estate transaction process.
   D. Consider the effectiveness of changes in financial reporting by title insurance companies and identify further improvements and clarifications to blanks, instructions, Statement of Statutory Accounting Principles (SSAPs), solvency tools, and other matters, as necessary. Coordinate efforts with the Statutory Accounting Principles (E) Working Group.
   E. Revise the Title Insurance Consumer Shopping Tool Template to include questions and answers about title insurance-related fraud topics, including but not limited to, closing protection letters and wire fraud.
   F. Evaluate the effectiveness of closing protection letters, including but not limited to, intent, state regulation and requirements, consumer protections offered and excluded, and potential alternatives for coverage.

NAIC Support Staff: Anne Obersteadt/Aaron Brandenburg
WORKERS’ COMPENSATION (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Workers’ Compensation (C) Task Force will:
   A. Oversee activities of the NAIC/IAIABC Joint (C) Working Group.
   B. Discuss issues with respect to advisory organizations, rating organizations, statistical agents, and insurance companies in the workers’ compensation arena.
   C. Monitor the movement of business from the standard markets to the assigned risk pools. Alert state insurance department representatives if growth of the assigned risk pools changes dramatically.
   D. Follow workers’ compensation issues regarding cannabis in coordination with the Cannabis Insurance (C) Working Group.

2. The NAIC/IAIABC Joint (C) Working Group will:
   A. Study issues of mutual concern to insurance regulators and the International Association of Industrial Accident Boards and Commissions (IAIABC). Review relevant IAIABC model laws and white papers and consider possible charges in light of the Working Group’s recommendations.
   B. Complete the drafting and adoption of the white paper, Changing Employee Relationships – Completion date anticipated in early 2020.

NAIC Support Staff: Sara Robben/Aaron Brandenburg
MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Market Regulation and Consumer Affairs (D) Committee will:
   A. Monitor the centralized collection and storage of market conduct data, national analysis and reporting at the NAIC, including issues regarding the public availability of data.
   B. Monitor and assess the current process for multi-jurisdictional market conduct activities and provide appropriate recommendations for enhancement, as necessary.
   C. Evaluate all data currently collected in the NAIC Market Information Systems (MIS) and considered confidential to determine what, if any, can be made more widely available.
   D. Oversee the activities of the Antifraud (D) Task Force.
   E. Oversee the activities of the Market Information Systems (D) Task Force.
   F. Oversee the activities of the Producer Licensing (D) Task Force.
   G. Monitor the underwriting and market practices of insurers and producers, as well as conditions of insurance marketplaces, including urban markets, to identify specific market conduct issues of importance and concern. Hold public hearings on these issues at the NAIC national meetings, as appropriate.
   H. In collaboration with other technical working groups, discuss and share best practices through public forums to address broad consumer concerns regarding personal insurance products.
   I. Coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) and/or other related groups on issues regarding market regulation concepts.
   J. Coordinate with the Health Insurance and Managed Care (B) Committee to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA).
   K. Review the “Best Practices and Guidelines for Consumer Information Disclosures” (adopted October 2012) and update as needed.

2. The Advisory Organization Examination Oversight (D) Working Group will:
   A. Revise the protocols, as necessary, for the examination of national or multistate advisory organizations (includes rating organizations and statistical agents) to be more comprehensive, efficient and possibly less frequent than the current system of single-state exams. Solicit input and collaboration from other interested and affected committees and task forces.
   B. Monitor the data reporting and data-collection processes of advisory organizations (including rating organizations and statistical agents) to determine if they are implementing appropriate measures to ensure data quality. Report the results of this ongoing charge as needed.
   C. Actively assist with and coordinate multistate examinations of advisory organizations (including rating organizations and statistical agents).

3. The Market Actions (D) Working Group will:
   A. Facilitate interstate communication and coordinate collaborative state regulatory actions.

4. The Market Analysis Procedures (D) Working Group will:
   A. Recommend changes to the market analysis framework based on results over the past five years, including the current set of Level 1 and Level 2 questions. Provide recommendations by the Fall National Meeting.
   B. Discuss other market data-collection issues and make recommendations, as necessary.
   C. Consider recommendations for new lines of business for the Market Conduct Annual Statement (MCAS). Provide recommendations by the Fall National Meeting.
MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE (continued)

5. The Market Conduct Annual Statement Blanks (D) Working Group will:
   A. Review the MCAS data elements and the “Data Call and Definitions” for those lines of business that have been in effect for longer than 3 years and update them, as necessary.
   B. Develop an MCAS blank to be used for the collection of data for additional lines of business, where appropriate.

6. The Market Conduct Examination Standards (D) Working Group will:
   A. Develop market conduct examination standards and uniform market conduct procedural guidance, as necessary.
   B. Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models by the Fall National Meeting.
   C. Develop updated standardized data requests for inclusion in the Market Regulation Handbook by the Fall National Meeting.

7. The Market Regulation Certification (D) Working Group will:
   A. Develop a formal market regulation certification proposal for consideration by the NAIC membership that provides recommendations for the following: 1) certification standards; 2) a process for the state implementation of the standards; 3) a process to measure the states’ compliance with the standards; 4) a process for future revisions to the standards; and 5) assistance for jurisdictions to achieve certification.

8. The Privacy Protections (D) Working Group will:
   A. Review state insurance privacy protections regarding the collection, use and disclosure of information gathered in connection with insurance transactions, and make recommended changes, as needed, to certain NAIC models, such as the NAIC Insurance Information and Privacy Protection Model Act (#670) and the Privacy of Consumer Financial and Health Information Regulation (#672), by the 2020 Summer National Meeting.”

NAIC Support Staff: Timothy B. Mullen/Randy Helder
ANTIFRAUD (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Antifraud (D) Task Force will:
   A. Work with NAIC committees, task forces and working groups (e.g., Title Insurance (C) Task Force, etc.) to review issues and concerns related to fraud activities and schemes related to insurance fraud.
   B. Coordinate efforts to address national concerns related to agent fraud and activities of unauthorized agents related to insurance sales.
   C. Coordinate the enforcement and investigation efforts of state and federal securities regulators with state insurance fraud bureaus.
   D. Coordinate with state, federal and international law enforcement agencies in addressing antifraud issues relating to the insurance industry.
   E. Review and provide comments to the International Association of Insurance Supervisors (IAIS) on its Insurance Core Principles (ICPs) related to insurance fraud.
   F. Coordinate activities and information from national antifraud organizations and provide information to state insurance fraud bureaus.
   G. Coordinate activities and information with state and federal fraud divisions to determine guidelines that will assist with reciprocal involvement concerning antifraud issues resulting from natural disasters and catastrophes.
   H. Coordinate efforts with the insurance industry to address antifraud issues and concerns.
   I. Evaluate and recommend methods to track national fraud trends.

2. The Antifraud Education Enhancement (D) Working Group will:
   A. Develop seminars, trainings and webinars regarding insurance fraud. Provide three webinars by the 2020 Fall National Meeting.

3. The Antifraud Technology (D) Working Group will:
   A. Review and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.
   B. Evaluate sources of antifraud data and propose methods for enhancing the utilization and exchange of information among insurance regulators, fraud investigative divisions, law enforcement officials, insurers and antifraud organizations. Complete by the 2020 Fall National Meeting.

NAIC Support Staff: Greg Welker/Lois E. Alexander
MARKET INFORMATION SYSTEMS (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Market Information Systems (D) Task Force will:
   A. Ensure the NAIC Market Information Systems support the strategic direction set forth by the Market Regulation and Consumer Affairs (D) Committee.
   B. Develop recommendations for the incorporation of artificial intelligence (AI) abilities in NAIC Market Information Systems for use in market analysis. Complete by the 2020 Fall National Meeting.
   C. Analyze the data in the NAIC Market Information Systems. If needed, recommend methods to ensure better data quality. Complete by the 2020 Fall National Meeting.
   D. Provide guidance on the appropriate use of the NAIC Market Information Systems and the data entered in them.
      1. Complaint Database System (CDS).
      2. Electronic Forums.
      4. Market Analysis Profile.
      5. Market Analysis Prioritization Tool (MAPT).
      9. 1033 State Decision Repository (in conjunction with the Antifraud (D) Task Force).

2. The Market Information Systems Research and Development (D) Working Group will:
   A. Serve as the business partner to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure an efficient use of available NAIC staffing and resources.
   B. Assist the Task Force with tasks as assigned, such as:
      1. Analyze NAIC Market Information Systems data.
      2. Provide state users with query access to NAIC Market Information Systems data.
      3. Provide guidance on the appropriate use of the NAIC Market Information Systems.

NAIC Support Staff: Randy Helder
PRODUCER LICENSING (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Producer Licensing (D) Task Force will:
   A. Work closely with the National Insurance Producer Registry (NIPR) to encourage full utilization of NIPR products and services by all of the states and producers, and encourage accurate and timely reporting of state administrative actions to the NAIC’s Regulatory Information Retrieval System (RIRS) to ensure this data is properly reflected in the State Producer Licensing Database (SPLD) and the Producer Database (PDB).
   B. Facilitate roundtable discussions, as needed, with the state producer licensing directors for the exchange of views, opinions and ideas on producer-licensing activities in the states and at the NAIC.
   C. Discuss, as necessary, state perspectives regarding the regulation and benefit of the activities of the federal Affordable Care Act (ACA) established enrollment assisters (including navigators and non-navigator assisters and certified application counselors) and the activities of producers in assisting individuals and businesses purchasing in the health insurance marketplaces. Coordinate with the Health Insurance and Managed Care (B) Committee and the Antifraud (D) Task Force, as necessary.
   D. Monitor the activities of the National Association of Registered Agents and Brokers (NARAB) in the development and enforcement of the NARAB membership rules, including the criteria for successfully passing a background check.
   E. Coordinate through NAIC staff to provide guidance to NIPR on producer licensing-related electronic initiatives. Hear a report from NIPR at each national meeting.
   F. Coordinate with the Market Information Systems (D) Task Force and the Antifraud (D) Task Force to evaluate and make recommendations regarding the entry, retention and use of data in the NAIC’s Market Information Systems (MIS).
   G. Monitor state implementation of adjuster licensing reciprocity and uniformity; update, as necessary, NAIC adjuster licensing standards.
   H. Finalize the white paper on the role of chatbots and artificial intelligence (AI) in the distribution of insurance and the regulatory supervision of these technologies by the 2020 Spring National Meeting.
   I. Draft procedures for amending the NAIC’s uniform producer licensing applications and uniform appointment form to ensure consistency with the NAIC membership’s goal of maintaining uniform and stable applications that encourage the efficient use of electronic technology.

2. The Producer Licensing Uniformity (D) Working Group will:
   A. Work closely with state producer licensing directors and exam vendors to ensure: 1) the states achieve full compliance with the standards in order to achieve greater uniformity; and 2) the exams test the qualifications for an entry-level position as a producer.
   B. Provide oversight and ongoing updates, as needed, to the State Licensing Handbook. Complete by the 2020 Fall National Meeting.
   C. Monitor and assess the state implementation of the Uniform Licensing Standards (ULS) and update the standards, as needed. Complete by the 2020 Fall National Meeting.
   D. Review and update, as needed, the NAIC’s uniform producer licensing applications and uniform appointment form. Provide any recommended updates to the Producer Licensing (D) Task Force by June 1.

3. The Uniform Education (D) Working Group will:
   A. Update, as needed, the reciprocity guidelines, the uniform application forms for continuing education (CE) providers, and the process for state review and approval of courses. Provide any recommended updates to the Producer Licensing (D) Task Force by the 2020 Fall National Meeting.
PRODUCER LICENSING (D) TASK FORCE (continued)

B. Coordinate with NAIC parent committees, task forces and/or working groups to review and provide recommendations, as necessary, on prelicensing education and CE requirements that are included in NAIC model acts, regulations and/or standards.

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

Ongoing Support of NAIC Programs, Products or Services

1. The Financial Condition (E) Committee will:
   B. Appoint and oversee the activities of the following: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Long-Term Care Insurance (B/E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; and Valuation of Securities (E) Task Force.
   C. Recommend salary rate adjustments for examiners.
   D. Oversee a process to address financial issues that may compromise the consistency and uniformity of the U.S. solvency framework, referring valuation and other issues to the appropriate committees as needed.
   E. Use the Risk-Focused Surveillance (E) Working Group to address specific industry concerns regarding regulatory redundancy and review any issues industry subsequently escalates to the Committee.

2. The Financial Analysis (E) Working Group will:
   A. Analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled; determine if appropriate action is being taken.
   B. Interact with domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and action(s).
   C. Support, encourage, promote and coordinate multistate efforts in addressing solvency problems, including identifying adverse industry trends.
   D. Increase information-sharing and coordination between state regulators and federal authorities, including through representation of state regulators in national bodies with responsibilities for system-wide oversight.

3. The Group Capital Calculation (E) Working Group will:
   B. Provide direction to the Group Solvency Issues (E) Working Group on appropriate changes to existing authority or existing regulatory guidance related to the GCC. Complete by the 2020 Fall National Meeting.
   C. Liaise, as necessary, with the International Insurance Relations (G) Committee on international group capital developments and consider input from participation of U.S. state insurance regulators in the International Association of Insurance Supervisors (IAIS) monitoring process.
   D. Continually review and monitor the effectiveness of the GCC and consider revisions, as necessary, to maintain the effectiveness of its objective under U.S. solvency system.

4. The Group Solvency Issues (E) Working Group will:
   A. Continue to develop potential enhancements to the current regulatory solvency system as it relates to group- solvency-related issues.
   B. Critically review and provide input and drafting to the International Association of Insurance Supervisors (IAIS), Insurance Groups Working Group or on other IAIS material dealing with group supervision issues.
   C. Continually review and monitor the effectiveness of the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) and consider revisions as necessary to maintain effective oversight of insurance groups.
   D. Assess the IAIS Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) and make recommendations on its implementation in a manner appropriate for the U.S.
5. The **ORSA Implementation (E) Subgroup** of the Group Solvency Issues (E) Working Group will:
   A. Continue to provide and enhance an enterprise risk management (ERM) education program for regulators in support of the Own Risk and Solvency Assessment (ORSA) implementation.
   B. Continually review and monitor the effectiveness of the *Risk Management and Own Risk and Solvency Assessment Model Act* (#505) and its corresponding *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual*; consider revisions as necessary.

6. The **Mortgage Guaranty Insurance (E) Working Group** will:
   A. Develop changes to the *Mortgage Guaranty Insurance Model Act* (#630) and other areas of the solvency regulation of mortgage guaranty insurers, including, but not limited to, revisions to *Statement of Statutory Accounting Principles (SSAP) No. 58—Mortgage Guaranty Insurance* and develop an extensive mortgage guaranty supplemental filing. Oversee the work of the consultant on the testing and finalization of proposed risk-based mortgage guaranty capital model and finalize Model #630 by the 2020 Spring National Meeting.

7. The **NAIC/AICPA (E) Working Group** will:
   A. Continually review the *Annual Financial Reporting Model Regulation* (#205) and its corresponding implementation guide; revise as appropriate.
   B. Address financial solvency issues by working with the American Institute of Certified Public Accountants (AICPA) and responding to AICPA exposure drafts.
   C. Monitor the federal Sarbanes-Oxley Act, as well as rules and regulations promulgated by the U.S. Securities and Exchange Commission (SEC), the Public Company Accounting Oversight Board (PCAOB) and other financial services regulatory entities.
   D. Review annually the premium threshold amount included in Section 16 of Model #205, with the general intent that those insurers subject to the Section 16 requirements would capture at least approximately 90% of industry premium and/or in response to any future regulatory or market developments.

8. The **National Treatment and Coordination (E) Working Group** will:
   A. Increase utilization and implementation of the *Company Licensing Best Practices Handbook*.
   B. Encourage synergies between corporate changes/amendments and rate and form filing review and approval to improve efficiency.
   C. Continue to monitor the usage and make necessary enhancements to the Form A Database.
   D. Maintain educational courses in the existing NAIC Insurance Regulator Professional Designation Program for company licensing regulators.

9. The **Biographical Third-Party Review (E) Subgroup** of the National Treatment and Coordination (E) Working Group will:
   A. Increase the uniformity of the third-party vendors that prepare background investigative reports to those state insurance departments that require them. Reduce the inefficiency of applications by developing procedures and approval processes.
   B. Monitor the ongoing adherence of background investigation reports and third-party vendors.
   C. Encourage uniformity of requirements in relation to individuals’ fitness and propriety and the company’s responsibility in notifying state insurance departments of concerns or changes to key individuals.

10. The **Restructuring Mechanisms (E) Working Group** will:
    A. Evaluate and prepare a White Paper that:
        1. Addresses the perceived need for restructuring statutes and the issues those statutes are designed to remedy. Also, consider alternatives that insurers are currently employing to achieve similar results.
        2. Summarizes the existing state restructuring statutes.
        3. Addresses the legal issues posed by an Order of a Court (or approval by an Insurance Department) in one state affecting the policyholders of other states.
        4. Considers the impact that a restructuring might have on Guaranty Associations and policyholders that had Guaranty Fund protection prior to the restructuring. Complete by the 2020 Summer National Meeting.
    B. Identifies and addresses the legal issues associated with restructuring using a protected cell. Complete by the 2020 Summer National Meeting.
FINANCIAL CONDITION (E) COMMITTEE (continued)

C. Consider requesting approval from the Executive (EX) Committee on developing changes to specific NAIC models as a result of findings from the development of the White Paper. Complete by the 2020 Fall National Meeting.

11. The Restructuring Mechanisms (E) Subgroup will:
   A. Develop best practices to be used in considering the approval of proposed restructuring transactions, including among other things, the expected level of reserves and capital expected after the transfer along with the adequacy of long-term liquidity needs, and also develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for their consideration. Complete by the 2020 Summer National Meeting.
   B. Consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff. Complete by the 2020 Fall National Meeting.
   C. Review the various restructuring mechanisms and develop, if deemed needed, protected cell accounting and reporting requirements for referring to the Statutory Accounting Principles (E) Working Group. Complete by the 2020 Fall National Meeting.

12. The Risk-Focused Surveillance (E) Working Group will:
   A. Continually review the effectiveness of risk-focused surveillance and develop enhancements to processes as necessary.
   B. Continually review regulatory redundancy issues identified by interested parties and provide recommendations to other NAIC committee groups to address as needed.
   C. Oversee and monitor the Peer Review Program to encourage consistent and effective risk-focused surveillance processes.
   D. Continually maintain and update standardized job descriptions/requirements and salary range recommendations for common solvency monitoring positions to assist insurance departments in attracting and maintaining suitable staff.

13. The Valuation Analysis (E) Working Group will:
   A. Respond to states in a confidential forum regarding questions and issues arising during the course of annual principle-based reserving (PBR) reviews or PBR examination and which also may include consideration of asset adequacy analysis questions and issues.
   B. Work with NAIC resources to assist in prioritizing and responding to issues and questions regarding PBR and asset adequacy analysis including actuarial guidelines or other requirements making use of or relating to PBR such as Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38), Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued Under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48), and the Term and Universal Life Insurance Reserve Financing Model Regulation (AG 787).
   C. Develop and implement a plan with NAIC resources to identify outliers/concerns regarding PBR/asset adequacy analysis.
   D. Refer questions/issues as appropriate to the Life Actuarial (A) Task Force that may require consideration of changes/interpretations to be provided in the Valuation Manual.
   E. Assist NAIC resources in development of a standard asset/liability model portfolio used to calibrate company PBR models.
   F. Make referrals as appropriate to the Financial Analysis (E) Working Group.
   G. Perform other work to carry out the Valuation Analysis (E) Working Group procedures.

NAIC Support Staff: Dan Daveline/Julie Gann/Bruce Jenson
ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Accounting Practices and Procedures (E) Task Force will:

2. The Blanks (E) Working Group will:
   A. Consider improvements and revisions to the various annual/quarterly statement blanks to:
      1. Conform these blanks to changes made in other areas of the NAIC to promote uniformity in reporting of financial information by insurers.
      2. Develop reporting formats for other entities subject to the jurisdiction of state insurance departments.
      3. Conform the various NAIC blanks and instructions to adopted NAIC policy.
      4. Oversee the development of additional reporting formats within the existing annual financial statements as needs are identified.
   B. Continue to monitor state filing checklists to maintain current filing requirements.
   C. Continue to monitor and improve the quality of financial data filed by insurance companies by recommending improved or additional language for the Annual Statement Instructions.
   D. Continue to monitor and review all proposals necessary for the implementation of statutory accounting guidance to ensure proper implementation of any action taken by the Accounting Practices and Procedures (E) Task Force affecting annual financial statements and/or instructions.
   E. Continue to coordinate with other task forces of the NAIC to ensure proper implementation of reporting and instructions changes as proposed by these task forces.
   F. Coordinate with the Life Actuarial (A) Task Force to use any special reports developed and avoid duplication of reporting.
   G. Review requests for investment schedule blanks and instructions changes in connection with the work being performed by the Investment Risk-Based Capital (E) Working Group.
   H. Review changes requested by the Valuation of Securities (E) Task Force relating to its work on other invested assets reporting for technical consistency within the investment reporting schedules and instructions.

3. The Statutory Accounting Principles (E) Working Group will:
   A. Maintain codified statutory accounting principles by providing periodic updates to the guidance that address new statutory issues and new generally accepted accounting principles (GAAP) pronouncements. Provide authoritative responses to questions of application and clarifications for existing statutory accounting principles. Report all actions and provide updates to the Accounting Practices and Procedures (E) Task Force.
   B. At the discretion of the Working Group chair, develop comments on exposed GAAP and International Financial Reporting Standards (IFRS) pronouncements affecting financial accounting and reporting. Any comments are subject to review and approval by the chairs of the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee.
   C. Coordinate with the Life Actuarial (A) Task Force on changes to the Accounting Practices and Procedures Manual (AP&P Manual) related to the Valuation Manual VM-A, Requirements, and VM-C, Actuarial Guidelines, as well as other Valuation Manual requirements. This process will include the receipt of periodic reports on changes to the Valuation Manual on items that require coordination.
ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE (continued)

D. Obtain, analyze and review information on permitted practices, prescribed practices or other accounting treatments suggesting that issues or trends occurring within the industry may compromise the consistency and uniformity of statutory accounting, including, but not limited to, activities conducted by insurers for which there is currently no statutory accounting guidance or where the states have prescribed statutory accounting that differs from the guidance issued by the NAIC. Use this information to consider possible changes to statutory accounting.

E. Review and possibly modify Schedule F and any corresponding annual financial statement pages to determine how best to reflect the expected changes to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786). Give due consideration to alternatives, including whether an allowance for doubtful accounts is appropriate. Complete by the 2020 Fall National Meeting.

NAIC Support Staff: Robin Marcotte
CAPITAL ADEQUACY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Capital Adequacy (E) Task Force will:
   A. Evaluate emerging “risk” issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
   B. Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).

2. The Health Risk-Based Capital (E) Working Group, Life Risk-Based Capital (E) Working Group and Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Evaluate refinements to the existing NAIC risk-based capital (RBC) formulas implemented in the prior year. Forward the final version of the structure of the current year life and fraternal, property/casualty (P/C) and health RBC formulas to the Financial Condition (E) Committee by June.
   B. Consider improvements and revisions to the various RBC blanks to: 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity; and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified. Any proposal that affects the RBC structure must be adopted no later than April 30 in the year of the change and adopted changes will be forwarded to the Financial Condition (E) Committee by the next scheduled meeting or conference call. Any adoptions made to the annual financial statement blanks or statutory accounting principles that affect an RBC change adopted by April 30 and results in an amended change may be considered by July 30 for those exceptions where the Capital Adequacy (E) Task Force votes to pursue by super-majority (two-thirds) consent of members present, no later than June 30 for the current reporting year.
   C. Monitor changes in data quality problems in the prior year RBC filings at the summer and fall national meetings.

3. The Investment Risk-Based Capital (E) Working Group will:
   A. Evaluate relevant historical data and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the risk-based capital (RBC) formulas and delivering those recommendations to the Capital Adequacy (E) Task Force.

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

5. The Longevity Risk (A/E) Subgroup a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Provide recommendations for recognizing longevity risk in statutory reserves and/or risk-based capital (RBC), as appropriate. Complete by the 2020 Spring National Meeting.
CAPITAL ADEQUACY (E) TASK FORCE  (continued)

6. The **Catastrophe Risk (E) Subgroup** of the Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Recalculate the premium risk factors on an ex-catastrophe basis, if needed.
   B. Continue to update the U.S. and non-U.S catastrophe event list.
   C. Continue to evaluate the need for exemption criteria for insurers with minimal risk.
   D. Evaluate the risk-based capital (RBC) results inclusive of a catastrophe risk charge.
   E. Refine instructions for the catastrophe risk charge.
   F. Continue to evaluate any necessary refinements to the catastrophe risk formula.
   G. Evaluate other catastrophe risks for possible inclusion in the charge.

NAIC Support Staff: Jane Barr
EXAMINATION OVERSIGHT (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Examination Oversight (E) Task Force will:
   A. Accomplish its mission using the following groups:
      5. IT Examination (E) Working Group.

2. The Electronic Workpaper (E) Working Group will:
   A. Monitor and support the state insurance departments in using electronic workpaper software tools to conduct and document solvency monitoring activities.
   B. Provide ongoing oversight to the NAIC’s Electronic Workpaper Hosting Project.
   C. Develop a framework to meet the long-term hosting and software needs of state insurance regulators in using electronic workpapers to conduct and document solvency monitoring activities. Ensure that solutions developed consider various state insurance regulator uses, as appropriate.

3. The Financial Analysis Solvency Tools (E) Working Group will:
   A. Provide ongoing maintenance and enhancements to the Financial Analysis Handbook and related applications for changes to the NAIC annual/quarterly financial statement blanks, as well as enhancements developed to assist in the risk-focused analysis and monitoring of the financial condition of insurance companies and groups. Monitor the coordination of analysis activities of holding company groups, and coordinate and analyze input received from other state regulators.
   B. Provide ongoing development maintenance and enhancements to the automated financial solvency tools developed to assist in conducting risk-focused analysis and monitoring the financial condition of insurance companies and groups. Prioritize and perform analysis to ensure that the tools remain reliable and accurate.
   C. Coordinate with the Financial Examiners Handbook (E) Technical Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.
   D. Adjust the Financial Analysis Handbook and current financial analysis solvency tools for life insurance companies based on any recommendations as requested from the Life Actuarial (A) Task Force to incorporate principle-based reserving (PBR) changes.

4. The Financial Examiners Coordination (E) Working Group will:
   A. Develop enhancements that encourage the coordination of examination activities with regard to holding company groups.
   B. Promote coordination by assisting and advising domiciliary regulators and exam coordinating states as to what might be the most appropriate regulatory strategies, methods and actions regarding financial examinations of holding company groups.
   C. Facilitate communication among regulators regarding common practices and issues arising from coordinating examination efforts.
   D. Provide ongoing maintenance and enhancements to the Financial Examination Electronic Tracking System (FEETS).
EXAMINATION OVERSIGHT (E) TASK FORCE (continued)

5. The **Financial Examiners Handbook (E) Technical Group** will:
   A. Continually review the *Financial Condition Examiners Handbook* and revise, as appropriate.
   B. Coordinate with the Risk-Focused Surveillance (E) Working Group to monitor the implementation of the risk-assessment process by developing additional guidance and exhibits within the *Financial Condition Examiners Handbook*, including consideration of potential redundancies affected by the examination process, corporate governance and other guidance as needed to assist examiners in completing financial condition examinations.
   C. Coordinate with the Financial Analysis Handbook (E) Working Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.
   D. Coordinate with the IT Examination (E) Working Group and the Financial Examiners Coordination (E) Working Group to maintain specialized areas of guidance within the *Financial Condition Examiners Handbook* related to the charges of these specific working groups.
   E. Adjust the *Financial Condition Examiners Handbook* based upon any recommendations as requested from the Life Actuarial (A) Task Force to incorporate principle-based reserving (PBR) changes.

6. The **IT Examination (E) Working Group** will:
   A. Continually review and revise, as needed, the “General Information Technology Review” and “Exhibit C—Evaluation of Controls in Information Systems” sections of the *Financial Condition Examiners Handbook*.
   B. Coordinate with the Market Conduct Examination Standards (D) Working Group to assist in the development of regulatory oversight policy with respect to cybersecurity examination issues, as requested by the Innovation and Technology (EX) Task Force.

NAIC Support Staff: Miguel Romero
LONG-TERM CARE INSURANCE (E/B) TASK FORCE

Ongoing Support of NAIC Programs, Products or Services

1. The Long-Term Care Insurance (E/B) Task Force of the Health Insurance and Managed Care (B) Committee and Financial Condition (E) Committee will:
   A. Coordinate all aspects of the NAIC’s work regarding the long-term care insurance (LTCI) market. In addition to coordinating all current Health Insurance and Managed Care (B) Committee and Financial Condition (E) Committee projects, the Task Force should pursue the following general objectives:
      1. Evaluate the sufficiency of actuarial valuation standards.
      2. Evaluate the sufficiency of current financial reporting.
      3. Assess state activities regarding the regulatory considerations on rate increase requests on blocks and to identify common elements for achieving greater transparency and predictability.
      4. Consider product innovations and the development of potential state and federal solutions for stabilizing the LTCI market.
      5. Provide periodic reports to the Health Insurance and Managed Care (B) Committee and the Financial Condition (E) Committee, as well as the Executive (EX) Committee, regarding key issues and progress toward the general objectives set forth above. Conduct meetings in regulator-to-regulator session, as appropriate.

NAIC Support Staff: Dan Daveline/Jolie Matthews
RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Receivership and Insolvency (E) Task Force will:
   A. Monitor and promote efficient operations of insurance receiverships and guaranty associations.
   B. Monitor and promote state adoption of insurance receivership and guaranty association model acts and regulations and monitor other legislation related to insurance receiverships and guaranty associations.
   C. Provide input and comments to the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB) or other related groups on issues regarding international resolution authority.
   D. Monitor, review and provide input on federal rulemaking and studies related to insurance receiverships.
   F. Monitor the work of other NAIC committees, task forces and working groups to identify and address any issues that affect receivership law and/or regulatory guidance.
   G. Perform additional work as directed by the Financial Condition (E) Committee and/or received through referral by other groups.

2. The Receivership Financial Analysis (E) Working Group will:
   A. Monitor receiverships involving nationally significant insurers/groups to support, encourage, promote and coordinate multistate efforts in addressing problems.
   B. Interact with the Financial Analysis (E) Working Group, domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and/or action(s) with regard to potential or pending receiverships.

3. The Receivership Large Deductible Workers' Compensation (E) Working Group will:
   A. Complete work based on recommendations for possible enhancements to the U.S. receivership regime, as approved and directed by the Receivership and Insolvency (E) Task Force, resulting from a study of the states' receivership laws and practices related to the receivership of insurers with significant books of large deductible workers' compensation business. Complete by the 2020 Summer National Meeting.

4. The Receivership Law (E) Working Group will:
   A. Review and provide recommendations on any issues identified that may affect the states’ receivership and guaranty association laws; for example, any issues that arise as a result of market conditions, insurer insolvencies, federal rulemaking and studies, international resolution initiatives or as a result of the work performed by other NAIC committees, task forces and/or working groups.
   B. Discuss significant cases that may affect the administration of receiverships.
   C. Complete work, as assigned from the Task Force, to address recommendations from the Financial Stability (EX) Task Force’s Macroprudential Initiative (MPI) referral as follows:
      2. Explore if bridge institutions could be implemented under regulatory oversight pre-receivership to address an early termination of qualified financial contracts (QFCs), and if appropriate, develop applicable guidance. Review the Receiver's Handbook guidance on QFCs and, if necessary, draft enhancements. Identify related pre-receivership considerations related to QFCs and, if necessary, make referrals to other relevant groups to enhance pre-receivership planning, examination and analysis guidance.
RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE (continued)

3. Review and provide recommendations for remedies to ensure continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Consult with the Group Solvency Issues (E) Working Group as the topic relates to affiliated intercompany agreements. Complete by the 2020 Fall National Meeting.

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

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

1. The **Reinsurance (E) Task Force** will:
   A. Provide a forum for the consideration of reinsurance-related issues of public policy.
   C. Oversee the activities of the Qualified Jurisdiction (E) Working Group.
   D. Monitor the implementation of the 2011, 2016 and 2019 revisions to the Credit for Reinsurance Model Law (#785); and the 2011 and 2019 revisions to the Credit for Reinsurance Model Regulation (#786) and the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).
   E. Communicate and coordinate with the Federal Insurance Office (FIO) and other federal authorities on matters pertaining to reinsurance.
   F. Consider any other issues related to the revised Model #785, Model #786 and Model #787.
   G. Monitor the development of international principles, standards and guidance with respect to reinsurance. This includes, but is not limited to, monitoring the activities of various groups within the International Association of Insurance Supervisors (IAIS), including the Reinsurance and Other Forms of Risk Transfer Subcommittee, the Reinsurance Mutual Recognition Subgroup and the Reinsurance Transparency Group.
   H. Consider the impact of reinsurance-related federal legislation, including, but not limited to, the federal Nonadmitted and Reinsurance Reform Act (NRRA) and the Federal Insurance Office Act, and coordinate any appropriate NAIC action.
   I. Continue to monitor the impact of reinsurance-related international agreements, including the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement).

2. The **Reinsurance Financial Analysis (E) Working Group** will:
   A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings and operate in open session when discussing certified reinsurance topics and policy issues, such as amendments to the Uniform Application for Certified Reinsurers.
   B. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.
   C. Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities or individuals.
   D. Support, encourage, promote and coordinate multistate efforts in addressing issues related to certified reinsurers, including, but not limited to, multistate recognition of certified reinsurers.
   E. Provide analytical expertise and support to the states with respect to certified reinsurers and applicants for certification.
   F. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.
   G. Ensure the public passporting website remains current.
   H. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.

3. The **Qualified Jurisdiction (E) Working Group** will:
   A. Maintain the NAIC List of Qualified Jurisdictions and the NAIC List of Reciprocal Jurisdictions in accordance with the Process for Evaluating Qualified and Reciprocal Jurisdictions.
REINSURANCE (E) TASK FORCE (continued)

B. Perform a yearly due diligence review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions.
C. Consider evaluations of any additional jurisdictions for inclusion on the NAIC List of Qualified Jurisdictions.

NAIC Support Staff: Jake Stultz/Dan Schelp
RISK RETENTION GROUP (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Charles Therriault
FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

The mission of the NAIC accreditation program is to establish and maintain standards to promote sound insurance company financial solvency regulation. The accreditation program provides a process whereby solvency regulation of multi-state insurance companies can be enhanced and adequately monitored with emphasis on the following:

1. Adequate solvency laws and regulations in each accredited state to protect consumers and guarantee funds.
2. Effective and efficient financial analysis and examination processes in each accredited state.
3. Appropriate organizational and personnel practices in each accredited state.
4. Effective and efficient processes regarding the review of organization, licensing and change of control of domestic insurers in each accredited state.

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Becky Meyer/Sara Franson
INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Ethan Sonnichsen/Ryan Workman
NAIC/CONSUMER LIAISON COMMITTEE

The mission of the NAIC/Consumer Liaison Committee is to assist the NAIC in its mission to support state insurance regulation by providing consumer views on insurance regulatory issues. The Liaison Committee provides a forum for ongoing dialogue between NAIC members and NAIC consumer representatives. The Liaison Committee’s activities in 2020 will be closely aligned with the priorities of the NAIC Consumer Board of Trustees.

NAIC Support Staff: Lois E. Alexander

NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE

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

NAIC Support Staff: Lois Alexander

NAIC/INDUSTRY LIAISON COMMITTEE

The mission of the NAIC/Industry Liaison Committee is to meet at least twice a year to discuss issues of common interest to state insurance regulators and insurance industry representatives.

NAIC Support Staff: Mark Sagat/Chara Bradstreet

NAIC/STATE GOVERNMENT LIAISON COMMITTEE

The mission of the NAIC/State Government Liaison Committee is to discuss issues of common interest to state insurance regulators and state officials.

NAIC Support Staff: Mark Sagat/Chara Bradstreet
APPENDIX

NAIC Audit Committee
Committee Charter

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

E. Conduct other activities when necessary, including:

1. Arrange for the independent auditor to be available to the full Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, as needed.

2. Review and approve requests for any management consulting engagement to be performed by the independent auditor and be advised of any other study undertaken at the request of management that is beyond the scope of the audit engagement letter.

3. Conduct and/or authorize investigations into any matters within the Committee’s scope of responsibilities. The Committee shall be empowered to retain independent counsel and other professionals to assist in the conduct of any investigation.

4. Ensure members of the Committee receive the appropriate orientation to the Committee and receive a copy of the policy manual.

NAIC Support Staff: Jim Woody

W:\National Meetings\2019\Fall\Plenary\Att 2 2020 Proposed Committee Charges.docx
TABLE 1
PROPOSED 2020 GRET FACTORS, Based on Average of 2017/2018 Data

<table>
<thead>
<tr>
<th>Description</th>
<th>Acquisition Per Policy</th>
<th>Acquisition Per Unit</th>
<th>Maintenance Per Policy</th>
<th>Companies Included</th>
<th>Average Premium Per Policy Issued During Year</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$168</td>
<td>$0.90</td>
<td>42%</td>
<td>550</td>
<td>118</td>
<td>3,263</td>
</tr>
<tr>
<td>Career</td>
<td>214</td>
<td>1.20</td>
<td>54%</td>
<td>64</td>
<td>63</td>
<td>2,661</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>217</td>
<td>1.20</td>
<td>54%</td>
<td>65</td>
<td>20</td>
<td>2,489</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>125</td>
<td>0.70</td>
<td>32%</td>
<td>38</td>
<td>21</td>
<td>757</td>
</tr>
<tr>
<td>Other*</td>
<td>140</td>
<td>0.80</td>
<td>35%</td>
<td>42</td>
<td>104</td>
<td>876</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>326</td>
</tr>
</tbody>
</table>

TABLE 2
CURRENT (2019) FACTORS, Based on Average of 2016/2017 Data

<table>
<thead>
<tr>
<th>Description</th>
<th>Acquisition Per Policy</th>
<th>Acquisition Per Unit</th>
<th>Maintenance Per Policy</th>
<th>Companies Included</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$167</td>
<td>$0.90</td>
<td>42%</td>
<td>550</td>
<td>130</td>
<td>3,496</td>
</tr>
<tr>
<td>Career</td>
<td>231</td>
<td>1.30</td>
<td>58%</td>
<td>69</td>
<td>69</td>
<td>2,287</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>221</td>
<td>1.20</td>
<td>55%</td>
<td>66</td>
<td>22</td>
<td>2,492</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>139</td>
<td>0.80</td>
<td>35%</td>
<td>42</td>
<td>21</td>
<td>702</td>
</tr>
<tr>
<td>Other*</td>
<td>136</td>
<td>0.70</td>
<td>34%</td>
<td>41</td>
<td>119</td>
<td>839</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>361</td>
</tr>
</tbody>
</table>

Appendix A -- Distribution Channels
The following is a description of distribution channels used in the development of recommended 2020 GRET values:

1. **Independent** – Business written by a company that markets its insurance policies through an independent insurance agent or insurance broker not primarily affiliated with any one insurance company. These agencies or agents are not employed by the company and operate without an exclusive distribution contract with the company. These include most PPGA arrangements.

2. **Career** – Business written by a company that markets insurance and investment products through a sales force primarily affiliated with one insurance company. These companies recruit, finance, train, and often house financial professionals who are typically referred to as career agents or multi-line exclusive agents.

3. **Direct Marketing** – Business written by a company that markets its own insurance policies direct to the consumer through methods such as direct mail, print media, broadcast media, telemarketing, retail centers and kiosks, internet or other media. No direct field compensation is involved.

4. **Niche Marketers** – Business written by home service, pre-need, or final expense insurance companies as well as niche-market companies selling small face amount life products through a variety of distribution channels.

5. **Other** – Companies surveyed were only provided with the four options described above. Nonetheless since there were many companies for which we did not receive a response (or whose response in past years’ surveys confirmed an “other” categorization (see below), values for the “other” category are given in the tables in this memo. It was also included to indicate how many life insurance companies with no response (to this survey and prior surveys) and to indicate whether their exclusion has introduced a bias into the resulting values.
Appendix B – Unit Expense Seeds

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

The unit expense seeds used in the 2019 GRET and the 2020 GRET recommendation were based on the average of the 2006 through 2010 Annual SOA expense studies. These studies differentiated unit expenses by type of individual life insurance policy (term and permanent coverages). As neither the GRET nor the Annual Statement data provided differentiates between these two types of coverage, the unit expense seed was derived by judgment based on this information. The following shows the averages derived from the Annual SOA studies and the seeds used in this study. Beginning with the 2019 Annual Statement submission this information may become more readily available.

**2006-2010 (average) CLICE Studies:**

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<thead>
<tr>
<th>Term</th>
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<th>Acquisition/Face Amount</th>
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<table>
<thead>
<tr>
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<td>Median</td>
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<td>$1.30</td>
<td>41%</td>
<td>$67</td>
</tr>
</tbody>
</table>

**Current Unit Expense Seeds:**

<table>
<thead>
<tr>
<th></th>
<th>Acquisition/Policy</th>
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<tbody>
<tr>
<td>All distribution channels</td>
<td>$200</td>
<td>$1.10</td>
<td>50%</td>
<td>$60</td>
</tr>
</tbody>
</table>
TO: Reggie Mazyck, NAIC
FROM: Dale Hall, Managing Director of Research, Society of Actuaries (SOA)
Leon Langlitz, Chair, SOA Committee on Life Insurance Company Expenses
DATE: July 16, 2019
RE: 2020 Generally Recognized Expense Table (GRET) – SOA Analysis

As in previous years, the Society of Actuaries expresses its thanks to NAIC staff for their assistance and responsiveness in providing Annual Statement expense and unit data for the 2020 GRET analysis for use with individual life insurance sales illustrations. The analysis is based on expense and expense related information reported on companies’ 2017 and 2018 Annual Statements. This project has been completed to assist the Life Actuarial Task Force (LATF) in its consideration of potential revisions to the GRET that could become effective for calendar year 2020. This memo describes the analysis and resultant findings.

NAIC staff provided Annual Statement data for life insurance companies for calendar years 2017 and 2018. This included data from 707 companies in 2017 and 722 companies in 2018. This increase breaks the trend of small decreases over the previous few years. Of the total companies, 326 were in both years and passed the outlier exclusion tests and were included as a base for the GRET factors (361 companies passed similar tests last year).

Approach Used

The methodology for calculating the recommended GRET factors based on this data is similar in broad outline to that followed in the last several years. The methodology was last altered in 2015. The changes which were made at that time can be found in the recommendation letter sent on July 30, 2015.¹

To calculate updated GRET factors, the average of the factors from the two most recent years (2017 and 2018 for those with data available for both years) of Annual Statement data was used. For each company an actual to expected ratio was calculated. Companies with ratios that fall outside predetermined parameters are excluded and this process is computed three times in order to stabilize the average rates. The boundaries of the exclusions are modified from time to time and there was a slight adjustment this year to increase the number of companies in the final study. Unit expense seed factors (the seeds for all distribution channel categories are the same), as given in Appendix B, were used to compute total expected expenses. Thus, these seed factors were used to implicitly allocate expenses between acquisition and maintenance expenses, as well as among the three acquisition expense factors (on a direct of ceded reinsurance basis).

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

¹ https://www.soa.org/Files/Research/Projects/research-2016-gret-recommendation.pdf
years to increase the response rate to the surveys of companies that submit Annual Statements in order to reduce the number of companies in the “Other” category would be most welcomed.

Prior to 2014, when responding to the survey if a company indicated they used multiple channels to distribute their individual life sales, the percentage weights provided to us were applied to that company’s reported results in the tabulations of each of the distribution channel’s unit expense results. In 2015 this was changed so that all expenses for a company will go to the channel with the highest percentage weight. This approach was changed because: (1) as fewer channel types were used, it was expected that fewer companies would have multiple channels as currently defined and (2) an insufficient number of multiple distribution responses were provided in that year’s survey to result in a significantly different outcome. The intention is to continue surveying the companies in future years to enable enhancement of this multiple distribution channel information.

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

The Recommendation

Employing the above methodology results in the proposed 2020 GRET values shown in Table 1. To facilitate comparisons, the current 2019 GRET factors are shown in Table 2.

Further characteristics of the type of companies represented in each category are included in the last two columns in Table 1, including the average premium per policy issued and the average face amount ($000s) per policy issued.

**TABLE 1**

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<td></td>
<td>326</td>
<td></td>
</tr>
</tbody>
</table>
In previous recommendations, an effort was made to reduce volatility in the GRET factors from year-to-year by limiting the change in GRET factors between years to about ten percent of the prior value. The changes from the 2019 GRET were reviewed to ensure that a significant change was not made in this year’s GRET recommendation. Only the Niche Marketing distribution channel category experienced a change greater than ten percent so the factors for this line were capped at the ten percent level (the Acquisition per unit factor changed more than 10% because of rounding) from the corresponding 2019 GRET values. The change occurred due to the change in the composition of the companies in this category where there is a small number of companies included.

**Usage of the GRET**

Also asked in this year’s survey, responded to by companies’ Annual Statement correspondent, was a question regarding whether the 2018 GRET table was used by the company. Last year, 28% of the responders indicated their company used the GRET for sales illustration purposes, with similar percentage results by size of company; this contrasted with about 30% in the prior year. This year, 26% of responding companies indicated that they used the GRET in 2018 for sales illustration purposes, with similar results for each of the distribution channels with a significant number of responders. Based on the information received over the last several years, the variation in GRET usage appears to be in large part due to the relatively small sample size and different responders to the surveys.

We hope LATF finds this information helpful and sufficient for consideration of a potential update to the GRET. If you require further analysis or have questions, please contact Dale Hall at 847-273-8835.

Kindest personal regards,

Dale Hall, FSA, MAAA, CERA, CFA  
Managing Director of Research  
Society of Actuaries

Leon Langlitz, FSA, MAAA  
Chair, SOA Committee on Life  
Insurance Company Expenses
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</table>

W:/National Meetings/2019/Fall/plenary/03 GRET2020.pdf
Actuarial Guideline (VAED)

Background:

Beginning in 2015, the NAIC commissioned a study of the reserve and RBC framework for Variable Annuity products. The study concluded that the existing requirements resulted in non-economic volatility, providing incentive for companies to engage in the use of financial planning techniques that the NAIC deemed inappropriate. Considerable effort was spent to develop and test updates to the reserve and RBC framework to address these issues. That revised framework was adopted by the NAIC during 2018, and the changes to NAIC models, the NAIC Valuation Manual, and the NAIC Life RBC instructions have been developed and adopted by the NAIC on August [xx], 2019. By the provisions of the SVL (Model 820), the changes to the Valuation Manual will be effective on January 1, 2020 and impact subsequent financial statements.

During the discussion of the Framework by the Variable Annuities Issues Working Group, the question was raised whether companies would have the option to ‘early adopt’; that is, to apply the new framework for the reserve and RBC values used for the December 31, 2019 financial statements. Since the new framework has been determined to provide improved financial measurement of the company’s liability and risk, there was agreement that optional application of the new framework for the December 31, 2019 financial statements would be appropriate.

Guideline:

A company may elect to apply the VM-21 requirements from the 2020 NAIC Valuation Manual as the Valuation Manual requirements for the valuation on December 31, 2019. For such election, the phase-in provision of Valuation Manual VM-21 Section 2.B. may not be elected. Any company electing early adoption of VM-21 shall also:

1. apply the provisions of Actuarial Guideline XLIII as amended for 2020 to the December 31, 2019 valuation of contracts within the scope of that guideline;
2. apply the Life RBC instructions for 2020 in the calculation of C-3 RBC in LR027 for 2019;
3. follow the documentation and certification requirements of VM-31 from the 2020 Valuation Manual for the Variable Annuity Business. In the VA Summary, clearly indicate the use of the new requirements in the section on change in methods from prior year; and
4. notify the Commissioner of the state of domicile of such elections.
REGULATORY GUIDE
UNDERSTANDING THE MARKET FOR CANNABIS INSURANCE

NAIC White Paper

July 9, 2019

Drafted by the
Cannabis Insurance (C) Working Group
of the
Property and Casualty Insurance (C) Committee
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III. SEED-TO-SALE OPERATIONS—AN OVERVIEW AND ARCHITECTURE
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IV. TYPE, SCOPE, AND AVAILABILITY OF COVERAGE AND INSURANCE GAPS...
V. BEST PRACTICES AND RECOMMENDATIONS.....................................................
VI. CONCLUSIONS.................................................................................................

ADDITIONAL CANNABIS INFORMATIONAL RESOURCES...........................................
I. INTRODUCTION

A. EXECUTIVE SUMMARY

The cannabis industry is evolving and expanding as more states legalize either or both medicinal and recreational cannabis use throughout the U.S. With new entrepreneurs, investors, large corporate businesses, companies going public and executives entering the market, there is a new level of sophistication to the cannabis industry. The state-legalized cannabis businesses, like any other businesses, face a variety of risks and would like to have access to insurance to mitigate these risks. It is important for state insurance regulators to understand the insurance needs of the cannabis industry and to consider steps to address insurance needs in their respective state markets. Several state insurance regulators have taken steps successfully to encourage insurers to provide insurance for state-legalized cannabis businesses. However, major cannabis insurance gaps exist in many states and even in those states that have encouraged successfully the entrance of insurers into the cannabis insurance market.

The National Association of Insurance Commissioners (NAIC) Cannabis Insurance (C) Working Group was formed in August 2018 to identify insurance issues, gaps and opportunities facing the cannabis industry and to identify best regulatory practices to address these issues—starting with developing a white paper. The purpose of this white paper is to provide information to state insurance regulators, insurers and the broader public about the architecture of the cannabis business supply chain, types of insurance needed by the cannabis industry, the availability of cannabis business insurance in state insurance markets and the extent of insurance gaps, and best practices that state insurance regulators can adopt to encourage insurers to write insurance for the cannabis industry.

B. CANNABIS

The cannabis market rapidly changed over the last few years and continues to change on a daily basis. In 2017, the cannabis industry took in nearly $9 billion in sales. Nationally, in 2018, the overall cannabis industry was worth $10.4 billion1 and is anticipated to bring in $21 billion in 2021.2 Other estimates project that by 2022, the cannabis industry will create an estimated $80 billion in sales annually.3

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of medical and recreational cannabis in the U.S. were nearly nine times higher than Oreo cookies and almost on par with Americans’ collective spending on Netflix subscriptions. With the addition of California’s recreational market sales in 2018, cannabis sales could easily eclipse McDonald’s annual U.S. revenue."4

Additionally, a majority of the U.S. population supports cannabis legalization. About six in 10 Americans say the use of cannabis should be legalized.5 Since June 2019, cannabis is legal for medicinal use in 33 states and Washington, DC, and cannabis is legal for recreational use in 11 states and Washington, DC.

Not only is cannabis a growing industry, but also it is a significant employer. In 2017, the cannabis industry employed 121,000 people. With the current trajectory, the number of workers could reach 292,000 by 2021.6 These jobs can range from budtenders7 and extraction technicians to employees at ancillary companies that generate a large portion of revenue from the cannabis industry. The industry is projected to add as many as 340,000 full-time jobs by 2022. This type of increase in job availability is significant; but, despite the demand for employees in the cannabis sector, there remains an issue with inconsistent positions on the legality of cannabis.

One of the most complex issues facing the cannabis industry is the different treatment of cannabis under federal and state law in states that have legalized cannabis.8 Despite being legal in many states, at the federal level, cannabis is a Schedule 1 substance that is illegal to manufacture, distribute or sell in the U.S.9 Currently, federal law also prohibits the sale of cannabis for medical and adult recreational use. Because cannabis is illegal at the federal level, many individuals are not comfortable working in a field where their employment could be considered illegal. Moreover, financial institutions are hesitant or unwilling to work with cannabis companies. Most banks prohibit cannabis-based businesses from opening accounts, which has led to the cannabis industry being mostly cash-based. This proves problematic as cannabis businesses often find it difficult to engage in standard business practices such as paying employees and vendors. It also

makes many cannabis-based businesses targets for criminal activity because of the increased risk of robberies and other theft-related crimes.

In states that have legalized cannabis, some community banks and credit unions are providing banking services to the cannabis industry, but in other locales, state-chartered financial institutions are unavailable. For example, during a regulatory tour, Delaware regulators witnessed one vendor to the market (that was not growing or selling cannabis) receive notice from its state-chartered bank that it would no longer be doing business with the company because of its involvement in the cannabis industry. The magnitude of this concern should not be ignored. “An estimated 70 percent of cannabis businesses have no relationship with a financial institution and thus use cash for all transactions, including salaries for employees.”

The U.S. Department of the Treasury’s Financial Crimes Enforcement Network (FinCEN) has issued guidance for financial institutions to follow regarding reporting revenues from the cannabis industry in those states in which cannabis is legal, which reflects the Treasury Department’s recognition that some banks and credit unions are providing banking services to the cannabis industry. “Surplus lines insurers mainly focus on the development of new coverages and the structuring of policies and premiums appropriate for risks. New and innovative insurance products for which there is no loss history are difficult, if not impossible, to appropriately price using common actuarial methods. Often, after a new coverage has generated sufficient data, the coverage eventually becomes a standard product in the admitted market.”

Despite the risks, state insurance regulators should encourage insurers who choose to enter the cannabis market to do so on the admitted market to drive the costs of policies down and make cannabis insurance more accessible for the cannabis industry.

C. Insurance Gaps

The following list shows the different types of cannabis businesses that are in the supply chain: cannabis cultivation, processors/harvesters, manufacturing, retail, distribution, testing labs and microbusinesses.

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Below is a list of the types of insurance most frequently needed by the cannabis industry:

- Automobile, including Distribution (auto and cargo)
- Commercial General Liability
- Crop (Indoor/Outdoor)
- Crime Insurance
- Disaster Coverage
- Director and Officer Liability
- Employment Practices Liability
- Equipment Breakdown
- Errors and Omissions
- Excess/Umbrella
- General Liability
- Product Liability
- Premises Liability
- Property
- Surety Bonds
- Workers’ Compensation

As the industry continues to expand, there are more cannabis businesses to insure. No longer is cannabis just the flower used for smoking; the market has expanded to oils, shatter, wax, edibles, topical products, the beauty industry, and other cannabis-infused products. However, even with the increased market activity, many insurers are not willing to write cannabis insurance products due to the cannabis industry’s inability to bank, the federal illegality, and the unknown risks associated with insuring cannabis businesses. Insurance is essential to the security and safety of cannabis businesses, their employees, and their customers. Lack of insurance for the industry adds layers of unnecessary risk and exposure for all market participants.

While cannabis laws vary from state to state, the types of risks facing the cannabis industry generally remain the same. Many of the risks the cannabis industry faces are no different from any other business in the same area of business activity. Outdoor cannabis cultivators face the same risks that other cultivators or agricultural industry businesses face. Outdoor cannabis cultivators, for example, would be most vulnerable to adverse weather conditions and theft, which is not too different from other types of outdoor crop cultivators. The distinguishing factor with outdoor cannabis crops versus other types of outdoor crops is the federal illegality. For example, a cannabis farmer in Carpinteria, CA, was able to use his insurance policy with a payout in excess of $1 million after ash from
the 2017 southern California Thomas Fire destroyed thousands of his cannabis plants.\textsuperscript{12} Ash from the Thomas Fire seeped into the cannabis farmer’s greenhouse and contaminated the cannabis plants with toxic chemicals, which triggered the “atmospheric change” language in the insurance policy.\textsuperscript{13} This is the same exposure and the same coverage that applies to any other farm, nursery or orchard. The farmer accordingly filed a claim and received an insurance payout of more than $1 million. This may be the largest insurance payout given to a legal cannabis business to date.

In contrast, Delaware has not yet identified an insurer willing to write crop insurance for any Delaware cannabis growers. A cannabis farmer cannot get crop insurance in Delaware because he or she is growing cannabis and, consequently, it is considered “untouchable” per se. This difference between states illustrates that some insurers are treating cannabis businesses as regular commercial enterprises and are deciding to make a business risk decision, including financial and legal implications, to insure the cannabis industry, despite federal law differences, while in other states, some insurers are not ready to write insurance for the cannabis industry.

The cannabis industry is diverse in the type of insurance it needs from seed to sale. Crop failure and destruction can occur at the nursery and growth stage. Growing cannabis plants and keeping them healthy during the maturation phases is a laborious process. The cannabis is grown from its seedling stage in nurseries. It must be tended to by experienced cannabis farmers and growers and then harvested and trimmed (either by hand or machine). Even within the cannabis industry, there is great disparity between the sizes of companies and their operating and insurance needs. Crops can range from small craft batch cultivation to large scale nurseries. At the cultivation site alone, the types of insurance needed are different from the needs of a manufacturing site. One of the newest types of manufacturing sites is vertical integration locations where cannabis is grown and trimmed, and low-quality flowers are processed into oil and refined into shatter, wax or another concentrate through expensive machinery. Manufacturers will most likely want to insure these products. Once the cannabis product is in a consumable form, it is tested for contaminants and pesticides.

States often require some form of testing to ensure consumer protection. One bad test or pesticide report can make a crop or product completely unsafe and, therefore, unsellable. Many states have a track and trace system that records the movement of cannabis and cannabis products through the commercial supply chain. The cannabis plants are often tagged, and the packaging of cannabis products is marked with serial numbers to identify

the chain of liability. This allows for the ease of pinpointing exactly where contamination occurred.

The ability to have insurance is critical, and these controls should make insurers confident that they can selectively underwrite this business. This ability to pinpoint exactly where the product contamination occurred helps to identify which cannabis producer should be accountable for a bad batch of cannabis products and, in turn, which insurer will be responsible for paying the claims.

As the cannabis industry continues to expand in states and U.S. territories, insurance availability lags behind the needs of the cannabis industry. Sectors of the cannabis industry that need to be insured include ancillary cannabis businesses, cannabis-infused product manufacturers, cannabis dispensaries, cannabis events, cannabis growers and harvesters, cannabis landlords, cannabis distributors and transporters, cannabis medical physicians, cannabis waste facilities, cyber liability, and more.

Insurance companies have hesitated to enter the admitted market due to little data, as well as the unknown risk factors. There is not only an increased need for insurance by the cannabis industry, but there is also a need for insurance with the roll-out of state and local licensing requirements. As regulations shift from being general to specific, many local and state licensing authorities require insurance. States such as California and Massachusetts require proof of insurance, such as a general liability policy, for cannabis business applicants seeking licensure from state and local jurisdictions.14,15

The risk tolerance differences between state regulatory systems can also be stark. For instance, to access a Delaware retail medical marijuana outlet, a patient must first enter a vestibule with locked doors on either end: one for ingress and the other egress. Patients are scanned in the vestibule when entering a facility. They must produce both a driver’s license (or other state ID) and their Medical Marijuana Program (MMP) card before gaining entrance to a second locked chamber. Once there, patients pass their same ID to the intake processor. Only after satisfying the intake specialist protocol, the patient gains admittance to the store itself. No electronics are permitted in a Delaware cannabis store. In states that have legalized cannabis, security concerns are a prime concern of retail operators. However, state insurance regulators’ security protocols differ for retail outlets.

14. State of Massachusetts, Code of Massachusetts Regulations, Title 935, Cannabis Control Commission, Code of Massachusetts Regulations §§ 500.101(c)(5) and (6) and § 500.105(10).
As the size of the cannabis industry continues to increase, the need and the demand for insurance in the cannabis industry correspondingly increases. State insurance regulators will be forced to deal with the intersection of cannabis and insurance. They should be ready by educating themselves about the cannabis industry and the various types of insurance risks associated with it.

This white paper will focus on the federal, state and local authority; seed-to-sale operations; the type, scope and availability of coverage and insurance gaps; and regulatory best practices and recommendations. State insurance regulators, should they choose to do so, can play an important role in encouraging insurers to write insurance for the cannabis industry.

II. OVERVIEW OF KEY AUTHORITIES

A. FEDERAL AUTHORITY

Legalization of cannabis for any purpose is a topic that has been discussed and debated for decades. While cannabis was once prohibited nationwide, in the 1970s, 12 states either removed or reduced the penalties for possession of small amounts of cannabis. By the late 1970s, the momentum had stalled and would remain that way until the beginning of the 21st century.

However, by 2018, 33 states; Washington, DC; and the territories of Guam and Puerto Rico had legalized the use of cannabis for medical reasons. Eleven states, and Washington, DC, now also permit the recreational use of cannabis. Certainly, the pendulum of public opinion has swung since the late 1970s, with fewer people seeing cannabis as harmful when compared to 20 years ago. While one reason for this change may be generational, public opinion has perhaps also been swayed by the rise in laws permitting the use of medical marijuana.

“Medical marijuana” refers to the use of cannabis, which may involve use of the entire plant or its extracts—most frequently, delta-9-tetrahydrocannabinol (THC) and/or cannabidiol (CBD)—as a physician-recommended form of medicine to treat symptoms of

16. Alaska, California, Colorado, Maine, Minnesota, Mississippi, Nebraska, New York, North Carolina, Ohio, Oregon and South Dakota. (South Dakota later reversed its decriminalization of the drug.)
illness and other conditions. By 2019, 12 states had enacted laws permitting the use of products rich in CBD, which does not have psychoactive effects. Currently, the U.S. Food and Drug Administration (FDA) has not recognized or approved the use of cannabis as medicine, due to its classification as a Schedule I substance under the federal Controlled Substances Act (CSA) of 1970. However, researchers continue to explore its possible uses for medical treatment. Now that hemp-derived CBD is legal, retailers continue to sell CBD products in all 50 states, claiming that they are derived from industrial hemp plants and, therefore, are legal. To date, this is a position that has received mixed treatment from the federal government.

While not addressing every law or regulation that may apply to cannabis-related businesses or consumption, the following section will illustrate the myriad of laws that may complement or contradict each other. As will be seen, the legal and regulatory framework governing cannabis is in a constant state of flux. This constant change has led to great uncertainty in the cannabis industry with regard to business operations throughout the industry.

Signed into law by President Richard Nixon on Oct. 27, 1970, the CSA is the federal U.S. drug policy under which the manufacture, importation, possession, use and distribution of certain narcotics, stimulants, depressants, hallucinogens, anabolic steroids and other chemicals are regulated. Any addition, deletion or change to schedule designation of a medicine or substance may be requested by the U.S. Drug Enforcement Agency (DEA), the U.S. Department of Health and Human Services (HHS), the FDA or from any other party via petition to the DEA.

The DEA implements the CSA and may prosecute violators of the laws set forth in the CSA at both the domestic and international level. Within the CSA, there are federal schedule designations (I–V) that are used to classify drugs based upon their:

- Abuse potential
- Accepted medical applications in the U.S.
- Safety and potential for addiction

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Cannabis is regulated as a Schedule I substance. Schedule I substances are those that have a high potential for abuse and for which there are currently no accepted medical uses in treatment in the U.S.\(^{25}\)

At the federal level, the government’s authority to regulate and control cannabis can be broken into three distinct categories: 1) criminal; 2) administrative; and 3) civil. While these categories are not mutually exclusive and often overlap, conceptualizing the federal level of control in this way is helpful to understand how federal law regulates cannabis and interacts with state and local law. It is also important to bear in mind that the executive, legislative and judicial branches of the federal government all have a role to play in each of these categories, and often, each branch seems to take a different approach in the regulation and control of cannabis.

**B. Federal Criminal Laws**

As mentioned above, cannabis is a Schedule I drug for purposes of the CSA, which triggers certain other federal criminal statutes. Of primary concern for this section, cannabis’ prohibited status triggers three main federal criminal laws when individuals engage in transactions involving cannabis or proceeds from cannabis. The first, the federal Bank Secrecy Act (BSA),\(^{26}\) requires financial institutions to report to the Treasury Department any transactions over $5,000 that the institution knows, or has reason to know, involve assets derived from illegal sources.

“Financial institution” is defined broadly and includes banks, credit unions, broker-dealers, insurance companies, pawnbrokers, travel agencies and a host of other institutions that may come into contact with assets derived from illegal sources. Because cannabis is a prohibited substance, any institution that transacts business with a cannabis or cannabis-related entity is subject to these reporting requirements. The penalty for a violation of the BSA is severe: up to a $250,000 civil penalty and up to five years in prison. Any transaction associated with a cannabis business must be reported under the BSA, even if that activity is legal under state law, and a violation of the BSA may result in a financial institution’s loss of its charter.

The second federal statute implicated in transactions involving cannabis is the money laundering statute.\(^{27}\) This statute makes it a felony for any person to engage in a financial transaction that the individual knows involves the proceeds of an unlawful activity. Because cannabis is a prohibited substance, any transaction that derives proceeds,
directly or indirectly, from cannabis transactions could be considered money laundering for the purposes of the money laundering statute. The penalties for violating this statute are severe: up to a $500,000 civil penalty or twice the value of the property involved in the transaction, whichever is greater, and up to 20 years in prison.

The third federal statute implicated by cannabis transactions is the unlicensed money transmitter statute.\(^{28}\) Under this statute, it is a felony to engage in an unlicensed money transmitting business. The statute defines “unlicensed money transmitting business” to include a transaction that involves the transportation or transmission of funds that are known to have been derived from a criminal offense or are intended to be used to promote unlawful activity. Because of this definition, any transaction that involves the transmission or transportation of funds derived, directly or indirectly, from the cannabis industry is a violation of the unlicensed money transmitter statute and subjects the individual to up to five years’ imprisonment.

In enforcing these statutes, the executive branch has, on the one hand, been consistent and on the other hand inconsistent. Regarding clearly illegal cannabis activities, the executive branch has been consistent in its enforcement and prosecution of such activities. However, the executive branch has been less consistent in its treatment of cannabis in states where it has become legal. For example, in February 2014, then Deputy Attorney General James Cole issued a memorandum that announced guidance to U.S. Department of Justice (DOJ) attorneys on the Obama administration’s priorities in the prosecution of cannabis-related federal crimes.\(^{29}\) Intended to update federal guidance considering ongoing changes to state laws, it applied to all federal enforcement activity, both civil and criminal, in all states.

Noting that the DOJ had previously issued memoranda setting forth federal enforcement priorities in jurisdictions that authorized cannabis cultivation and distribution for medical use, Deputy Attorney General Cole concluded that, with some exceptions, the federal government would again exercise discretion in its enforcement determinations in jurisdictions that had implemented strong, effective regulatory and enforcement systems to control the cultivation, distribution, sale and possession of cannabis for industrial or recreational use.\(^{30}\) While noting that any cannabis transaction was prosecutable, the Cole

\(^{30}\) Continued priorities included preventing the distribution of marijuana to minors and preventing revenue from the sale of marijuana going to criminal enterprises.
Memorandum indicated that the DOJ would not actively seek to prosecute legalized cannabis transactions.

The exceptions to the Cole Memorandum were eight federal priorities for prosecution, including criminal enterprises, sale to minors, growing cannabis on public grounds, and preventing diversion of legal cannabis into states where cannabis was illegal. However, in January 2018, former Attorney General Jeff Sessions rescinded the Cole Memorandum by way of his own memorandum that emphasized the DOJ’s “well-established principles” with regard to the prosecution of cannabis crimes. While the memorandum did not specifically address legalized cannabis, it did indicate a return to a more active DOJ role in regulation and control of cannabis. The federal guidance previously issued by former Attorney General Sessions leaves financial institutions that now accept money from cannabis-related businesses potentially exposed to violations of federal law, including money laundering statutes. In 2019 Attorney General William Barr indicated he will not pursue cannabis businesses that are operating legally within their state jurisdiction. Insurers have no assurance that the Attorney General's comments extend to financial institutions engaging with cannabis businesses, nor, is there any guarantee that this policy extends beyond the tenure of the Attorney General who made the statement. Insurers must assess a business risk decision, including legal risks and financial implications, about whether they will provide services to the cannabis industry.

The federal judiciary has been more consistent in its interpretation of the CSA and related cannabis prohibitions. The U.S. Supreme Court, in its landmark 2005 Gonzales v. Raich opinion, reaffirmed the supremacy of the CSA over state legalization statutes. Since the Gonzales decision, the judiciary has upheld criminal prosecutions involving cannabis transactions, even where legalized at the state level. To date, the Supreme Court has not expressed a willingness to revisit the Gonzales decision. Similarly, lower federal courts have shown a reluctance to address the issue of state legalized cannabis.

In February 2018, a federal judge dismissed a lawsuit seeking to legalize cannabis under federal law. The plaintiffs in that suit argued that the CSA’s classification of cannabis as a Schedule I substance is unconstitutional and that the federal cannabis policies in the U.S. discriminate against minorities. In dismissing the suit, the judge found that the plaintiffs should first petition the DEA to ask that it be removed from the list of dangerous substances, as that agency, along with the FDA, oversees the classification and

33. Gonzales v. Raich, 545 U.S. 1 (2005).
scheduling of the drug. Given these judicial developments, state legalization of cannabis does not pose a bar to prosecution in the federal judiciary.³⁴

The legislative branch, however, has been ambivalent to state-legalized cannabis. In 2003, in the face of several states legalizing cannabis on some level, U.S. Rep. Maurice Hinchey (D-NY) brought an amendment to the House floor that would have prohibited the DOJ from expending funds to prosecute state-legalized medical cannabis operations.³⁵ While this amendment would ultimately fail by a 152-273 vote, by 2014 the amendment was revived by U.S. Rep. Dana Rohrabacher (R-CA) and had been included as an amendment to the 2014 omnibus spending bill.³⁶ Since the enactment of this amendment, Congress has reapproved it yearly in appropriations bills. Other legislative enactments, however, have seen less enthusiasm from Congress.

On June 7, 2018, U.S. Sen. Cory Gardner (R-CO) and U.S. Sen. Elizabeth Warren (D-MA) introduced the Strengthening the Tenth Amendment Through Entrusting States (STATES) Act (S. 3032 and H.R. 6043). The STATES Act was aimed at amending the CSA to exempt cannabis-related activities that were in accordance with state laws. It also sought to protect banks working with cannabis businesses and legalize at the federal level the cultivation of industrial hemp. As of June 2019, The STATES Act has been introduced this congressional session (S. 1028 and H.R. 2093).

In March 2019, the House Financial Services Committee voted in favor of advancing the SAFE Banking Act (H.R. 1595), which would allow cannabis businesses to work with banks and credit unions.³⁷ It would bar federal regulators from terminating a bank’s FDIC deposit insurance, a threat that prevents most banks from accepting cannabis businesses. One of the greatest obstacles of entry for admitted market insurers is the threat of felonious liability under federal law. The SAFE Banking Act would remove some of the direct conflict between state and federal law barriers for insurer and broker participation in the cannabis market. As of June 2019, H.R. 1595 has been discharged from the Judiciary Committee. The bill’s advancement is a significant step for the cannabis industry. With the bill’s passage, it is likely that more banks would open their doors to cannabis businesses. In turn, cannabis businesses would be able to operate as normal businesses. The regulatory landscape of the cannabis industry is evolving rapidly.

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Thus, it’s critical to stay up-to-date on federal and state cannabis-related legislation. Doing so ensures the insurance industry’s underwriting risk assessment and client policy advisement reflects recently passed laws.

Recent developments on both the federal and state levels support the notion that as the commercial investment and scientific research intersect with changing public attitudes about cannabis usage, the risk management portfolio of firms on the supply side will expand to meet market needs. With passage of the new Farm Bill in 2018, Congress moved to fully legalize hemp,38 opening the way for broad distribution of CBD products and creating the first cannabis market insurers may find to be a much more palatable risk. The United States Department of Agriculture (USDA) also subsequently issued a memorandum on new hemp authorities.39

Driving demand is CBD, a non-psychoactive cannabinol that can be derived from hemp or cannabis. CBD is one of the substances in cannabis, but in hemp, it comes with no mind-altering effect from THC. Proponents say CBD helps relieve pain, anxiety, nausea and inflammation. Currently sold mostly online and in specialty shops, CBD can be found in oils, candies, capsules and even sparkling water. In June 2018, the FDA approved the first CBD-based medicine, Epidiolex, made by GW Pharmaceuticals to treat childhood epilepsy.

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C. Federal Regulatory Level

At the federal regulatory level, state-legalized cannabis faces numerous challenges as individuals engaged in business in the cannabis industry attempt to navigate a host of complex federal regulatory regimes. While it is impossible to enumerate every point at which the cannabis industry interacts with federal regulatory regimes, some of these include banking, finance and insurance; securities; environmental protection; intellectual property; taxation; and agriculture, just to name a few.

D. Financial Services Sector

The first area of regulatory authority is in the financial services sector. As noted above, many of the criminal laws that are implicated by legalized cannabis are financially orientated, and lack of access to banking and financial services even in states where cannabis is legal is a significant issue. For example, in order to comply with the BSA, financial institutions must send Suspicious Activity Reports (SARs) to the Treasury Department when the institution is involved in a transaction involving funds over $5,000 that the institutions knows, or has reason to know, come from illegal sources, such as cannabis.40

Beyond mere compliance with federal criminal law, a host of other regulations complicate financial transactions involving legalized cannabis. For example, for financial institutions to be able to transmit funds electronically through the Federal Reserve’s electronic network, the institution must have a master account with the Federal Reserve. However, the Federal Reserve has been reluctant to provide master accounts to institutions that deal exclusively in legal cannabis due to the federal prohibition on cannabis, leaving such institutions without the ability to transmit money.41 There are exceptions such as Colorado, which has a limited scope and strict parameters, but it does have a Federal Reserve account. Even where cannabis businesses attempt to raise funds outside the ordinary banking system, federal regulations may pose a barrier. If a cannabis business seeks to raise capital through the issuance of securities, such securities must be registered by the U.S. Securities and Exchange Commission (SEC) unless the security falls within an exemption.42 It is unclear whether the SEC would approve such securities given the prohibited status of cannabis.

40. 31 CFR § 1020.320.
41. Fourth Corner Credit Union v. Federal Reserve Bank of Kansas City, 861 F.3d 1052 (10th Cir. 2017).
In response to these concerns, and in recognition of the Obama administration's
deprioritizing of criminal prosecution of cannabis-related businesses in cases where they
are otherwise compliant with the laws of the state in which they are operating, on
February 14, 2014, FinCEN issued its own guidance. This guidance was intended to
clarify how financial institutions can provide services to such businesses while remaining
compliant with their obligations under the BSA. It instructed financial institutions providing
such services—when they reasonably believed, based on their due diligence, that a given
business did not implicate the Cole Memorandum’s priorities or state law—to file a
“Marijuana Limited” SAR. Further, a financial institution that reasonably believed a
cannabis-related business was violating a Cole Memorandum priority or state law was
instead instructed to file a “Marijuana Priority” SAR, and FinCEN’s guidance set forth the
“red flags” that would suggest the business was engaged in such activity. Despite the
guidance issued by Attorney General Sessions in 2018, FinCEN has stated that the
structure set forth in its 2014 guidance remains in place. What FinCEN’s guidance did
not and could not do, however, was amend federal law or grant immunity to a financial
institution providing services to a cannabis-related business.

Despite FinCEN’s guidance, the number of financial institutions accepting this risk
dropped slightly in the months that immediately followed its issuance. It has, however,
grown steadily since then. According to FinCEN, by the end of March 2018, 411 banks
and credit unions were “actively” operating accounts for marijuana-related businesses.
States continue their attempts to navigate these murky waters between federal and state
law. By way of example, in 2014, Colorado passed a law that would allow the formation
of “cannabis credit co-ops.” These co-ops were to function similarly to a credit union and
had restrictions on the number of businesses they could serve. Despite the passage of
this bill, no co-ops have been formed under this law. Several other state initiatives have
been introduced since. On July 3, 2018, the New York State Department of Financial
Services published its own guidance to encourage banks and credit unions to offer
services to marijuana-related businesses licensed by the state and advised them to
continue to follow FinCEN’s 2014 guidance. Still, given the risk of not only losing their

43. Those subject to FinCEN’s regulations were still required to report currency transactions in connection with
marijuana-related business the same as they otherwise would.

www.forbes.com/sites/tomangell/2018/05/17/congressional-committee-protects-medical-marijuana-from-jeff-
sessions/#546c1ca11e55.

www.forbes.com/sites/tomangell/2018/06/14/more-banks-working-with-marijuana-businesses-despite-federal-
moves/#39002b6b1b1b.


47. Miyoga, D., 2014. “Promise for Pot-Banking Co-Op Sees Little Progress Since It Was Law,” The Denver Post,

Conference of State Legislators Legislative Summit, accessed at
charter but also the threat of facing criminal prosecution for a federal offense, many financial institutions have been hesitant to embrace the cannabis business.

E. Intellectual Property

The cannabis industry faces other complications related to federal regulation. One example of this is in the area of intellectual property. As the cannabis industry has become legitimized, many cannabis businesses such as growers, distributors, and retailers have sought to protect their intellectual property in brand names, business names and similar identifiers. However, the U.S. Patent and Trade Office (USPTO) has historically taken the position that trademarks cannot be granted to applications promoting or involving illegal conduct. To date, the USPTO has not approved any filings for trademarks or copyrights for products related to cannabis. Interestingly, however, the USPTO has approved trademarks for certain cannabis derivatives. Specifically, the USPTO has approved trademarks for specific types of CBD products. As noted above, these approvals stemmed from confusion as to whether CBD was illegal under the CSA. This confusion has since been resolved. However, the CBD trademarks are still valid and still exist. Thus, while the USPTO has seemed to take a straightforward approach to the registration of cannabis trademarks, there is still some inconsistency in how the USPTO previously handled such trademarks.

F. Environmental and Agricultural Regulations

One last area of interest worth noting is the cannabis industry’s interaction with environmental and agricultural regulations. Cannabis, after all, is an agricultural product, which gives rise to environmental concerns. There are two key areas of concern at the federal level in this regard: 1) the federal Clean Water Act (CWA); and 2) the provision of water rights from federally administered facilities. The CWA regulates, in part, the pollution generated by agriculture operations. However, the CWA relies, in large part, on federal-state cooperation. The CWA is largely implemented at the state level using federal funds and grant projects. Given the prohibited status of cannabis at the federal level, it is unclear whether such grants would be available to states for cannabis remediation projects. Indeed, state programs aimed at environmental cleanup and


partnership with the cannabis industry have been subject to federal raids and subpoenas.51

An additional agricultural concern arises regarding water rights and irrigation. In particular, regulatory complexities arise for cannabis growers in the western U.S., who must contend with the U.S. Bureau of Reclamation (USBR). The USBR is the largest wholesaler of water in the U.S. and provides one out of five western farmers with irrigation water.52 Because of the prohibited status of cannabis under the CSA, the USBR has issued guidance stating that it will not approve the use of its facilities for the cultivation of cannabis.53 As such, cannabis cultivators and growers may find it difficult to find the water sources necessary to support their growth operations.

G. Civil Level

At the civil level, the federal judiciary has created confusion as to civil obligations. This section will highlight two of significant importance: 1) the enforceability of contracts; and 2) the ability to declare bankruptcy. The enforceability of contracts brings questions on whether contracts involving cannabis transactions are void against public policy. Without guidance from the U.S. Supreme Court, lower courts have been left to address this issue as a matter of first impression.

In Tracy v. USAA Casualty Insurance Company, the District Court for the District of Hawaii was asked to determine whether a contract of insurance was enforceable against an insurer in order to provide coverage for legal cannabis plants that had been lost during a fire.54 The Court in that case determined that since cannabis is illegal under the CSA, the Court would decline enforcing the contract on the grounds that it was against public policy. As such, no coverage was available under the policy. The opposite conclusion was reached in the District Court for the District of Colorado. In Green Earth Wellness Center, LLC v. Atain Specialty Insurance Company, the Court was asked whether a policy of insurance could cover legal cannabis plants that were damaged due to a wildfire.55 In addressing the “void as against public policy” argument, the Court reasoned that over the years, the federal public policy had eroded; thus, there no longer existed a clear and consistent public policy against legalized cannabis. As such, the Court expressly declined to follow Tracy and found that the contract of insurance provided coverage for legal cannabis plants. While there appears to be a trend of courts following Green Earth as

opposed to Tracy, until there is a definitive ruling on this issue by the Supreme Court, the enforceability of contracts involving cannabis will still be a point of contention.

One last area of concern at the civil level is the ability of cannabis-related businesses to declare bankruptcy. The ability of a business to seek bankruptcy protection is essential to a business when operations prove unsuccessful. However, this tool may not be available to cannabis-related businesses. In the case In re: Arenas, the 10th Circuit Court of Appeals was asked to determine the availability of bankruptcy protections for cannabis growers.56 In that case, after litigation returned a negative verdict against the cannabis growers, the growers sought bankruptcy protection. The U.S. Trustee objected to the bankruptcy, and the bankruptcy court dismissed the petition due to the criminal nature of the business. The 10th Circuit affirmed the dismissal, reasoning that since the substantial assets of the estate were cannabis, and since cannabis was illegal under federal law, the U.S. Trustee could not administer the bankruptcy estate without violating federal law.57 As such, the Court ruled that dismissal of the bankruptcy was permissible. As with the enforceability of contracts, until guidance is provided by the Supreme Court, there will be uncertainty as to whether bankruptcy protections are available to cannabis-related businesses. In addition, different states have distinctive laws allowed in bankruptcies, such as a homestead exemption, so there are no general bankruptcy laws applicable to all states.

**H. McCarran-Ferguson Act**

One of the areas unique to insurance is how the federal laws affecting cannabis interact with the federal McCarran-Ferguson Act.58 The McCarran-Ferguson Act precludes federal law from preemption state law regarding the business of insurance unless the federal law specifically relates to the business of insurance. Arguments have been made that because the CSA does not specifically apply to the business of insurance, state laws governing cannabis insurance are not preempted; therefore, states are free to engage the cannabis insurance industry without concern of federal liability.59 However, the nuances of how federal cannabis laws interact with the federal McCarran-Ferguson Act have not been clearly explored, and uncertainty still exists in this regard.

While it is true that the CSA does not specifically relate to the business of insurance, this, in and of itself, does not save a state statute regulating cannabis insurance from

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56. In re Arenas, 535 B.R. 845 (10th Cir. 2015).
57. See also, In re Rent-Rite Super Kegs West Ltd, 484 B.R. 799 (D. Colo. 2012) (Dismissing a Bankruptcy Petition Because Marijuana Remains Illegal Under the CSA).
preemption. While the fixing of rates, regulation of advertising of insurance policies, and the licensing of companies and their agents are clearly the business of insurance and, therefore, are not subject to preemption under the federal McCarran-Ferguson Act,\(^{60}\) other aspects of cannabis insurance regulation are not so clearly regulating the business of insurance as to prevent preemption. For example, the Supreme Court has held that priority provisions of state insolvency law, to the extent that they are attempting to provide for priority of payments beyond policyholders, are not saved from preemption under the federal McCarran-Ferguson Act.\(^{61}\) Thus, state insurance regulators may find that their authority to orderly liquidate an insurer may, to a greater or lesser extent, be preempted by the CSA.

Another example of where a state’s law may not be protected by the federal McCarran-Ferguson Act is in the field of corporate transactions. While the licensing of insurers is clearly protected by the federal McCarran-Ferguson Act, the Supreme Court has held that the SEC may unwind transactions that are in violation of federal securities law.\(^{62}\) Therefore, a state insurance regulator may approve a transaction involving a cannabis insurer only to see it unwound by the SEC on the grounds of illegality.

Putting aside the CSA, other federal laws directly affecting the cannabis insurance industry are clearly not protected by the federal McCarran-Ferguson Act. Specifically, the criminal statutes mentioned above (the BSA, the money laundering statutes and the unlicensed money transmitted statute) are all not subject to the anti-preemption provisions of the federal McCarran-Ferguson Act. This is because each of these laws specifically relates to the business of insurance. Each of these acts specifically defines financial institutions to include insurers\(^{63}\); therefore, on the statutes’ face, the anti-preemption provisions of the federal McCarran-Ferguson Act do not apply. As such, the federal government may enforce these criminal provisions against both the industry and potentially state insurance regulators. Indeed, courts that have been faced with the question of whether the federal McCarran-Ferguson Act bars prosecution under these statutes have found no such bar to exist.\(^{64}\)

Despite issues at the federal level, states recognize the additional revenue that could be generated by the sale of cannabis, and those that currently have this income stream are using it to fund projects they may not otherwise have been able to afford. For example, Colorado is using the first $40 million of tax revenue to fund school construction costs, and Nevada intends to earmark 40% of its wholesale tax to the state’s Distributive School

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\(^{64}\) U.S. v. Blumeyer, 114 F.3d 758 (8th Cir. 1997); U.S. v. Cavin, 39 F.3d 1299 (5th Cir. 1994).
Account (DSA). Others intend to use the extra money to fund drug treatment and enforcement programs.  

The additional revenue, however, may not come without a cost. To balance public safety concerns with the rights of individual users, cities and towns are also beginning to regulate the use of medical and recreational cannabis. The myriad of local laws further complicates the landscape as evidenced by the attempt to summarize the specific policies for all 482 cities in the state of California. This summary serves to further illustrate the patchwork of laws and lack of uniformity with respect to this issue.

III. SEED-TO-SALE OPERATIONS—AN OVERVIEW AND ARCHITECTURE OF THE CANNABIS INDUSTRY

A. OVERVIEW

States have taken varying approaches to regulating the cannabis industry. While some states regulate medical and recreational cannabis separately, others have delegated authority to a single administrative agency. For example, Oregon has had a medical cannabis program since 1998 and a recreational program since 2016. The medical program is run by the Oregon Health Authority (OHA), which registers and regulates medical cannabis patients, medical cannabis growers, grow sites, processors, dispensaries and caregivers. OHA also promulgates cannabis testing rules. The recreational program is run by the Oregon Liquor Control Commission (OLCC), which licenses producers, wholesalers, processors, laboratories, retailers and researchers. The OLCC also issues permits for individual workers in the recreational cannabis industry.

In contrast, both medical and recreational cannabis in Colorado are regulated by the Colorado Department of Revenue (DOR). Medical cannabis was decriminalized through an amendment (Amendment 20) to the Colorado Constitution in 2000. Recreational cannabis was added in 2012 (Amendment 64).

Colorado and Oregon represent two versions—one separate and one unified—of the regulation of the cannabis industry. As cannabis remains illegal under federal law, individual states have, and increasingly are, legalizing parts of the cannabis industry and setting up regulatory structures unique to their respective states. It can be anticipated that

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as these regulatory structures mature, there will be increased emphasis on unification and coordination to avoid regulatory pressure points caused by differing legal and regulatory schemes.

B. Cultivation

The cannabis cultivation component of the industry has developed along two paths: 1) a “cottage” industry of small-scale craft cultivation (i.e., cultivation for home and/or personal use); 2) and the development of large-scale producers engaged in cannabis as a commercial crop. There are further subdivisions between recreational and medicinal cannabis.

States typically allow residents to grow a limited number of home-grown cannabis plants for personal use, while registered medical and recreational cannabis caregivers can produce in greater quantities. Registered medical cannabis producers are often required by states to be vertically integrated in some way with the rest of the supply chain. For example, registered growers in Oregon must be designated by a patient to produce cannabis on their behalf. The patient may designate themselves or another person as their grower. There are 16,600 registered growers who are producing at 13,959 grow sites.

In Colorado, medical cannabis caregivers who cultivate more than 36 plants must register with the Colorado Department of Public Health and Environment and disclose: 1) the location of each cultivation; 2) the cannabis registration identification number for each patient they serve; and 3) any extended plant count numbers (patients with physician recommendations exceeding six plants and their patient registry numbers). As of December 2018, caregiver cultivation registrations numbered 1,963.

Medical marijuana cultivators (“optional premises cultivation” (OPC) or “grow” operations) in Colorado must be vertically integrated or associated with a licensed medical marijuana center (a business that sells medical cannabis to patients or primary caregivers, but is not, itself, a primary caregiver) or a licensed manufacturer who creates products infused

67. Oregon residents are allowed up to four homegrown plants per residence. (ORS 475B.301) Colorado home grow laws allow no more than 12 plants in any residence. Counties and municipalities may have stricter laws in place. The plants must be kept in an enclosed, locked space and inaccessible to anyone under 21 years of age living in or outside of the residence. (Colorado Marijuana Official State Web Portal: www.colorado.gov/pacific/marijuana/home-grow-laws.


With medical cannabis intended for use/consumption other than by smoking.\textsuperscript{70} There were 673 licensed medical cannabis cultivation entities in Colorado in January 2019.\textsuperscript{71}

In contrast to the medical cannabis grow operations, the recreational side shows significantly larger-scale operations. In Oregon, there are 1,108 licensed recreational producers who participate in some aspect of producing, cultivating, growing and drying cannabis. In Colorado, there were 735 recreational cultivation entities in January 2019. Although there was a similar number of medicinal cultivation entities, the monthly average ratio of cannabis plants cultivated as of June 30, 2018, was almost 3:1 recreational over medicinal.\textsuperscript{72}

There are often more stringent limits on the amount of medical cannabis that can be produced as compared to the limits for recreational cannabis. For example, in Oregon, the largest non-grandfathered medical-only producer is limited to 48 mature plants.\textsuperscript{73} On the other hand, the largest-tier outdoor recreational producer is not limited by the number of plants and can produce on as much as 40,000 square feet of land.\textsuperscript{74} In Colorado, recreational cannabis cultivators can grow up to 1,800 plants at a time (Tier 1), and after one harvest season of sales, may seek authorization to grow more plants at progressive increments up to the tier in excess of 13,800 plants (Tier 5).\textsuperscript{75}

\section*{C. Distribution, Manufacturing and Delivery/Transportation}

States have taken varying approaches to licensing the distribution, manufacturing and transportation of cannabis products. In Oregon, wholesalers purchase cannabis from licensed producers (cultivators). They may dry, trim, arrange for lab testing, package, store and deliver cannabis to retailers. There are 139 licensed wholesalers in Oregon.\textsuperscript{76} Processors extract oils from cannabis plants and package them into vaporizers or vaporizer cartridges. Processors may also produce cannabinoid extracts and bulk oil used for manufacturing edibles or topical products. Edible manufacturers are required to obtain

\begin{itemize}
\item \textsuperscript{71} Colorado Marijuana Official State Web Portal, accessed at www.colorado.gov/pacific/med-resources-and-statistics.
\item \textsuperscript{72} Colorado Department of Revenue, 2018. MED 2018 Mid-Year Update, pp. 4–6; accessed www.colorado.gov/pacific/sites/default/files/MED%202018%20Mid%20Year%20Update.pdf.
\item \textsuperscript{73} ORS 475B.831.
\item \textsuperscript{74} OAR 845-025-2040.
\item \textsuperscript{76} Oregon Liquor Control Commission, November 2018. For current data, visit www.oregon.gov/dli/cannabis/Documents/mj_app_stats_by_county.pdf.
\end{itemize}
a processor license. There are 204 licensed processors in Oregon, with three registered processors in the medical cannabis program.77,78

Colorado’s regulatory system is different in that a cultivation facility is licensed to cultivate, prepare and package recreational cannabis and sell it to retail stores, product manufacturing facilities or other retail cultivation facilities. Consequently, Colorado does not have a wholesaler category. However, it does have separate categorizations for medicinal and recreational manufacturers who concentrate and make products for consumption other than by smoking, including edibles, ointments and tinctures.79 There are 239 medical infused product manufacturers and 282 recreational product manufacturing facilities in Colorado as of January 2, 2019.80

In Oregon, an entity must be a licensed producer, wholesaler, processor, laboratory or retailer in order to transport cannabis. Wholesalers may provide transportation services to other licensees throughout the supply chain. Colorado’s structure provides for licensure of a transporter. A medical cannabis transporter is a person or business that transports medical cannabis from one business to another and may include the provision of logistics, distribution and storage of medical cannabis and manufactured medical cannabis products. There are 10 medical cannabis transporters licensed in Colorado. On the recreational side, there are 13 transporters licensed in Colorado.81

D. Retail and Consumers

Retailers sell items directly to consumers. Medical cannabis dispensaries receive cannabis, immature cannabis plants or cannabis products and transfer them to a patient or a patient’s caregiver. There are approximately five registered dispensaries in Oregon. Retailers are responsible for verifying the age of every customer for every purchase. Retailers may sell usable cannabis, cannabinoid products, cannabinoid extract or concentrate, immature plants, and cannabis seeds. There are 598 licensed recreational

cannabis retailers in Oregon\textsuperscript{82} and approximately 620 licensed cannabis retailers in California\textsuperscript{83}

In Colorado, as of November 1, 2018, there are 477 distinct licensed medical cannabis centers; of those, there are 413 unique licensees. There are 547 distinct licenses held for recreational retail stores; of those, there are 457 unique licensees.\textsuperscript{84} There are several products available to the consumer, which fall under the flower and non-flower categories. In Oregon, cannabis flower represented 54.4\% of recreational sales in 2018, followed by concentrate/extract at 29.4\% and edible products at 10.3\%. All other products represent roughly 6\% of sales.

The flower also holds most of the market share in Colorado at 54.1\% of recreational and 61.2\% of medicinal use.\textsuperscript{85} In 2015, the non-flower products were about 25\% of total sales. In 2017, the non-flower products sales jumped to 37.7\% of the regulated market. The non-flower products include concentrate, edibles and non-edibles.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|}
\hline
State & Flower & Extract/Concentrate & Edibles \\
\hline
OR (2018) & 54.4\% & 29.4\% & 10.3\% \\
\hline
CO (2017) & 54.1\% & 23.4\% & 13.4\% \\
\hline
\end{tabular}
\caption{Recreational Sales by Type of Product}
\end{table}

E. Testing

Testing is an important regulatory component in the cannabis supply chain. States that have legalized the use of cannabis generally require that product be tested by a lab before distribution to a dispensary and sale to the consumer. Labs use a variety of testing methods based on different products (oils, shatter, wax, edibles, topical products, etc.) in

\textsuperscript{82} Oregon Liquor Control Commission, November 2018. For current data, visit www.oregon.gov/olcc/marijuana/Documents/mj_app_stats_by_county.pdf.


order to determine potency—the amount of THC, CBD and pesticide concentrations in the product. However, the testing and methodologies have not developed standardized metrics or methods, which leave these aspects open for future research.

All cannabis products in Oregon are required to be tested by a licensed laboratory before being sold to consumers. Laboratories test for contaminants, pesticides, solvents and potency. There are 23 licensed laboratories in Oregon. In Colorado, under both the recreational and medical cannabis laws, regulated cannabis must be tested in five categories: 1) microbials (bacteria and fungi); 2) mycotoxins (toxins produced by fungi); 3) residual solvents; 4) pesticides; and 5) potency. Licensed retail entities must submit samples of recreational cannabis and recreational cannabis products to a licensed testing facility for testing in the five categories. All medical cannabis products must be labeled with a list of all chemical additives that were used in the cultivation and production of a medical cannabis product. Persons holding a retail testing license may not have an interest in any other cannabis license, either recreational or medical. Currently, there are 11 each of testing facilities for medical and recreational cannabis in Colorado.

**F. Tracking**

Oregon and Colorado have several risk management requirements for cannabis-related businesses. Participants in the recreational and medical cannabis industries must use state-administered systems to track inventories throughout the production, processing, transportation, sale and testing of cannabis. Every plant is assigned a unique code and tracked through the supply chain in order to allow for more effective audits, to satisfy federal guidelines and to allow for product recalls when consumer safety issues are present.

**G. Security**

Most states require individuals who work in the cannabis industry to obtain some sort of license. The scope of the licensing laws may vary. For example, all employees who perform work on behalf of an Oregon licensed producer, processor, wholesaler or retailer—including, but not limited to, individuals who participate in the possession, securing, or selling of cannabis items—are required to possess a valid cannabis worker permit. In Colorado, all individuals who own or work for a licensed cannabis business

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must pass a fingerprint-based criminal history background check and demonstrate Colorado residency and financial responsibility. Cannabis businesses must also document their funding sources and ownership structure.

In Colorado and Oregon, all entities in the cannabis supply chain are required to implement certain security precautions, including:

- Video cameras that produce 24/7 high-quality, non-light dependent recordings of all areas where cannabis items are present.
- Armed alarm systems.
- Panic buttons or the equivalent to call for emergency services.
- The ability to lock and secure cannabis items at all times.

H. Existing Economic Impacts

The cannabis industry provides a significant source of jobs and tax revenue in states where it has been legalized. The market is characterized by steady growth. In jurisdictions where recreational cannabis was legalized after the legalization of medical cannabis, recreational production and sales have overtaken the medical side to be the dominant force in the market.

The legalization of cannabis provides employment opportunities directly within the cannabis industry, such as retail stores, dispensaries, cultivation, infused product manufacturing, transportation and laboratory testing. Additional ancillary jobs include security guards, construction and HVAC specialists, consulting, legal, and other business services. In Colorado, as of Nov. 1, 2018, there are 41,429 individuals licensed in the cannabis industry.99 There are 36,228 individuals licensed to work in Oregon.90 Considering worker turnover, economists estimate that about 12,500 individuals are employed at any one time.91

States realize a significant increase in tax revenues from the sale of cannabis. For example, Colorado’s revenues from excise and sales tax increased 91.1% from 2014 to

In Oregon, $82 million in cannabis tax dollars were collected in FY 2018. This represents a 17% increase from FY 2017. Recreational cannabis tax revenue is expected to increase by another 34% by the 2019–2021 biennium. Since recreational cannabis became legal in Oregon in 2016, sales have steadily increased. Consumer sales in July 2018 were approximately $57.5 million, approximately 20% higher than the consumer sales in July 2017. Sales of all types of products—including edibles, extracts and usable cannabis—have steadily increased.

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96. Ibid.
In contrast, the number of medical cannabis growers, processors and dispensaries has declined sharply since 2016, when recreational cannabis was legalized in Oregon.\(^{97}\) There has been a significant amount of consolidation in the industry, which has led to frequent ownership changes and continuous business structure modifications.\(^{98}\)

Nationwide, the *NAMIC Issue Analysis* cites information from the *Marijuana Business Daily* in May 2017 that estimated demand for recreational cannabis approaches $45 billion to $50 billion compared to $106 billion for beer, $76.9 billion for cigarettes and $70.3 billion for nutraceuticals.\(^{99}\) Moreover, the *NAMIC Issue Analysis* summarizes:

> In 2017, the legal medical and adult-use market reached $8.5 billion, according to the “State of Legal Marijuana Markets” executive report. The same report projects that the U.S. Cannabis market will reach $23.4 billion by 2022. Another report even likened the industry’s 25 percent compound growth rate through 2021 to cable television at 19 percent in the 1990s and broadband internet at 29 percent in the 2000s. Other reports project the industry would reach as much as $50 billion by 2026 if marijuana were legalized at the federal level. In addition, medical and adult use retail cannabis tax revenues

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97. From October 2015 to October 2018, the number of growers dropped from 48,699 to 16,600. From October 2016 to October 2018, the number of processing sites dropped from 117 to three, and the number of dispensaries dropped from 46 to five. Oregon Health Authority, October 2015, 2016 and 2018. *Oregon Medical Marijuana Program Statistical Snapshot*, accessed at [www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/MEDICALMARIJUANAPROGRAM/Pages/data.aspx](http://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/MEDICALMARIJUANAPROGRAM/Pages/data.aspx).


tipped $645 million in 2017 and are expected to hit $2.3 billion in 2020.\textsuperscript{100}

IV. TYPE, SCOPE, AND AVAILABILITY OF COVERAGE AND INSURANCE GAPS

A. INTRODUCTION

The cannabis industry can be broken down into multiple segments. This includes cultivation, processors/harvesters, manufacturing, retail distribution, testing labs, and microbusinesses or affiliated businesses (e.g., construction, security, cargo/transportation companies). While each of these segments is unique and require insurance products specific to their type of business, there are coverages that apply to all the business segments. These coverages include, but are not limited to, general liability, workers’ compensation, product liability, and property insurance.

There are a few admitted insurers issuing policies in the cannabis industry, and they are treating cannabis businesses as “regular” businesses despite the federal illegality of the product. One exception to this statement is workers’ compensation. Some states—including Colorado, Oregon and California—include a workers’ compensation market of last resort through a state-admitted carrier for this coverage. However, most other available insurance products for the cannabis industry are currently insured through the non-admitted (surplus lines) market.

The primary challenge in engaging admitted insurers in many states to write any coverage type is the requirement of a “lawful purpose.” Under general law, any contract or agreement entered for an illegal purpose is not legally binding. Because cannabis continues to be illegal at the federal level, the argument is made that there can be no legal contract or insurance policy. There are legislative efforts underway at both the federal and state level to address this conundrum of legality in a state and illegality at the federal level.\textsuperscript{101}

Moving toward an admitted market for cannabis business insurance is a key objective for states that have legalized. This is a rapidly changing area with businesses seeking admitted coverage but only able to find coverage in the non-admitted market. As the


\textsuperscript{101} See discussion at p. 24.
cannabis industry develops, their insurance needs become more sophisticated and differentiated.

The chart below is intended to provide examples on the needs of the industry ranging from general coverages anticipated for all cannabis businesses to those more specialized for various business segments, such as testing labs.

**Sample General Insurance Needs for Cannabis Industry (Product Liability)**

- Business Owners Policy Programs
- Commercial General Liability
- Premises Liability
- Products/Completed Operations Coverage

**Sample Specialized Coverage Needs by Business Segments**

<table>
<thead>
<tr>
<th>Cultivation</th>
<th>Processors/Manufacturers</th>
<th>Testing Labs</th>
<th>Distribution</th>
<th>Retail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crop Insurance</td>
<td>Equipment Breakdown</td>
<td>Equipment Breakdown</td>
<td>Automobile Liability</td>
<td>Employment Practices</td>
</tr>
<tr>
<td>Equipment Breakdown</td>
<td>Errors and Omissions</td>
<td>Errors and Omissions</td>
<td>Cargo</td>
<td>Directors and Officers Liability</td>
</tr>
<tr>
<td>Earthquake/Volcanic Eruption/Sprinkler Leakage</td>
<td>Directors and Officers Liability</td>
<td>Directors and Officers Liability</td>
<td>Employee Theft</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Crime Insurance</td>
</tr>
</tbody>
</table>
Other Potential Insurance Needs

- Lessor’s Risk
- Medical Professional Liability
- Surety Bonds

B. How Insurers Determine Cannabis Rates

The cannabis insurance market is presently expanding with insurers emerging onto the admitted market. These insurers are submitting rate filings for regulated products, which allows state insurance regulators to gain insights into the types of coverages and design ratemaking approaches with respect to the coverage filings. Preliminary reviews of recent admitted-market filings suggest that policies and coverages offered to cannabis-oriented operations are similar to those provided to other non-cannabis businesses, including various limit and deductible options that are routinely offered in the commercial insurance marketplace. As the cannabis insurance market continues to grow the types of coverage and options do as well.

a. General Observations Regarding Cannabis Insurance Rates

Optional coverages such as earthquake, terrorism and sprinkler leakage are generally available at an additional premium to insureds who elect these coverages. Both rates and minimum premiums can vary on the basis of the nature of the risk (e.g., the classification of the insured as a store, dispensary, grower, warehouse, distributor, and whether the insured grows the product solely for its own use or for sale to other businesses) and the territory (as defined by the insurer in its rating plan). Possible segments include, but are not necessarily limited to, the following: 1) store/dispensary; 2) indoor cultivation; 3) outdoor cultivation; and 4) manufacturing/processing.

Exposure bases for loss costs can be either sales or payroll, as appropriate, based on the coverage and the business operations. For multiplicative increased-limits factors (ILFs), lower factors apply to lower limits of coverage; higher factors apply to higher limits. Claims-made policies are available, with options to choose retroactive dates and extended reporting periods. The further back the retroactive date is in the past, the larger the premium. Premiums for extended reporting periods are determined as percentages of the annual premium.
Schedule rating is often available to adjust the manual rates up to +/-25%, and in infrequent cases up to +/- 40% (also depending on allowable schedule-rating constraints pursuant to the laws of individual states). Some cannabis-specific characteristics that some insurers use in schedule rating include: 1) number and type of cannabis licenses; 2) depth of experience in cannabis operations; and 3) the use of blockchain, including Hyperledger, technology in processing, distribution and retail transactions.

Some rates may be premised on certain packages of coverages being mandatory. For instance, some insurers may require a package of general liability and property coverages to be purchased together, while other coverages—e.g., product liability, crime, earthquake, sprinkler leakage or terrorism—may be optional.

Package discounts for property and liability coverages together may be available, along with multi-policy credits. Rates may be affected by the owner's years of experience and financial position. New ventures may be significantly surcharged, as may inexperienced business owners or insureds with prior bankruptcies.

Rates may also depend on the following attributes: 1) presence of video surveillance; 2) use of locked display/storage cases; 3) use of flammable solvents, tinctures and/or hash oil; 4) local surroundings, including traffic volume and proximity to police services; and 5) the selection and training of employees. Rates may also be premised on the business complying with certain requirements, such as background checks on employees.

b. Businessowners’ Policy (BOP) Programs

Classification relativities for various businesses are often derived from existing proxy classifications. For instance, some insurers have noted the following similarities in their filed rating plans:

- Distributors have similarities to warehouses and wholesale businesses, such as baked goods, tobacco, and grocery.
- Testing labs have similarities to businesses specializing in scientific tools and instruments and dental labs.
- Dispensaries have similarities to other retail stores, such as drug stores and tobacco stores.
- Manufacturers have similarities to other small business operation/manufacturing exposures, such as bakeries (no restaurant) and beverage stores (no liquor).
c. Commercial General Liability (CGL) Insurance

Many CGL exposures can be rated with gross sales as the exposure base. However, certain classifications pertaining to transportation and/or distribution may be rated based on payroll, while classifications pertaining to subcontracted work may be rated based on the cost of that work. Within a schedule-rating plan, underwriters may consider such criteria of individual risks as: 1) the experience of the management; 2) internal controls; 3) structural features and condition of the building; 4) compliance with safety protocols; 5) types of equipment; and 6) the selection, training and experience of employees.

Loss costs for liability coverages and related endorsements are affected by:

- Applicable limitations on territories.
- Requirements for persons on premises to be escorted by employees.
- Hours of operation.
- Customer age restrictions.
- Type of exit packaging.
- Advertising injury liability, which is affected by restrictions on marketing to youthful persons.
- Requirements for security guards and protective devices. For instance, rates may be affected by: 1) employing state-certified security guards; 2) whether they are employees or subcontractors; and 3) whether they are armed or unarmed.

d. Premises/Operations Coverage

Premises or operations coverage can be rated by area of building. Possible hybrid exposure bases would be the square footage if the building area is smaller and gross sales if the building area is larger. Deductibles per occurrence are often available. The potential for inhalation/exposure liability is likely to be higher than for other typical properties and would be reflected in rates accordingly.

e. Products/Completed Operations Coverage

For products or completed operations coverage, gross sales are a possible exposure base. Rates vary by type of operation; e.g., medical dispensaries may be charged different rates from retail stores. Deductibles per occurrence are often available. There may be a default deductible, and further discounts could apply for the selection of higher deductibles.
f. Optional Coverages for Businessowners’ and/or Commercial General Liability Programs

In exchange for additional premiums, the following optional coverages may be available:

- Coverage for risks arising from employment of security guards (rated based on payroll/cost of security guards).
- Hired and non-owned automobile coverage (may be available for flat additional premiums).
- Assault and battery coverage (premium for various sublimits may be calculated as a percentage of the main commercial general liability coverage premium, with variation based on whether defense coverage is within or outside the policy limits).
- Terrorism (federal Terrorism Risk Insurance Act [TRIA]) coverage (premium may be calculated as a percentage of the main commercial general liability coverage premium).
- Waiver of subrogation (may be available for flat additional premium).
- Product withdrawal expense coverage (may be available for flat premium charges, based on the limit of coverage, with deductibles per occurrence set as dollar amounts and/or percentages of the limit of coverage).
- Special event coverage, which may be considered short-term coverage for which premium is fully earned. Premiums may vary depending on the type of event and may be proportional to the duration of the special event in days. Special events may include trade shows, fairs and music festivals. Rates vary based on the perceived level of hazard, which may be categorized as low, moderate or high. Event history, on-site security and limitations on consumer access are all factors taken into consideration.

g. Crime Insurance

Coverages for employee dishonesty, money and securities, and counterfeit money are highly affected by the current cash nature of the business. Rating is highly variable accordingly, with the potential for high premiums to be set. Several large brokerages have represented that the theft hazard is the most significant among the risks faced by cannabis-related businesses today.
h. Crop Insurance

Crop insurance availability is a significant issue because federal crop insurance is not offered for cannabis crops. Private crop insurance for cannabis-related operations is also virtually impossible to secure. Insurers do not wish to cover any product that crosses state lines, due to fear of federal involvement. Accordingly, information regarding rates for crop insurance for cannabis is extremely limited.

i. Earthquake/Volcanic Eruption/Sprinkler Leakage Insurance

Coverages pertaining to the perils of earthquake or volcanic eruption can be purchased via an endorsement to a commercial property policy. Rates are often developed per dollar amount of insured exposure.

j. Lessor’s Risk Insurance

Special rates for lessor’s risk insurance are often applicable if the cannabis occupancy is more than a certain threshold of the property (e.g., more than 25%). Otherwise, the exposure is just rated on the standard policy. Rating appears to follow the approach used in insurers’ standard lessors’ risk programs. Cannabis factors are higher than for regular mercantile operations, ranging from +80% to +200% over standard mercantile rates. Categories include dispensaries, retail, medicinal, labs, product manufacturer, infused products, oil extraction and cultivation/grower. Additional schedule rating may apply to manual rates, with +/-25% maximum schedule-rated credits or debits.

k. Medical Professional Liability (Medical Malpractice) Insurance

Many traditional medical professional liability policies may exclude liability for recommended prescription of controlled substances. Accordingly, practitioners who prescribe or recommend medical cannabis to patients may seek special coverage limited to liability losses arising from prescription, recommendation or failure to prescribe or recommend medical cannabis. Coverage limits for such policies resemble those of traditional medical professional liability policies; the base limit is often $1 million per occurrence/$3 million annual aggregate. Rates are derived based on traditional medical professional liability policies in a given jurisdiction. Base-rate adjustments reflect a focus

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102. The DEA Practitioner’s manual indicates that all drugs listed in Schedule I have no currently accepted medical use in treatment in the United States and therefore may not be prescribed, administered, or dispensed for medical use,” some states are using the terms “prescribe” or “prescription” rather than “recommend” or “recommendation” in their statutes with respect to cannabis. Therefore, both terms “prescribe” or “prescription” and “recommend” or “recommendation” are used in this section. See https://www.deadiversion.usdoj.gov/pubs/manuals/pract/section2.htm
on claims arising from medical cannabis. Otherwise, classification plans may follow those filed for traditional medical professional liability insurance products.

An insurer’s actuaries may estimate, often with historical data as a reference where available (although such historical data may be sparse), the proportion of medical cannabis-related losses to total medical professional liability losses and adjust the loss costs implied in the traditional medical professional liability policy rates accordingly. Afterward, the loss costs could be adjusted by a typically multiplicative load to reflect the insurer’s expenses and targeted profit provision. It is possible that data related to frequency and severity of medication errors could be used as a proxy for data related to medical cannabis-related losses. This could result in a conservative estimate of loss costs because medication errors are a broader category.

I. Product Liability

The available programs for product liability insurance are often on a claims-made basis. Loss costs may vary between “producer” and “retail” classes. Producers include cultivators, growers and manufacturers, while the retail class includes distributors. Cultivator-only licensees receive a discount (sometimes substantial) from general producer rates.

Rating factors can relate to:

- Compliance with testing protocols.
- Operational maturity of the business.
- Management experience in the industry.
- Presence of a compliance officer.
- Compliance with packaging standards.
- Counterfeit products.
- Cleanliness of water supply.
- Location of suppliers.
- Use of petroleum gases during the extraction process.
- Existence of prior product recalls or regulatory infractions.
- Existence and quality of documentation of standard operating protocols.
- Whether the product needs to be applied topically or is vaporized.
m. Property Insurance

Premiums for property insurance may vary by type of covered property and the coverages purchased; e.g., building, business personal property, stock, business income/extra expense. Some insurers may require insureds who wish to purchase property coverage to also purchase general liability coverage. The insured may have an option to include or exclude coverage resulting from the peril of theft. Premium, including the minimum premium, may vary based on that selection.

Rates may be set proportionally to the insured value of the property. For plants before harvest, coverage limits may be set per plant and may vary based on the developmental stage of the plant; e.g., cloned/pre-vegetative, vegetative, pre-flowering, and flowering. For harvested plants, coverage limits may be set up to a fixed dollar amount per unit of weight (e.g., per pound). Coverage may also be available for the replacement cost of unplanted seeds. Additional property coverages may be purchased for: 1) money and securities; 2) accounts receivable; 3) personal effects; 4) valuable papers; 5) property of others; 6) signs; 7) tenant glass; 8) robbery and safe burglary; and 9) loss arising from employee dishonesty.

Loss costs for property coverages and related endorsements are often affected by the following considerations:

- Applicable limitations on territories where owned property is located; e.g., no out-of-state coverage.
- Ordinances/laws requiring cannabis businesses to make improvements to properties.
- Theft exclusions.
- Natural disasters, which could affect business interruption/loss of income coverages.
- Legal requirements applicable to tracking of inventory.
- Exposure to fungus.

n. Surety Bonds

The rating structure for surety bonds may use multiple tiers, determined based on such characteristics as commercial credit score, business experience, risk-management programs and prior regulatory actions. Rates may range between 2% to 10% of the bond amount, depending on tier. Additional schedule rating with variation up to +/-25% is available, with some insurers selecting a narrower range of variation in schedule-rated credits and debits.
C. Gaps in Coverage

Cannabis insurance is still relatively new to both the surplus and admitted market and the cannabis industry is constantly evolving and changing. With regulations and new laws being implemented at the federal, state, and local levels the way that the cannabis industry cultivates, manufactures, distributes, sells, and is consumed changes daily. The adequacy of coverage can change substantially in a short amount of time. For example, the price of cannabis can increase and decrease quickly and change for different regional areas. Therefore, a sufficient level of loss protection for the asset of cannabis will change. The quantitative measurement in the adequacy of coverage is in constant change especially with the cannabis industry evolving with innovation. For example, new strains of cannabis are being cultivated and new technology for vape pens for ease and increased consumption are emerging at a rapid pace. With new products emerging daily, it’s difficult for insurers to not only assess the risk; but, also provide policies that meet the cannabis industry’s needs. In addition, insurers are looking for data to determine the risk associated with cannabis to fill the gaps in coverage. But, with little to no data in areas such as drug-free workplace standard procedures or auto insurers impacted by the current inability to test for cannabis intoxication of drivers, insurers are finding it difficult to fulfill all insurance coverage needs in the cannabis industry. The lack of data creates an unknown which in turn creates gaps. It is difficult for insurance to keep up with the demands of such a bourgeoning industry.

V. BEST PRACTICES AND RECOMMENDATIONS

A. EDUCATION, OUTREACH AND PUBLIC COMMUNICATION

Understanding the various facets of the cannabis industry is critical to learning about its insurance needs. Educational site visits to the different types of cannabis business operations (such as cultivation sites, manufacturing companies, distribution companies, testing labs and retail operations) should help state insurance regulators understand how the cannabis products are regulated on a state and local level. They will also assist in identifying where the areas of risk are decreased/increased throughout the supply chain.

Another educational avenue available to most regulators is reaching out to the cannabis industry trade associations, such as the National Cannabis Industry Association (NCIA), or a state trade association, such as the California Cannabis Industry Association (CCIA) as well as insurance trade associations. Many of the cannabis trade associations have insurance subgroups that meet and discuss matters related to the topics of insurance availability, gaps and emerging trends in the cannabis insurance space. Insurance trade
associations are able to identify and work with their individual insurer members to encourage writing cannabis insurance products. Reaching out to both the cannabis and insurance trade associations is a helpful way to begin a dialogue about the importance of cannabis insurance and the presence of the state insurance regulator.

State insurance regulator participation in various outreach events is another option to learn more about the cannabis industry and teach the cannabis industry about insurance. Interacting with other state insurance regulators and stakeholders at conferences, workshops and meetings can also be beneficial. Doing so provides information on how the cannabis insurance intersects with other state insurance departments and entities, such as state cannabis licensing agencies. It also allows for more information on the various supply chain risks.

B. Dedicated Internal Infrastructure and Resources

State insurance departments should have a web page or outreach materials dedicated to providing information and answering commonly asked questions regarding cannabis insurance coverage. In addition to a web page, it is advisable to have an in-house subject-matter expert (SME) on the issue of cannabis insurance. This expert can help bridge the gaps between state insurance department staff, the cannabis industry and the insurance industry. At a minimum, each insurance department should have a point of contact to guide interested parties in reaching the appropriate department staff. Additionally, departments should identify an internal team across the department to ensure all critical players of the process are engaged and understand the various issues or goals. This also helps to streamline needed answers or resources to insurers interested in writing cannabis insurance.

C. Monitoring the Market and Gap Analysis

As the degree to which insurers are meeting the coverage needs of cannabis businesses continues to evolve, it would be useful for regulators and policy makers to have up to date information on the types of coverages available in each state and gaps in the market. State insurance departments could survey carriers and producers on the types of policies available in their state, and this information could be aggregated and posted on the NAIC website.

D. California’s Path to Approving Admitted Carriers

California was the first state to approve admitted insurance carriers for cannabis-based businesses in the cannabis industry. Through education and outreach the California
Department of Insurance (CDI) laid the groundwork for cannabis insurance on the admitted market. As of the publication of this white paper, the CDI had approved six carriers. It launched the Cannabis Insurance Initiative (Initiative) in 2017 in anticipation of the insurance industry's role in the legalization of cannabis for adult recreational use, which took effect on January 1, 2018 with the passage of Proposition 64. The first phase of the Initiative focused on education and outreach in order to develop the CDI and insurers' understanding of the cannabis industry. The goal was to ensure the availability of insurance products for the cannabis industry by identifying challenges, opportunities, and solutions.

The CDI encouraged insurers to write on the admitted market by bringing them together in a meeting with leaders in the cannabis industry. The meeting focused on educating insurers about the cannabis industry and its insurance needs. The cannabis industry discussed issues they faced with finding and obtaining insurance. Insurers were able to ask questions and have an open discussion.

Subsequently, the insurer meeting participants were invited to a tour of an indoor grow, dispensary and manufacturing facility in San Jose, California. This allowed insurers to witness first-hand the sophistication, risk management, regulatory oversight, professionalism and transparency of the cannabis industry and the opportunities for the insurance industry. This further allowed the insurance industry to gain a better understanding of the cannabis industry and its insurance needs, while addressing questions and concerns.

The CDI continued educational efforts to bridge the gap between the cannabis and insurance industries on a larger stage by hosting a public hearing in Los Angeles, California in October 2017. The hearing was co-hosted by the California Cannabis Industry Association (CCIA) and the LA Cannabis Task Force. Hundreds of participants attended to hear cannabis businesses and the insurance industry provide their respective perspectives on cannabis insurance gaps. The public hearing revealed that while there was some insurance availability from surplus lines insurers, insurance was limited in scope and the California market would benefit from the entrance of admitted commercial carriers.

In addition to education and outreach efforts, CDI implemented operational procedures within the department to facilitate approval of admitted insurers for the cannabis industry. An in-house cannabis insurance SME was designated to lead the Initiative and serve as the primary point of contact to stakeholders. An internal cross-departmental team, which included rate filing and legal staff, also served respective roles to reach the goal of product availability. A website with key resources and contacts for the Initiative was launched.
Through these resources, interested stakeholders and insurers can immediately identify an entry point to the CDI on cannabis insurance, as well as educational materials and upcoming events.

These efforts by the CDI led to the filing and approval of the first admitted commercial insurance company to offer coverage to cannabis business owners in November 2017. This was just months away from the January 1, 2018 legalization of adult cannabis use. Golden Bear Insurance Company was the first insurance company in California to write insurance on the admitted market.

Since the first filing and approval, five additional admitted market insurance companies have followed suit. Additionally, in 2018, the American Association of Insurance Services (AAIS) designed the new Cannabis Business Owners Policy (CannaBOP) for cannabis dispensaries, storage facilities, processors, manufacturers, distributors, and other cannabis-related businesses operating in the state. CannaBOP is the first-of-its-kind standardized cannabis policy form that was approved by CDI.

**E. Industry Trends and Policy Engagement**

Given federal laws, such as the CSA and Banking Secrecy Act/Anti-Money Laundering Law, various industries (including insurance) are hesitant to engage in the cannabis supply chain. They fear exposure to criminal or civil liability. Policy changes at the federal level could play a critical role in encouraging more admitted insurers to write cannabis insurance.

Despite existing laws that may deter regulators, there has been an increase in federal legislative efforts to provide states greater regulatory authority over cannabis businesses without federal interference. Currently, the Rohrabacher-Blumenauer amendment, which prevents the DOJ from spending funds on prosecuting cannabis businesses in states that have medical cannabis laws, was extended through a federal spending bill. As mentioned above, the STATES Act, if passed, would allow states to regulate cannabis without federal interference.

However, as the cannabis industry continues to expand, there is a degree of uncertainty under President Trump and his administration. Former Attorney General Sessions had a longstanding public opposition toward the cannabis industry and actively removed

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protections. Recently appointed Attorney General Barr has indicated that he will not go after states that have legalized cannabis.¹⁰⁴

Many operators in the cannabis industry are willing to move forward despite these actions; but, such activities at the federal level also worried others outside of the cannabis space about the industry’s stability. President Trump repudiated former Attorney General Sessions’ rescission of the Cole Memorandum based on a request from U.S. Sen. Cory Gardner (R-CO), but the rescission nonetheless influenced business decisions such as offering insurance to the industry.¹⁰⁵ The change in the attorney general presents a new opportunity for the DOJ to clarify the administration’s position on state-legalized cannabis. However, it is too soon to tell what Attorney General Barr’s priorities will be with respect to the cannabis industry other than his public statements that he will not pursue state-legalized cannabis businesses.

With new regulations, rising consumer demands and the market landscape constantly changing, the cannabis business is booming and needs insurance protections in the cannabis industry. As such, state insurance regulators should follow the legislative landscape and impacts related to the cannabis industry. Policy changes at the federal level may influence the readiness of admitted insurers to write cannabis insurance. Thus, knowledge of the environment may guide insurance departments in their preparation for potential filings.

Collaboration with federal, state, and local entities may also serve to address barriers that prohibit access to insurance protection for cannabis business owners. With the deep knowledge of insurance issues, state insurance regulators can and should contribute their subject matter expertise and perspectives in these public policy discussions. Federal, state, and local entities may find it helpful to identify staff to address specific departmental and outreach needs. Additionally, state insurance regulators may sponsor legislation related to cannabis insurance. They may also further engage in policy-making by offering support for legislation addressing barriers.


VI. CONCLUSIONS

As more states continue to legalize cannabis, the need and demand for cannabis insurance will only continue to increase. There are substantial gaps in insurance coverage for the cannabis industry, which means that consumers, workers, vendors, owners and investors face risks that are not covered as they interact or engage with the cannabis industry. It is important for state insurance regulators to understand and address insurance availability and coverage gaps in their markets. State insurance regulators who have encouraged insurers to cover the cannabis industry have been successful in getting more insurers to enter this market. State insurance regulators can play a critically important role in working with the insurance industry to encourage more insurance availability for the cannabis industry.
ADDITIONAL CANNABIS INFORMATIONAL RESOURCES

- Americans for Safe Access: https://www.safeaccessnow.org/
- Cannabis Business Times: https://www.cannabisbusinesstimes.com/
- Cannabis Now: https://cannabisnow.com/
- Drug Policy Alliance: http://www.drugpolicy.org/
- Global Commission on Drug Policy: http://www.globalcommissionondrugs.org/
- Law Enforcement Action Partnership: https://lawenforcementactionpartnership.org/
- National Cannabis Industry Association: https://thecannabisindustry.org/
- Patients out of Time: https://www.medicalcannabis.com/
- Smart Approaches to Marijuana: https://learnaboutsam.org/
- Students for Sensible Drug Policy: https://ssdp.org/
- Transform Drug Policy Foundation: https://transformdrugs.org/
- Veterans for Cannabis: http://www.vfcusa.com/
- White House, Office of National Drug Control Policy- Marijuana: https://www.whitehouse.gov/ondcp/key-issues/marijuana/
1. Description of the Project, Issues Addressed, etc.

The Understanding the Market for Cannabis Insurance white paper outlines issues related to commercial cannabis insurance and includes recommendations for the development of regulatory guidance. As more states continue to legalize cannabis, the need and demand for cannabis insurance will only continue to increase. The white paper findings show there are substantial gaps in insurance coverage for the cannabis industry, exposing those who engage with the cannabis industry. The white paper also explores other regulatory issues related to insurance issues in the cannabis industry, including how insurance rates are set; legal and regulatory authority at the federal, state and local levels; cannabis operations; and best practices.

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

The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee was responsible for drafting the white paper.

States Participating:

<table>
<thead>
<tr>
<th>Name</th>
<th>State</th>
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<tbody>
<tr>
<td>Ricardo Lara, Chair</td>
<td>California</td>
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<tr>
<td>Michael Conway, Vice Chair</td>
<td>Colorado</td>
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<tr>
<td>Jerry Workman</td>
<td>Alabama</td>
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<tr>
<td>Lori K. Wing-Heier</td>
<td>Alaska</td>
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<tr>
<td>Michael Gould/Tanisha Merced</td>
<td>Delaware</td>
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<tr>
<td>Angela King</td>
<td>District of Columbia</td>
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<tr>
<td>Robert H. Murlie/Judy Mottar</td>
<td>Illinois</td>
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<tr>
<td>John Melvin</td>
<td>Kentucky</td>
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<tr>
<td>Robert Baron</td>
<td>Maryland</td>
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<tr>
<td>Anita G. Fox</td>
<td>Michigan</td>
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<tr>
<td>Barbara D. Richardson</td>
<td>Nevada</td>
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<tr>
<td>Marlene Caride</td>
<td>New Jersey</td>
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<tr>
<td>Glen Mulready</td>
<td>Oklahoma</td>
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<tr>
<td>Andrew Stolfi</td>
<td>Oregon</td>
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<tr>
<td>John Lacek</td>
<td>Pennsylvania</td>
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<tr>
<td>Javier Rivera Rios</td>
<td>Puerto Rico</td>
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<tr>
<td>Elizabeth Kelleher Dwyer</td>
<td>Rhode Island</td>
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<tr>
<td>Christina Rouleau</td>
<td>Vermont</td>
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<tr>
<td>David Forte/Michael Bryant</td>
<td>Washington</td>
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3. Project Authorized by What Charge and Date First Given to the Group

The project was authorized when the Executive (EX) Committee appointed the Cannabis Insurance (C) Working Group during its Aug. 5, 2018, meeting at the 2018 Summer National Meeting to study insurance issues related to legal cannabis business. The Working Group was given the following charge:

The Working Group will consider the insurance regulatory issues surrounding the legalized cannabis business, including availability and scope of coverage, workers' compensation issues, and consumer information and protection. It will also develop a white paper outlining the issues and containing recommendations for the development of regulatory guidance as appropriate. The Working Group will complete its work by first quarter 2020.
4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated

The white paper was drafted by an informal drafting group consisting of the following members of the Cannabis Insurance (C) Working Group: California; Colorado; Delaware; Nevada; New Jersey; Oregon; Pennsylvania; and Vermont. There were eight drafting conference calls between Sept. 17, 2018, and adoption of the white paper by the Property and Casualty Insurance Committee during its Aug. 5, 2019, meeting at the 2019 Summer National Meeting. The National Cannabis Industry Association (NCIA) submitted background information, and the drafters also utilized independent research. The draft white paper went before the full Cannabis Insurance (C) Working Group during its May 23, 2019, conference call. During the call, the Working Group exposed the Understanding the Market for Cannabis Insurance white paper for a 30-day public comment period ending June 24, 2019.

After accounting for all submitted comments, the Working Group unanimously adopted the white paper during its July 9, 2019, conference call. Comments were received from New Jersey, Vermont and the APCIA. New Jersey suggested updating the status of referenced federal legislation. Vermont suggested updates reflecting that Illinois now permits the recreational use of cannabis, bringing the total number of such states to eleven (11). The APCIA suggested amending certain sentences to be more balanced in discussing insurers’ choice to enter the market and write cannabis insurance products in certain states or countrywide, the legal status of cannabis under current law and of hemp under the 2018 Farm Bill, and the amendment of the federal Secure and Fair Enforcement (SAFE) Banking Act of 2019 to provide a limited safe harbor for insurers. Further suggestions from the APCIA included adding discussion on concerns related to coverage and claims issues for policies not issued to cannabis businesses and the use of “prescribe” and “prescription” versus “recommend” and “recommendation” to describe access to medical cannabis. The informal drafting group adopted all of the suggested changes and the white paper was accordingly revised to incorporate the substantive edits discussed above.

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

The Cannabis Insurance (C) Working Group exposed the Understanding the Market for Cannabis Insurance white paper during its May 23, 2019, conference call for a 30-day public comment period ending June 24, 2019. The Working Group unanimously adopted the white paper during its July 9, 2019, conference call. The Property and Casualty Insurance (C) Committee unanimously adopted the white paper during its Aug. 5, 2019, meeting at the 2019 Summer National Meeting. The white paper will be submitted for potential adoption by the Executive (EX) Committee and Plenary during its Dec. 10, 2019, meeting at the 2019 Fall National Meeting.

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

All submitted comments were accounted for to the extent possible. Suggested revisions that were not incorporated apply to areas intentionally drafted at a high level because they only applied to certain states; varied considerably by state; or required more detailed state-by-state data not available to the informal drafting group, such as drug-free workplace standards. Additionally, the use of the word “marijuana” was kept only where it was used in a direct quote or legislation. Footnotes adding clarification were added where language could not be modified, satisfying all parties.

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

None.

W:\National Meetings\2019\Fall\Plenary\Att 5 CannabisInsNewWhitePaper.pdf
THERE'S BEEN A DISASTER - **WHAT SHOULD I DO NOW?**

Learn more in the sections described below.

**SAFE AND SOUND**
After a disaster hits, make sure you and your family are safe. Then secure your belongings. Do what you can to secure your home and property to prevent more damage or theft. For example, if windows are broken, board them up. If the roof has a few holes, cover it with a tarp to prevent water damage.

**REPORT A CLAIM**
Once you've determined your home is damaged and needs to be repaired or rebuilt, report or file a claim as soon as possible. The easiest way to report a claim is to call your insurance company or agent. You may be able to report or file a claim online or from your cell phone. If you have trouble finding a phone number, try searching for your insurance company online.

**ESTIMATE DAMAGE**
An insurance adjuster will figure out how much damage was done to your home and property. The adjuster will ask you for a home inventory (a list of your personal property) if your personal belongings were damaged or destroyed. The adjuster will visit your home to inspect and estimate the damage done. In this section, you can learn about the different types of adjusters who may work on your claim and what you should do to prepare to meet the adjuster.

**DETERMINE COVERAGE**
Once the adjuster has figured out how much it will cost to rebuild, repair or replace your home or property, the adjuster will review your policy to calculate how much the insurance company will pay. If you've never filed a claim before, this process can seem overwhelming. But you can read this section to learn how claim payments are calculated and how your coverage will impact what your insurance company pays. You can learn the meaning of some of the words insurance companies use.

**REBUILD, REPAIR AND REPLACE**
Your recovery from a disaster is not complete until you're living back in your home. During the recovery phase, you'll be replacing personal items (if damaged), choosing building materials and working with contractors. Read this section to find tips about working with contractors and how to avoid becoming a victim of fraud.

**PREPARE**
It may sound strange, but the recovery process is the best time to start preparing for the next disaster or claim. Create a home inventory list as you're replacing your belongings. Also as you're rebuilding, consider using building materials that will resist damage – so if there's another disaster, your home may have less damage. For example, you could use impact-resistant shingles or impact-resistant siding.
PROPERTY INSURANCE CLAIMS GUIDE

Disasters happen everywhere and can happen at any time. Any of the following can cause a significant amount of damage to homes and personal property:

- TORNADOES
- WILDFIRES
- HURRICANES
- FLOODS
- EARTHQUAKE

This might be the first time you’ve had an insurance claim — or maybe a claim this big.

This Guide will help you understand what to do after a natural disaster damages your home. It also gives you helpful tools and tips to navigate the insurance claims process, whether this is your first insurance claim or not.

This Guide provides general information to help you in any type of disaster. But remember, most policies won’t cover damage from floods or earthquakes unless you bought that coverage separately.

Your state insurance department will help you and answer any questions – free of charge.

SAFE AND SOUND

A disaster has hit my area and my home has been damaged. I’ve made sure my family is safe. What should I do next?

Make sure there are no safety issues like downed electrical lines or broken gas lines. If there are safety issues, leave your home and wait for or listen to your local authorities to learn when you can return.

When inspecting your home, avoid broken glass and sharp objects or remove them. Watch out for things that could cause you to trip or fall.

Take photos or videos of the damaged areas and personal property. You also can jot down notes about any significant damage you see.

My family and I were evacuated from our home. When can we go home?

Wait to return to your home until your state or local authorities tell you it’s safe. The authorities won’t let you return to your home if there are hazards like downed power lines or broken gas lines. This is for your safety.

There’s a lot of damage to my home. What should I do about the damage?

Try to prevent further damage by making essential repairs, like covering roofs, or windows with plywood, tarp, canvas, or other waterproof materials.

IMPORTANT: KEEP ALL RECEIPTS FOR EMERGENCY REPAIRS TO GIVE TO YOUR INSURANCE COMPANY. Because you have to prevent more damage, you may want to hire a contractor to make any emergency repairs.

Don’t make permanent repairs before talking with your insurance agent or insurance company. Your company may not pay for repairs it didn’t authorize.

If you’re contacted by any contractors, review the section on Avoiding Insurance Fraud to avoid being taken advantage of.
ADDITIONAL LIVING EXPENSE (ALE)

Most homeowners policies also will pay the additional expenses you have if you can’t stay in your home because of damage from a covered disaster. For example, if you’ve to move into a hotel or apartment while your home is repaired or rebuilt, the insurance company will pay your costs for temporary housing.

Just don’t expect the insurance company to pay for your stay at a 5-star spa and resort or to eat out every night at the most expensive restaurant in town.

ALE is limited; see below for more information.

What types of living expenses does ALE pay for?

The insurance company will not pay ALL of your living expenses. ALE is to help pay those expenses that are beyond your normal expenses because you can’t live in your home. For example, ALE coverage will pay hotel lodging, but it won’t make your mortgage payment.

ALE typically covers hotel bills, reasonable restaurant meals (if you’re staying in a hotel room with no kitchen), and other living costs above and beyond your normal housing expenses while you can’t live in your home because of damage.

You need to be sure you keep ALL receipts for any additional costs you have. The insurance company will need the receipts to reimburse you.

Is there a limit to how long or how much I can use for my additional living expenses?

Keep in mind that ALE coverage is limited. Some policies have a dollar limit; some also may have a time limitation.

The good news – these limits are separate from any coverage you have to rebuild or repair your home. They’re also separate from any coverage you have to replace your belongings.

Ask your insurance company or adjuster what your policy covers and any time or dollar limits that apply.
REPORTING AN INSURANCE CLAIM

When should I report damage to my home or personal property?

Before reporting the property damage to your home, find out what your deductible is. If the damage is minor, for example, just a few shingles were damaged, you might decide you’re better off paying for the repairs out of pocket instead of filing an insurance claim. But, remember you might not be able to see all the damage. You may want to have a contractor inspect your home.

If you believe the damage will cost more than your deductible to repair, or there’s a lot of damage, you may want to file a claim. It’s important to notify your insurance company as soon as you know there’s damage and you decide to file a claim.

The easiest way to report damage is to call your insurance company or agent directly.

What should I do if I don’t have my company or agent’s phone number?

If you have cell service, use your cell phone to search for phone numbers or the insurance company’s website. There may be a phone number to report a claim.

If you can access social media, you can search for information from your insurance company or state department of insurance about how to file a claim.

If you have limited or no cell service, look for mobile claims centers in your area. Local news outlets and social media usually announce their locations.

What do I need to know when I call to make a claim?

It will help if you have your policy number. But if you don’t, your insurance company or agent can find your policy with your name, address, and phone number. You’ll need to briefly explain what happened and describe the type and extent of the property damage.

If you aren’t staying in your home, be prepared to give your insurance company and agent your new contact information—a phone number and an address.

Let your insurance company and agent know when you call if you’ve taken photos and videos of the damage and have cost estimates.

What is a contractor?

An individual you hire to manage the repair of your home. The contractor is responsible for supplying the necessary equipment, material, labor and services to complete repairs.
What do I need to ask when I file a claim?

You should ask:

- For the name and phone number for every person you talk to.
- For your claim or reference number.
- How long you have to file a claim.
- If you need estimates to make repairs or rebuild before you can file a claim.
- For a general idea of what your policy will cover.
- If your insurance policy covers hotel costs. For how much? For how long?
- For information about your deductible. Are there separate deductibles for hail, hurricane, or wind damage? What are those?
- If there are any special processes or procedures you need to know about.
- When you can expect an adjuster to call.
- What other information the company will need to process the claim.

What if I don’t have a completed home inventory list?

Don’t worry; the adjuster will give you some time to make a list. Ask the adjuster how much time you have to submit this inventory list.

Work from memory if your property was destroyed and you have no records.

Review photos, for example on your cell phone or from family or friends, taken inside your home. That may help you make the list.

Search online shopping websites or online retailers to help estimate costs.

The National Association of Insurance Commissioners (NAIC) has a printable inventory listing that may help you as you’re making your list.

https://www.insureuonline.org/home_inventory_checklist.pdf
What is a company adjuster?
A company adjuster works only for that insurance company.
- The insurance company hires and pays a company adjuster. This adjuster will settle the claim based on the insurance coverage you have and the amount of damage to your home and property.
- You do not pay a company adjuster.

What is an independent adjuster?
An independent adjuster works for several different insurance companies. An insurance company uses independent adjusters when it doesn’t have its own adjusters on staff or when it needs more adjusters than it has available; this often happens in a large disaster.
- An independent adjuster does the same work as a company adjuster (see above).
- You do not pay an independent adjuster.

What is a public adjuster?
A public adjuster is a professional you can hire to handle your insurance claim.
- Public adjusters have no ties to the insurance company.
- They estimate the damage to your home and property, review your insurance coverage, and negotiate a settlement of the insurance claim for you.
- Many states require public adjusters to be licensed. Some states prohibit public adjusters from negotiating insurance claims for you. In those states, only a licensed attorney can represent you.
- You have to pay a public adjuster.

Remember in larger weather events or disasters, not all adjusters will live or work in your state. Some adjusters may be sent from other states to help when there’s a large number of claims.
How long after I file a claim will an adjuster come to inspect my home?

It depends – every disaster can be different. Ask your insurance company when you file the claim.

If you don’t hear from an adjuster in a reasonable amount of time, contact your agent or the company. A reasonable amount of time could be 3 to 5 days for a minor claim. But, it may take longer for the adjuster to reach you following a large disaster in your area. Be sure they know how to contact you.

What should I do to prepare to meet with the adjuster?

• Make a list of all damaged or destroyed personal property. Make a list of damage to the home and other structures, like a garage, tool shed, or in-ground swimming pool. Work from memory or from photos if you have no records of your destroyed property.

• Gather any photos or videos of your home and property before they were damaged or destroyed.

• Include receipts from when you bought the damaged or destroyed items, if you have them. Search online shopping sites or online retailers to help estimate costs.

• If you have time before the adjuster inspects your home, try to get written bids from contractors. You aren’t required to have bids, but it can help. The bids should detail the materials to be used, prices of those materials, and labor on a line-by-line basis.

• Take notes when you meet with the adjuster. Get the adjuster’s name and contact information and ask when you can expect to hear back. You can write this information down in the Claims Communication Section in the back of this resource.

What will happen when the insurance adjuster comes to my home?

• You should be there when the adjuster comes to your home. You can show the adjuster where you believe there has been structural damage and give the lists you’ve prepared of property or structural damage, photos or videos you’ve taken, and bids from contractors.

• The adjuster will inspect your home and take photographs and measurements. While the adjuster is there, they may even do some calculations of the damage and cost to repair.

• Before the adjuster leaves, make sure you have their contact information. Ask the adjuster what the next steps will be and to estimate when you'll hear back from them.

• Ask the adjuster if there’s any other information you should provide. After the adjuster leaves, you may need to gather more information or start a personal property inventory list.

If I hire a public adjuster, will the insurance company still send its own adjuster?

The insurance company doesn’t have to accept your public adjuster’s estimates.

The insurance company will typically send either a company adjuster or an independent adjuster to assess and estimate damage to your home or property.
How is a public adjuster paid?

- If you hire a public adjuster, it’s your responsibility to pay their fee.
- Depending on the laws of your state, public adjusters can charge a flat fee or a fee that’s based on a percentage of the settlement you get from your insurer.
- In some states, the maximum a public adjuster can charge is set by law. The maximum also may vary depending on whether a widespread catastrophe caused your loss.
- A public adjuster should give you a contract. The contract should explain what services the adjuster will provide and how much you will pay.
- If you hire a public adjuster after your insurer has made an initial offer, ask about the fee. The contract should say if the fee you’ll pay will be based on the total the insurance company pays or on the amount the public adjuster negotiates for you.
- You should ask your public adjuster to routinely provide you updates on the status of your claim.

DETERMINING COVERAGE
(SETTLING A CLAIM)

How do I get a settlement offer? Who gives me that?
The company adjuster or independent adjuster will calculate the amount of damage to your home and property. They will review your policy and determine what deductibles may apply and if there are any limits on what will be paid. Once they’ve made those calculations, they’ll contact you and your public adjuster or lawyer (if you have one) and share their estimates and calculations with you. They also may contact your contractor about their estimates and calculations.

Will I get a lump sum payment and when will I receive money?
The settlement process is not a single transaction. You’ll get a number of payments for different parts of your claim to help you start the rebuilding and repairing process. You’ll likely receive a payment for your additional living expenses mentioned above. Then you’ll start to receive payments to replace your personal property, followed by payments for the repairs and construction on your home.

Why did the insurance company make the check payable to me AND my mortgage company?
If you have a mortgage on your home, your lender has an interest in making sure the home is rebuilt – or that your loan is paid in full. Your mortgage lender required you to add them as an additional insured on your homeowners policy. Because of this, the insurer is obligated to include them on the check it pays for major repairs. You’ll need to work with your mortgage lender to get the claim money released for repairs. If you have problems working with your mortgage lender, contact your state’s agency that regulates banks and mortgage lenders or your state’s Attorney General’s Office for assistance. The federal government also has a website where you can make a complaint against your bank or mortgage lender, if you aren’t getting the help you need. That website is: https://www.usa.gov/complaints-lender. Your state department of insurance also may have suggestions for you.
How long will it take for my insurance claim to be settled?

Everyone wants the process to be done as fast as possible so they can return to a normal life.

If there’s substantial damage involving your home and property, an insurance claim is not going to be closed with a single payment. There will be claims payments for various parts of your claim as the rebuilding process moves along. Most people find it takes at least 18 to 24 months to repair/rebuild their home and replace their possessions after a major disaster. Your insurance claim will stay open until the insurer has made all payments you’re entitled to under your policy.

You should feel free to contact your insurance company or adjuster for a status on your claim at any time during the claims process.

What if I’m not satisfied with the amount of my insurance settlement?

- Your settlement won’t necessarily be the same as your neighbor’s. Your coverages, deductible, and policy limits may be different even if the damage looks the same.
- If the insurance company denies any part of the claim, ask for the denial in writing. Keep all paperwork.
- If you don’t believe the offer is fair, call the insurance company. Be prepared to explain why you think the offer is unfair. If you’re not satisfied with the response, contact your state insurance department.

What if the insurance company doesn’t agree with the public adjuster’s or my contractor’s estimate of the damage?

Differences in construction estimates are common. Ideally, you and the insurance company should reach agreement on a “scope of loss”. This is a detailed list of the quantities of construction materials, labor, profit and overhead, building code compliance, and every single item required to repair or rebuild your home.

Once you’ve submitted all the information that your insurance company needs, including written estimates from contractors, the adjuster will calculate the total cost.

If you disagree with the claim amount the adjuster has calculated, there are different ways to settle that disagreement without going to court. Two ways are appraisal and arbitration.

**Appraisal:** If you can’t agree with your insurance company about how much it will cost to rebuild your home and/or repair or replace your property, you can use the appraisal process to resolve the differences. This isn’t the same as an appraisal you may have of your home’s value.

The appraisal process begins with two appraisers comparing their estimates. The appraisal process only determines costs, not if your policy covers these costs. It isn’t a court proceeding.

If you use the appraisal process, you’ll have to pay some of the costs. What you’ll have to pay will depend on your state’s law.

If your policy has an appraisal clause, you must go through the appraisal process before you can sue your insurance company.

**Arbitration:** Arbitration is a legal process, but you don’t have to go to court. In an arbitration hearing, a neutral third party (arbitrator) hears from both you and your insurance company. Both parties agree to accept the arbitrator’s decision. Usually the decision is binding so you can’t go to court to appeal the decision.

Some insurance policies require arbitration to settle differences. Other policies will say how arbitration will work if both you and your insurance company agree to use it. If you use arbitration, you’ll have to split the cost with the insurance company. But, some state laws may require you or your insurance company to pay the full cost if you aren’t successful.

What can I do if my claim was denied?

If you think the insurance company should have paid your claim, you can use arbitration or file a lawsuit to get the insurance company to reverse its decision. But, before you do any of those, contact your state insurance department for help.

Some states may have a mediation process that you can use. Contact your state department of insurance for more information.
HOW IS A CLAIM PAYMENT AMOUNT CALCULATED?

A number of important insurance terms will help you understand how your insurance claim will be paid. The following sections explain terms like deductible, depreciation, Actual Cash Value, and Replacement Cost.

What is a deductible?
A deductible is the part (or amount) of the claim you’re responsible for. Insurance companies will deduct this amount from any claim settlements they pay to you or on your behalf. So if your insurance policy has a $1,000 deductible, that means you’ve agreed to pay $1,000 out of your pocket for the damage to your home.

Are there different types of deductibles?
Yes. A deductible can be either a specific dollar amount or a percentage of the total amount of insurance. There are special deductibles that apply to certain types of claims; some deductibles are applied to specific parts of your home. Look at the declarations page or the front page of most homeowners insurance policies.

HOW ARE DEDUCTIBLES USED TO CALCULATE A CLAIM?

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<tr>
<th>FLAT DOLLAR DEDUCTIBLE</th>
<th>PERCENTAGE DEDUCTIBLE</th>
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<td>$500 DEDUCTIBLE PER LOSS</td>
<td>2% DEDUCTIBLE PER LOSS</td>
</tr>
<tr>
<td>A disaster destroyed your home. Your home was insured for $250K (structure only) and it will cost $250K to rebuild it. You have a $500 deductible.</td>
<td>A disaster destroyed your home. Your home was insured for $250K (structure only) and it will cost $250K to rebuild it. You have a 2% deductible.</td>
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<tr>
<td>Insured Value: $250,000</td>
<td>Insured Value: $250,000</td>
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<tr>
<td>2% Deductible: $250,000 x 2% = $5,000</td>
<td>2% Deductible: $250,000 x 2% = $5,000</td>
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<tr>
<td>Damage and Cost to Rebuild: $250,000</td>
<td>Damage and Cost to Rebuild: $250,000</td>
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<tr>
<td>Minus the Deductible: - $500</td>
<td>Minus the Deductible: - $5,000</td>
</tr>
<tr>
<td>Claim Settlement Amount: $249,500</td>
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Some insurance policies have a special deductible for losses caused by wind, hurricanes, or other types of storms. The insurer applies this deductible when one of those types of disasters causes the damage. If something else damages your home, then the “all peril” deductible would apply.

Some policies also may have a special deductible that applies to a specific part of your home, like your roof. In these cases, the deductible could be either a flat dollar amount or a percentage.
REPLACEMENT COST VERSUS ACTUAL CASH VALUE

If you have Replacement Cost Value (RCV) coverage, your policy will pay the cost to repair or replace your damaged property without deducting for depreciation.

If you have Actual Cash Value (ACV) coverage, your policy will pay the depreciated cost to repair or replace your damaged property.

Check the declarations page of your homeowners policy to see whether the policy provides replacement cost coverage. If it doesn't specify replacement cost, then your policy likely only covers actual cash value. If it specifies replacement cost, then you have replacement cost coverage.

Under an RCV or ACV policy, your dwelling coverage pays for damage to the structure and will pay only up to the policy limit.

Even if you bought an RCV policy, there may be other limits on what the policy will pay for damage to certain surfaces, such as roofs. In some cases, the policy may pay ACV on your roof, but RCV on the rest of your home and property. If you have questions, call the adjuster or your insurer and ask what type of coverage you have.

Example:

The Smiths and the Johnsons are next door neighbors. Their homes are exactly the same size, built in the same year, and have the exact same floorplan. One night, a terrible storm tears through their town, destroying the Smith’s and the Johnson’s roofs. Both roofs have the same damage. The Smiths and the Johnsons have a $1,000 deductible, and both roofs will cost $15,000 to replace. The Smiths have a replacement cost policy, while the Johnsons have an actual cash value policy.

**SMITH’S REPLACEMENT COST VALUE**

- Insurance valuation method: RCV
- Cost of Smith’s roof ten years ago: $15,000
- Policy deductible: $1,000
- Cost to replace roof: $15,000
- Depreciation not applicable for RCV

**Insurance payment:**

- $15,000 cost of new roof
- $0 depreciation (no depreciation with RCV)
- $1,000 deductible

= $14,000 insurance payment

**JOHNSON’S ACTUAL CASH VALUE**

- Insurance valuation method: ACV
- Cost of Johnson’s roof ten years ago: $15,000
- Policy deductible: $1,000
- Cost to replace roof: $15,000
- Depreciation schedule: $1,000/year

**Insurance payment:**

- $15,000 cost of new roof
- $10,000 depreciation ($1000/yr x 10 years)
- $1,000 deductible

= $4,000 insurance payment
HOW DOES DEPRECIATION WORK?
IS ALL DEPRECIATION THE SAME?

No. Depreciation in an insurance claim is much different than depreciation on assets for taxes and is different from an accountant’s calculation of depreciation on property.

In an insurance claim, the deduction for depreciation may be significant, especially if the damaged property was at or near the end of its useful life. For example, if a covered cause of loss destroys your 20 year old roof and it must be replaced, a policy that pays RCV will cover the full cost to replace the roof. However, an ACV policy may pay as little as 20% of the cost to replace the roof, since the useful life of a roof is usually about 25 years.

WHAT IS “DEPRECIATION” AND HOW DOES THAT AFFECT MY CLAIM?

Everything covered under your homeowners policy is assigned a value. Your home, and most of its contents and components, are likely to decline in value over time because of age or wear and tear. This loss in value is known as depreciation.

Insurers usually calculate depreciation based on the condition of the property when it was lost or damaged, what a new one would cost, and how long the item would normally last.

For example, your two-year old laptop that was in good condition was destroyed in a disaster. A similar new laptop would cost $750. Your laptop normally lasts four years, so it had lost 50% of its value (25% a year). So, the value of your laptop at the time it was destroyed was half of $750, or $375. Your insurance settlement would include $375 to reimburse you for this laptop.

\[
\text{Cost of new laptop (Replacement cost value) } - \text{50% depreciation (2 years x 25% per year) = Value of your laptop (Actual cash value)}
\]

\[
$750 - $375 = $375
\]
I have a replacement cost policy, but my insurance company only paid for part of the claim. Can they do that?

When you have an RCV policy and turn in a claim for a covered loss, the insurer at first may pay only the ACV for the damage to your home or personal property.

But, when you present evidence that the damaged property has been repaired or replaced, the insurer will pay the difference (this is referred to as “recoverable depreciation”) up to the replacement cost.

Recoverable depreciation is calculated as the difference between an item’s replacement cost and ACV.

Is there a time limit on when I can get paid for the recoverable depreciation?

Yes, there’s usually a time limit. That time limit can range from 6 months to up to one year, depending on your state’s laws and your policy.

In certain circumstances, like a very large-scale disaster, insurance companies know it will take longer to rebuild homes and replace property. They’ll give you more time if you ask. Your state insurance department may require the insurance company to give you more time.

If you have questions about this time frame, ask your adjuster. You also can contact your state insurance department.

I was told I have to replace with “like kind and quality”. What does that mean?

Most insurance policies that are Replacement Cost cover repairs or replacements with property of “like kind and quality”.

Your insurance policy isn’t intended to pay for expensive improvements or upgrades. For example, if you had a 3-tab shingle roof before the loss, your insurance policy would cover the cost of another 3-tab shingle roof, but not a more expensive slate roof. If you had ceramic bathroom sinks in your home, your insurance policy won’t pay the extra cost to replace those with granite countertops.

What is “Functional Replacement”?

Another type of coverage becoming more common, particularly with older homes, is known as “Functional Replacement Coverage” (FRC). FRC replaces the damaged property with a functional replacement, which isn’t necessarily the same quality and craftsmanship as the original materials.

A simple example would be replacing plaster walls with drywall. Both provide solid walls and have the same function, yet the cost varies greatly between the two. Another example would be a damaged banister in a home. The repair could be made with wood carved in the same architectural style, but using a less expensive wood — for instance, replacing an oak banister with a pine banister. Another example would be replacing a tile roof with a shingle roof.
My adjuster mentioned that some of my property has a special limit. What is that?

A special limit caps how much money you'll be paid for certain types of property. Don’t confuse this with the contents or personal property limits. A special limit will apply to specific categories of property like jewelry, furs, guns, antiques, collector items, and coins.

My home and/or property were destroyed and can’t be repaired. Can I use the insurance settlement to build or buy another home somewhere else?

Check your insurance policy and talk with your agent or company. You also can call your state department of insurance.

You may not get the same settlement if you don’t rebuild on the same location.

WHAT IS ORDINANCE AND LAW COVERAGE?

- In many instances, your local government may require your home to be repaired or rebuilt to meet current local building codes. Unless you have Ordinance and Law coverage, a standard homeowners policy doesn’t cover that added expense.

- Ordinance and Law coverage in your homeowners insurance policy covers part or all of the cost to repair or rebuild your home to meet current local building codes. For example, electrical wiring, plumbing, windows, and roofing materials are some things that may need to be updated.

- Standard homeowners policies don’t cover the added expense to meet current building codes when you repair or replace your home. Look at the declarations page of your policy to see if you have Ordinance and Law coverage.
I’ve accepted the insurance company’s settlement and I’m ready to repair/rebuild. What do I need to know?

- Use reputable contractors. Reputable contractors usually don’t ask for a large payment upfront.
- Contractors may be licensed or registered. The difference is important. A licensed contractor has passed exams and met other requirements to show that he or she is competent. A registered contractor has provided contact information to a government authority. You can learn more about licensing and registration of contractors by calling your state Department of Insurance. They can help you contact the state agency that licenses and regulates contractors.
- Ask your contractor to show you the building permits. Contractors most likely will need to apply and pay for building permits before beginning work. And, don’t forget to check with your local officials about any requirements for permits or inspections.
- Get an estimate from more than one contractor. An estimate from a contractor that’s much lower than any of the others doesn’t mean it’s the best deal. Make sure all the quotes include the same things and check references.
- Contact your insurance company and adjuster any time you find damage that hasn’t already been reported or inspected or if you learn something new about damage to your home or property.

What should I know about a contractor before hiring one?

Get the following information:

- a copy of the contractor’s identification (the contractor’s name and the name of the business);
- a copy of the contractor’s business license (check the expiration date);
- a copy of the contractor’s proof of worker’s compensation insurance; and
- a copy of the contractor’s proof of liability insurance. A licensed insurance agent or company issues this certificate. The proof of insurance should show the company’s name, phone number, and the policy number. Call the insurance company to verify the coverage.
WHAT CAN I DO TO AVOID INSURANCE FRAUD?

After storms and other disasters, fraudsters and scam artists often arrive quickly. Watch for contractors who offer to do your repairs with upgraded or free building materials. Here are a few tips to help you avoid becoming a victim of a disaster fraudster or scam artist:

• If you’re working with contractors you don’t know, find out where they’re from. Many fraudsters will travel from state to state.
• Before you sign any contracts or pay any money, ask for references.
• Never pay the full amount before the work is complete.
• Ask your local Better Business Bureau and state Attorney General’s Office about complaints.
• Check online for information about the contractor.
• Most importantly, report any suspected fraud to your insurance agent and your state’s department of insurance as soon as possible.

ASSIGNMENT OF BENEFITS

Some states allow assignments of benefits (AOB) after a loss. This agreement transfers your rights under your insurance policy and your claim to a third party, most often your contractor.

Be cautious if you’re asked to sign an AOB. Typically, there’s a promise from the contractor to handle all matters with the insurance company for you, which may sound great. But you also may be giving up some, most, or even all of your rights, including having a lawsuit filed without your approval or knowledge.

Take your time to review any AOB carefully. Talk to your claims adjuster or you can ask an attorney to review and give you advice. You can also call your state department of insurance.
I’ve just gone through one disaster. What do I need to do to prepare for the next disaster? 
There are two different parts of preparation – preparing your home and preparing yourself financially.

Preparing your home
While you’re rebuilding, think about what you can do to minimize damage to your home during the next storm or disaster. This is called mitigation.

WAYS YOU CAN LIMIT FUTURE DAMAGE:

You can make changes to your home to limit damage during a future tornado, wildfire, hurricane, or high wind.

- **Secure entry doors.** Make sure entry doors have a two-inch deadbolt and three hinges with screws long enough to secure the door and frame to the wall. The frame should be well anchored.
- **Brace your garage door.** You can buy bracing products that will make your door stronger and more wind resistant. If you’re expecting bad weather and haven’t braced your garage door, you can put a vertical brace into the wall framing and floor, much as you would board up a window before a hurricane.
- **Install impact-resistant windows.** Local building codes in some areas require this.
- **Leave the windows closed in a storm.** Opening the window doesn’t equalize the pressure between the inside and outside of the house. Instead, it pressurizes the inside of the house, like blowing up a balloon until it pops. The air pushes off the roof or a wall and the house collapses.
- **Install wind-resistant roof structures.** Roofs are usually installed with roofing nails. But this type of roof can come off in high winds. Using hurricane clips to attach roofs creates a stronger connection between the roof and the house. Roofing clips come in a range of protection; the one you need depends on the weight of your roof. The building codes in hurricane-prone areas require roofing clips, but they’re a good idea in tornado-prone areas too.
- **Create a wildfire defense area,** Remove flammable materials from around your home. Trim over hanging branches. Remove dead trees and bushes. Clean gutters and clear them of leaves and pine needles.
- **Store firewood and other flammable materials away from home, garage, or deck.**
A number of great resources are available online can give you more ideas about ways you can reduce or avoid damage to your home.

- Ready.gov (US Department of Homeland Security)
- FEMA Mitigation Resources (US Department of Homeland Security)
- Ready, Set Go! (Wildfire resiliency)

PREPARING YOURSELF FINANCIALLY

Once you've rebuilt or repaired your home, and you're replacing damaged property, it's time to prepare for the future.

- You should make a list of all your stuff, called an inventory list. If you don't want to write everything down or type it into a spreadsheet, you can film a video to show your household items. As you film, you can describe important items, including when you bought the item, its condition, and how much you paid for it, if you know. There also are many mobile apps that will make it easier to create an inventory list. The National Association of Insurance Commissioners (NAIC) has a free app called the MyHOME Scr.APP:book that can be downloaded in the Apple App Store or on Google Play.

- Make a copy of your inventory list and keep it with your insurance policy. You could put the copy somewhere safe, such as a bank safety deposit box. You also could store a copy online.

- Put your insurance company name, policy number, and company contact information somewhere you could find it in a disaster.

- Review your policy with your insurance agent each year to see if your needs have changed.
### CLAIM INFORMATION

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### INSURANCE ADJUSTER INFORMATION

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<td>Phone Number:</td>
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<td>Adjuster License Number:</td>
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### CONTRACTOR(S)

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<td>Representative:</td>
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<td>License Number:</td>
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I checked:
- [ ] They have liability Insurance
- [ ] With my Insurance Company
- [ ] With the Better Business Bureau
- [ ] Online Search
# CLAIM COMMUNICATION LOG

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**EMERGENCY REPAIR LOG**

To help you keep track of any emergency repairs, here are some forms to help you.

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<thead>
<tr>
<th>Repair:</th>
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<th>Date of Repair:</th>
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## EMERGENCY REPAIR LOG

To help you keep track of any emergency repairs, here are some forms to help you.

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PROJECT HISTORY

Transparency and Readability of Consumer Information (C) Working Group’s Post-Disaster Claims Guide

1. Description of the project, issues addressed, etc.

The Catastrophe Insurance (C) Working Group referred the completion of the work of the Consumer Outreach and Assistance Post-Disaster (C) Subgroup, which was disbanded in spring 2018, to finish the drafting of the “Post-Disaster Claims Guide” to the Transparency and Readability of Consumer Information (C) Working Group.

The claims guide is a document the state insurance departments can use to provide to consumers following a disaster. The guide provides consumers with information regarding: 1) steps to take following a disaster that damaged a consumer’s home; 2) discussion regarding additional living expenses; 3) information regarding how to report an insurance claim; 4) definition of "insurance adjuster," as well as the various types of insurance adjusters and what they do; 5) items a consumer will need to provide to the insurance adjuster; 6) information regarding the settlement process; 7) information regarding how a claims payment is calculated; 7) discussion of the differences between replacement cost and actual cash value; 8) explanation of how depreciation works; 9) discussion of ordinance and law coverage; 10) the “three Rs” of recovery; 11) things a consumer can do to mitigate future damage; 12) assignment of benefits; 13) ways to prevent insurance fraud; and 14) information to help a consumer prepare financially for a possible future disaster.

The claims guide also includes logs for consumers to use to record information regarding their claim and communications with various parties during the claims process.

The claims guide can be edited and formatted by the state insurance departments to meet their needs. The Working Group plans to put this document into electronic format.

2. Name of group responsible for drafting the model and states participating.

The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee was responsible for drafting the claims guide. Participating states included: Alabama; California; Colorado; Connecticut; District of Columbia; Illinois; Kansas; Louisiana; Maryland; Minnesota; Missouri; North Carolina; North Dakota; Ohio; Oregon; Pennsylvania; Texas; and West Virginia.

3. Project authorized by what charge and date first given to the group.

The project was authorized by the charges of the Consumer Outreach and Assistance Post-Disaster (C) Subgroup of the Catastrophe Insurance (C) Working Group to: “Review findings from the fall 2012 public hearing on catastrophe issues and consider developing a model guideline, white paper and/or compilation of best practices to reduce post-disaster insurance recovery obstacles for insurance consumers.”

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

In 2017, the Consumer Outreach and Assistance Post-Disaster (C) Subgroup began discussing items to be included in a claims guide to be used to aid consumers through the process of a claim resulting from a disaster. The Subgroup was disbanded in spring 2018; therefore, the Catastrophe Insurance (C) Working Group referred the charge to the Transparency and Readability of Consumer Information (C) Working Group for completion. The Transparency and Readability of Consumer Information (C) Working Group met regularly via conference call to complete the drafting of the document.
5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

The Transparency and Readability of Consumer Information (C) Working Group met regularly via conference call, during which the Working Group heard comments and discussed suggested revisions from interested consumer and industry representatives. The claims guide was adopted by the Transparency and Readability of Consumer Information (C) Working Group via an e-vote that concluded July 26, 2019. The claims guide was then adopted by the Property and Casualty Insurance (C) Committee during its Aug. 5, 2019, meeting at the 2019 Summer National Meeting.

6. A discussion of the significant issues (items of some controversy raised during the due process and the group’s response).

There were no items of controversy raised during the due process.

7. Any other important information (e.g., amending an accreditation standard).

Not applicable.

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GUIDE LINE FOR STAY ON TERMINATION OF NETTING AGREEMENTS AND QUALIFIED FINANCIAL CONTRACTS

Drafting Note: State receivership and insolvency laws may permit a contractual right to cause the termination, liquidation, acceleration or close-out obligations with respect to any netting agreement or qualified financial contract (QFC) with an insurer because of the insolvency, financial condition or default of the insurer, or the commencement of a formal delinquency proceeding. These laws are based upon similar provisions contained in the federal bankruptcy code and the Federal Deposit Insurance Act (FDIA). The FDIA also provides for a twenty-four-hour stay to allow for the transfer of QFCs by the receiver to another entity rather than permitting the immediate termination and netting of the QFC. 12 U.S.C. § 1821(e)(9)-(12). States that permit the termination and netting of QFCs may want to consider adopting a similar stay provision following the appointment of a receiver.

States that consider the enactment of a stay should take into account the relevant federal rules. In 2017 the Board of Governors of the Federal Reserve System (the Federal Reserve), the Federal Deposit Insurance Corporation (the FDIC) and the Office of the Comptroller of the Currency (the OCC) each adopted final rules and accompanying interpretive guidance (Final Rules) setting forth limitations to be placed on parties to certain financial contracts exercising insolvency-related default rights against their counterparties that have been designated as a global systemically important banking organization (GSIB). The Final Rules include the definition of master netting agreement that allows netting even though termination of the transaction in the event of an insolvency may be subject to a “stay” under several defined resolution regimes including Title II of Dodd Frank, the FDIA, as well as comparable foreign resolution regimes. Notwithstanding NAIC’s request for inclusion, stays under the state insurance receivership regime (State Receivership Stays) were not included as an exemption within the definition. Therefore, unless the Final Rules are amended to recognize State Receivership Stays, if a state implements a stay as contemplated by the Guideline, insurers would find themselves disadvantaged, potentially resulting in additional costs and/or collateral requirements given the regulatory treatment for contracts that do not meet requirements for QFCs. Therefore, if a state is considering implementation of this Guideline, consideration should be given to whether the rules of the Federal Reserve, FDIC and OCC have been amended to recognize State Receivership Stays. For example, a state could adopt a stay that would be effective if and when the Final Rules recognize State Receivership Stays.

The following statutory language is not an amendment to the NAIC receivership models, but is intended as a Guideline for use by those states seeking to require a stay with respect to the termination of a netting agreement or QFC of an insurer in insolvency:

Stay on Termination of Netting Agreements and Qualified Financial Contracts

A person who is a party to a netting agreement or qualified financial contract under [cite to applicable state law addressing qualified financial agreements] with an insurer that is the subject of an insolvency proceeding may not exercise any right that the person has to terminate, liquidate, accelerate or close-out the obligations with respect to the contract by reason of the insolvency, financial condition or default of the insurer, or by the commencement of a formal delinquency proceeding,

(1) Until 5:00 p.m. (eastern time) on the business day following the date of appointment of a receiver; or

(2) After the person has received notice that the contract has been transferred pursuant to [cite applicable state law addressing transfer of qualified financial contracts].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)


PROJECT HISTORY

GUIDELINE FOR STAY ONTERMINATION OF NETTING AGREEMENTS AND QUALIFIED FINANCIAL CONTRACTS

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

In 2017 the Board of Governors of the Federal Reserve System (the Federal Reserve), the Federal Deposit Insurance Corporation (the FDIC) and the Office of the Comptroller of the Currency (the OCC) each adopted final rules and accompanying interpretive guidance (Final Rules) setting forth limitations to be placed on parties to certain financial contracts exercising insolvency-related default rights against their counterparties that have been designated as a global systemically important banking organization (GSIB). The Final Rules include the definition of master netting agreement that allows netting even though termination of the transaction in the event of an insolvency may be subject to a “stay” under several defined resolution regimes including Title II of Dodd Frank, the FDIA, as well as comparable foreign resolution regimes.

Notwithstanding NAIC’s request for inclusion through a formal comment letter and subsequent discussions, stays under the state insurance receivership regime (State Receivership Stays) were not included as an exemption within the definition. Therefore, unless the Final Rules are amended to recognize State Receivership Stays, if a state implements a stay as contemplated by the Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (Guideline #1556), insurers would find themselves disadvantaged, potentially resulting in additional costs and/or collateral requirements given the regulatory treatment for contracts that do not meet requirements for qualified financial contracts (QFCs).

On Dec. 2, 2017, the Receivership and Insolvency (E) Task Force received a referral from the Financial Stability (EX) Task Force that included three tasks, one of which was to “evaluate whether there are any current misalignments between federal and state laws that could be an obstacle to achieving effective and orderly recovery and resolutions for U.S. insurance groups (e.g., federal rule recognizing importance of temporary stays on the termination of master netting agreements for QFCs that does not recognize the utility and import of state-based stays in state receivership proceedings).

The RITF assigned the task of evaluating these issues to a drafting group, who evaluated the impact of the federal rule recognizing temporary stays on terminating master netting agreements for QFCs. The regulators held discussions with federal banking authorities regarding the handling of QFCs in banking resolutions to assess the utility of a stay on terminations in insurance receiverships.

To address the conflict with the federal rule, the drafting group proposed amendments to the drafting note of Guideline #1556 explaining the above issue. Therefore, if a state is considering implementation of Guideline #1556, consideration should be given to whether the rules of the Federal Reserve, FDIC and OCC have been amended to recognize State Receivership Stays. For example, a state could adopt a stay that would be effective if and when the Final Rules recognize State Receivership Stays.

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

The Receivership and Insolvency (E) Task Force is responsible for Guideline #1556. The 2019 members of the Task Force are: Texas (Chair); District of Columbia (Co-Vice Chair), Alaska, American Samoa, Arkansas, California, Colorado, Connecticut, Florida, Illinois, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Missouri, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Virginia, and Washington.

The amendments to Guideline #1556 were drafted by the Task Force’s drafting group. The drafting group was comprised of Texas (Lead), Colorado, Connecticut, District of Columbia, Illinois, Massachusetts, Michigan, New Jersey, New Mexico, Pennsylvania. Washington, and Wisconsin.

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

The Receivership and Insolvency (E) Task Force is charged with addressing any issues that affect receivership laws, including amendments to models and guidelines. The request to address misalignments with federal rules was first considered by the Task Force on March 25, 2018, at the NAIC 2018 Spring National Meeting, when a work plan to address the Financial Stability (EX) Task Force’s referral and formation of drafting groups were discussed.

4. **A General Description of the Drafting Process and Due Process**

The drafting group of the Receivership and Insolvency (E) Task Force discussed the proposed amendments on a conference call on March 14, 2019, which included twenty interested parties.

The Receivership and Insolvency (E) Task Force discussed the proposed amendments in open session on April 7, 2019, at the NAIC Spring National Meeting. The Task Force exposed the proposed amendments for a 30-day public comment period ending May 7, 2019. One comment was received supporting the need for Federal rule changes. No changes were made to the Guideline #1556.

The Receivership and Insolvency (E) Task Force adopted the amendments on Aug. 4, 2019, at the NAIC Summer National Meeting.

The Financial Condition (E) Committee adopted the amendments on October 31, 2019.

The Executive (EX) Committee and Plenary adopted the amendments on December 10, 2019.

5. **A Discussion of the Significant Issues**

None.

6. **Any Other Important Information**

None.

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Process for Evaluating Qualified and Reciprocal Jurisdictions
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I. Preamble

Purpose

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

Background

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

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

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

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

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

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

1. The NAIC model revisions applicable to certified reinsurers are intended to facilitate cross-border reinsurance transactions and enhance competition within the U.S. market, while ensuring that U.S. insurers and policyholders are adequately protected against the risk of insolvency. To be eligible for certification, a reinsurer must be domiciled and licensed in a Qualified Jurisdiction as determined by the domestic regulator of the ceding insurer. A Qualified Jurisdiction not subject to an in-force Covered Agreement under the Dodd-Frank Act may also be determined to be a Reciprocal Jurisdiction, and reinsurers that have their head office or are domiciled in any such Reciprocal Jurisdiction will not be required to post reinsurance collateral, provided they meet the minimum capital and financial strength requirements and comply with the other requirements of the Credit for Reinsurance Models.

2. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions and Reciprocal Jurisdictions will be conducted in accordance with the provisions of the Credit for Reinsurance Models and any other relevant guidance developed by the NAIC.

3. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Financial Regulation Standards and Accreditation Program (Accreditation Program), adherence to international supervisory standards, and relevant international guidance for recognition of reinsurance supervision. It is not intended as a prescriptive comparison to the NAIC Accreditation Program. In order for a Qualified Jurisdiction that is not subject to an in-force Covered Agreement to be evaluated as a Reciprocal Jurisdiction, that Qualified Jurisdiction must agree to recognize the states’ approach to group supervision, including group capital, and other such requirements as provided under the Credit for Reinsurance Models.

4. The states shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the Qualified Jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of Qualified Jurisdiction status is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

5. Each state may evaluate a non-U.S. jurisdiction to determine if it is a Qualified Jurisdiction. A list of Qualified Jurisdictions will be published through the NAIC committee process. A state must consider this list in its determination of Qualified Jurisdictions, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Qualified Jurisdictions contained in the Credit for Reinsurance Models. The creation of this list does not constitute a delegation of regulatory authority to the NAIC. The regulatory authority to recognize a Qualified Jurisdiction resides solely in each state and the NAIC List of Qualified Jurisdictions is not binding on the states.

6. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models.
7. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination that a jurisdiction is a Qualified or Reciprocal Jurisdiction. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings. The NAIC Lists of Qualified and Reciprocal Jurisdictions are intended to facilitate the passporting process.

8. Both Qualified Jurisdictions and Reciprocal Jurisdictions must agree to share information and cooperate with the state with respect to all applicable reinsurers domiciled within that jurisdiction. Critical factors in the evaluation process include but are not limited to the history of performance by assuming insurers in the applicant jurisdiction and any documented evidence of substantial problems with the enforcement of final U.S. judgments in the applicant jurisdiction. A jurisdiction will not be a Qualified Jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

9. The determination of Qualified Jurisdiction status can only be made with respect to the reinsurance supervisory system in existence and applied by a non-U.S. jurisdiction at the time of the evaluation.

10. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.
III. Procedure for Evaluation of Non-U.S. Jurisdictions

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

2. Evaluation of Jurisdiction
   a. Evaluation Materials. The Qualified Jurisdiction Working Group will initiate evaluation of a jurisdiction’s regulatory system by using the information identified in Section A through Section G of the Evaluation Methodology (Evaluation Materials). The Qualified Jurisdiction Working Group will begin by undertaking a review of the most recent Financial Sector Assessment Program (FSAP) Report prepared by the International Monetary Fund (IMF), including the Technical Note on Insurance Sector Supervision, and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Qualified Jurisdiction Working Group will also invite each jurisdiction or its designee to provide information relative to Section A through Section G of the Evaluation Methodology in order to update, complete or supplement publicly available information. The Qualified Jurisdiction Working Group may also request or accept relevant information from reinsurers domiciled in the jurisdiction under review.
   b. The Qualified Jurisdiction Working Group will notify the jurisdiction of any information upon which the Working Group is relying. In that communication, the NAIC will invite the supervisory authority to compare the materials identified by the NAIC to the materials described in Appendix A and Appendix B, and provide information required to update the identified public information or supplement the public information, as required, to address the topics identified in Section A through Section G of the Evaluation Methodology. The use of publicly available information (e.g., the FSAP Report and/or the Insurance Sector Technical Note) is intended to lessen the burden on applicant jurisdictions by requiring the production of information that is readily available, while still addressing substantive areas of inquiry detailed in the Evaluation Methodology. The Qualified Jurisdiction Working Group’s review at this stage will be focused on how the jurisdiction’s laws, regulations, administrative practices and procedures, and regulatory authorities regulate the financial solvency of its domestic reinsurers in comparison to key principles underlying the U.S. financial solvency framework\(^1\) and other factors set forth in the Evaluation Methodology.

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\(^1\) The U.S. financial solvency framework is understood to refer to the key elements provided in the NAIC Financial Regulation Standards and Accreditation Program. Appendix A and Appendix B are derived from this framework.
c. After reviewing the Evaluation Materials, the Qualified Jurisdiction Working Group may request that the applicant jurisdiction submit supplemental information as necessary to determine whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. The Working Group will address specific questions directly with the jurisdiction related to items detailed in the Evaluation Methodology that are not otherwise addressed in the Evaluation Materials.

d. The NAIC will request that all responses from the jurisdiction being evaluated be provided in English. Any responses submitted with respect to a jurisdiction’s laws and regulations should be provided by a person qualified in that jurisdiction to provide such analyses and, in the case of statutory analysis, qualified to provide such legal interpretations, to ensure that the jurisdiction is providing an accurate description.

e. The NAIC does not intend to review confidential company-specific information in this process, and has focused the procedure on reviewing publicly available information. No confidential company-specific information shall be disclosed or disseminated during the course of the jurisdiction’s evaluation unless specifically requested, subject to appropriate confidentiality safeguards addressed in a preliminary confidentiality and information-sharing agreement. If no such agreement is executed or the jurisdiction is unable to enter into such an agreement under its regulatory authority, the NAIC will not accept any confidential company-specific information.

3. **NAIC Review of Evaluation Materials**

   a. NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise will review the jurisdiction’s Evaluation Materials.

   b. Expenses with respect to the evaluations will be absorbed within the NAIC budget. This will be periodically reviewed.

   c. Timeline for review. A project management approach will be developed with respect to the overall timeline applicable to each evaluation.

   d. Upon completing its review of the Evaluation Materials, the internal reviewer(s) will report initial findings to the Qualified Jurisdiction Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to FIO and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.
4. Discretionary On-site Review

a. The NAIC may ask the jurisdiction under consideration for the opportunity to perform an on-site review of the jurisdiction’s reinsurance supervisory system. Factors that the Qualified Jurisdiction Working Group will consider in determining whether an on-site review is appropriate include the completeness of the information provided by the jurisdiction under review, the general familiarity of the jurisdiction by the NAIC staff or other state regulators participating in the review based on prior conduct or dealings with the jurisdiction, and the results of other evaluations performed by other regulatory or supervisory organizations. If the review is performed, it will be coordinated through the NAIC, utilizing personnel with the appropriate knowledge, experience and expertise. Individual states may also request that representatives from their state be added to the review team.

b. The review team will communicate with the supervisory authority in advance of the on-site visit to clearly identify the objectives, expectations and procedures with respect to the review, as well as any significant issues or concerns identified within the review of the Evaluation Materials. Information to be considered during the on-site review includes, but is not limited to, the following:
   i. Interviews with supervisory authority personnel.
   ii. Review of organizational and personnel practices.
   iii. Any additional information beneficial to gaining an understanding of document and communication flows.

c. Upon completing the on-site review, the reviewer(s) will report initial findings to the Qualified Jurisdiction Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation.

5. Standard of Review

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

6. Additional Information to be Considered as Part of Evaluation

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

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

a. NAIC staff and/or outside consultants will prepare a Preliminary Evaluation Report for review by the Qualified Jurisdiction Working Group. This preliminary report will be private and confidential (i.e., may only be reviewed by Working Group members, designated NAIC staff, consultants, the states, the FIO and other relevant federal authorities that specifically request to be kept apprised of this information, provided that such entities have entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction. Any outside consultants retained by the NAIC will be required to enter into a confidentiality and nondisclosure agreement.).

b. The report will be prepared in a consistent style and format to be developed by NAIC staff. It will contain detailed advisory information and recommendations with respect to the evaluation of the jurisdiction’s reinsurance supervisory system and the documented practices and procedures thereunder. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a Qualified Jurisdiction.

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


a. The Qualified Jurisdiction Working Group’s review of the Preliminary Evaluation Report will be held in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings.

b. The Qualified Jurisdiction Working Group will make a preliminary determination as to whether the jurisdiction under consideration satisfies the Standard of Review and is deemed acceptable to be included on the NAIC List of Qualified Jurisdictions. If the preliminary determination is that the jurisdiction should not be included on the NAIC List of Qualified Jurisdictions, the Qualified Jurisdiction Working Group will set forth its specific findings and identify those areas of concern with respect to this determination.

c. The results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review.


a. Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. This is not intended to be a formal appeals process that would initiate U.S. state administrative due process requirements.

b. The Qualified Jurisdiction Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Qualified Jurisdiction Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings. This report will be approved upon an affirmative vote of a majority of the members in attendance at this meeting.
c. Upon approval of the Final Evaluation Report, the Qualified Jurisdiction Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the summary for public comment. The detailed report will be a confidential, regulator-only document. The report may be shared with any state indicating that it is considering relying on the NAIC List of Qualified Jurisdictions and has entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction.

10. NAIC Determination regarding List of Qualified Jurisdictions

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

b. In the event that a jurisdiction is not approved as a Qualified Jurisdiction, the supervisory authority will be eligible for reapplication at the discretion of the NAIC.

c. Upon final adoption of the Qualified Jurisdiction Working Group’s determination with respect to a jurisdiction, the Final Evaluation Report will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential.

11. Memorandum of Understanding (MOU)

a. A Qualified Jurisdiction must agree to share information and cooperate on a confidential basis with the U.S. state insurance regulatory authority with respect to all certified reinsurers domiciled within that jurisdiction.

b. The International Association of Insurance Supervisors (IAIS) Multilateral Memorandum of Understanding (MMoU) is the recommended method under which a Qualified Jurisdiction will agree to share information and cooperate with U.S. state insurance regulatory authorities. However, until such time as a state has been approved as a signatory to the MMoU by the IAIS, the state may rely on an MOU entered into by a “Lead State” designated by the NAIC. This Lead State will act as a conduit for information between the Qualified Jurisdiction and other states that have certified a reinsurer domiciled and licensed in that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of information included in the applicable IAIS MMoU or bilateral MOU between the Lead State and the Qualified Jurisdiction and pursuant to the NAIC Master Information Sharing and Confidentiality Agreement. The jurisdiction must also confirm in writing that it is willing to permit this Lead State to act as the contact for purposes of obtaining information concerning its certified reinsurers, provided the Lead State share that information with the other states requesting the information consistent with the terms governing the further sharing of information included in the applicable IAIS MMoU or bilateral MOU between the Lead State and the Qualified Jurisdiction.

c. If a Qualified Jurisdiction has not been approved by the IAIS for use of the MMoU, it must enter into an MOU with a Lead State. The MOU will also provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions.
d. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.

12. Process for Evaluation after Initial Approval

a. The process for determining whether a non-U.S. jurisdiction is a Qualified Jurisdiction is ongoing and subject to periodic review. The Qualified Jurisdiction Working Group will perform a yearly review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. This yearly review shall follow such abbreviated process as may be determined by the Qualified Jurisdiction Working Group to be appropriate.

b. Qualified Jurisdictions must provide the Qualified Jurisdiction Working Group with notice of any material change in the applicable reinsurance supervisory system that may affect the status of the Qualified Jurisdiction. A U.S. jurisdiction should also notify the Qualified Jurisdiction Working Group if it receives notice of any material change in the applicable reinsurance supervisory system, or any adverse developments with respect to enforcement of final U.S. judgments, that may affect the status of the Qualified Jurisdiction. Upon receipt of any such notice, the Qualified Jurisdiction Working Group will consider whether it is necessary to re-evaluate the status of the Qualified Jurisdiction.

c. If the Qualified Jurisdiction Working Group finds the jurisdiction to be out of compliance at any time with the requirements to be a Qualified Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review, and the status as a Qualified Jurisdiction may be placed on probation, suspended or revoked.

d. The Qualified Jurisdiction Working Group will monitor those jurisdictions that have been approved as Qualified Jurisdictions by individual states, but are not included on the NAIC List of Qualified Jurisdictions.

13. Review of Qualified Jurisdictions as Reciprocal Jurisdictions

a. In undertaking the evaluation of a Qualified Jurisdiction as a Reciprocal Jurisdiction, the Qualified Jurisdiction Working Group shall utilize such processes and procedures as outlined in the immediately-preceding paragraphs 1 – 12 of Section III. Procedure for Evaluation of Non-U.S. Jurisdictions such as the Qualified Jurisdiction Working Group deems is appropriate. Specifically, the Qualified Jurisdiction Working Group will use processes and procedures outlined in paragraph 1 (Initiation of Evaluation of the Reinsurance Supervisory System of an Individual Jurisdiction), paragraph 3 (NAIC Review of Evaluation Materials), paragraph 7 (Preliminary Evaluation Report), paragraph 8 (Review of Preliminary Evaluation Report), paragraph 9 (Opportunity to Respond to Preliminary Evaluation Report), paragraph 10 (NAIC Determination regarding List of Qualified Jurisdictions), paragraph 11 (Memorandum of Understanding) and paragraph 12 (Process for Evaluation after Initial Approval), as modified for use with Reciprocal Jurisdictions.

b. A Qualified Jurisdiction may not be reviewed for inclusion on the NAIC List of Reciprocal Jurisdictions, unless it has undergone the Evaluation Methodology outlined in Section IV, and remains in good standing with the NAIC as a Qualified Jurisdiction. The Qualified Jurisdiction Working Group may, if it determines an extended review period to be appropriate after its initial approval of a new Qualified Jurisdiction, defer consideration of that jurisdiction as a possible Reciprocal Jurisdiction until there has been sufficient United States experience with that jurisdiction and its Certified Reinsurers that the Working Group believes it is appropriate to progress from collateral reduction to collateral elimination. Nothing in this process requires a finding that a Qualified Jurisdiction meets the standards for recognition as a Reciprocal Jurisdiction, and
the Qualified Jurisdiction Working Group may base such recommendation on factors not specifically included in this process.

c. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the NAIC List of Reciprocal Jurisdictions. In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the NAIC List of Reciprocal Jurisdictions, the Qualified Jurisdiction Working Group shall undertake the following analysis in making its evaluation:

i. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in that jurisdiction is received by United States ceding insurers;

ii. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

iii. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the Qualified Jurisdiction;

iv. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

v. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in in Section 9C(2) and (3) of Model #786; i.e., must maintain minimum capital and surplus of no less than $250,000,000, and maintains on an ongoing basis the required minimum solvency or capital ratio, as applicable.
d. In order to satisfy the requirements of subsection (c) above, the chief insurance supervisor of the Qualified Jurisdiction being evaluated as a Reciprocal Jurisdiction may provide the NAIC with a written letter confirming, as follows:

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

- An insurer which has its head office or is domiciled in [Jurisdiction] shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in [Jurisdiction] is received by United States ceding insurers. [Jurisdiction] does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by [Jurisdiction] or as a condition to allow the ceding insurer to recognize credit for such reinsurance.

- [Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that insurance groups that are domiciled or maintain their worldwide headquarters in jurisdictions accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the [Jurisdiction].

- [Jurisdiction] confirms that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the [Jurisdiction].

- [Jurisdiction] will annually provide to the states confirmation that applicable assuming insurers domiciled in [Jurisdiction] maintain minimum capital and surplus of no less than $250,000,000, and maintain on an ongoing basis the required minimum solvency or capital ratio, as applicable.

- Finally, I confirm that [Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

e. The Qualified Jurisdiction Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate, and will prepare for the review by the Reinsurance Task Force a Summary of Findings and Determination recommending that the Qualified Jurisdiction be recognized as a Reciprocal Jurisdiction. Upon approval by the Task Force, the Summary of Findings and Determination must be adopted by a vote of the NAIC Executive (EX) Committee and Plenary for inclusion on the List of Reciprocal Jurisdictions.
f. The Qualified Jurisdiction Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable equivalency assessment conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

g. Except for Reciprocal Jurisdictions entitled to automatic recognition, a jurisdiction’s status as a Reciprocal Jurisdiction may be placed on probation, suspended or revoked for good cause in the same manner as provided for Qualified Jurisdictions under paragraph 12. If cause is found to question the fitness of a Reciprocal Jurisdiction that is subject to an in-force covered agreement, or its compliance with applicable requirements of the covered agreement, the Qualified Jurisdiction Working Group would report any concerns to its parent Task Force for further discussion and communication with appropriate federal and/or international authorities.
IV. Evaluation Methodology

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

The Evaluation Methodology consists of the following:

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

This information will be the basis for the Final Evaluation Report and the determination of whether the jurisdiction will be included on the NAIC List of Qualified Jurisdictions.
**Section A: Laws and Regulations**

The NAIC will review publicly available information, as well as information provided by an applicant jurisdiction with respect to its laws and regulations, in an effort to evaluate whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. This will include a review of elements believed to be basic building blocks for sound insurance/reinsurance regulation.\(^2\) A jurisdiction’s effectiveness under Section A may be demonstrated through law, regulation or established practice that implements the general authority granted to the jurisdiction, or any combination of laws, regulations or practices that meet the objective.

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

1. Confirmation of the jurisdiction’s most recent FSAP Report, including relevant updates with respect to descriptions or elements of the FSAP Report in which changes have occurred since the assessment or where information might otherwise be outdated.

2. Confirmation of the jurisdiction’s ROSC, including relevant updates with respect to descriptions or elements of the ROSC in which changes have occurred since the report was completed or where information might otherwise be outdated.

3. If materials responsive to the topics under review have been provided in response to information exchanges between the jurisdiction under review and the NAIC, such prior responses may be cross-referenced provided updates are submitted, if required to address changes in laws or procedures.

4. Any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC’s evaluation process in order to address, on an outcomes basis, the key elements described within Appendix A.

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

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\(^2\) The basic considerations under this section are derived from Model #786, Section 8C(2), which include: (a) the framework under which the assuming reinsurer is regulated; (b) the structure and authority of the jurisdiction’s reinsurance supervisory authority with regard to solvency regulation requirements and financial surveillance; (c) the substance of financial and operating standards for reinsurers domiciled in the jurisdiction; and (d) the form and substance of financial reports required to be filed or made publicly available by reinsurers domiciled in the jurisdiction and the accounting principles used.
minimize the number and extent of supplemental information requests from the NAIC with respect to Section A of this Evaluation Methodology. The NAIC will provide a complete description in the Final Evaluation Report of the information provided in the Evaluation Materials, and any updates or other information that have been provided by the applicant jurisdiction.

**Section B: Regulatory Practices and Procedures**

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

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

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

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

**Section D: Regulatory Cooperation and Information-Sharing**

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

**Section E: History of Performance of Domestic Reinsurers**

The jurisdiction is requested to provide a general description with respect to the historical performance of reinsurers domiciled in the jurisdiction. The NAIC does not intend to review confidential company-specific information under this section. Rather, it is intended that any information provided would be publicly available, unless specifically addressed with the jurisdiction under review. This discussion should address, at a minimum, the following information:
a. Number of reinsurers domiciled in the jurisdiction, and a list of any reinsurers domiciled in the jurisdiction that have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, of no less than $250,000,000.

b. Up to a 10-year history of any regulatory actions taken against specific reinsurers.

c. Up to a 10-year history listing any reinsurers that have gone through insolvency proceedings, including the size of each insolvency and a description of the related outcomes (e.g., reinsurer rehabilitated or liquidated, payout percentage of claims to priority classes, payout percentage of claims to domestic and foreign claimants).

d. Up to a 10-year history of any significant industry-wide fluctuations in capital or profitability with respect to domestic reinsurers.

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

Section F: Enforcement of Final U.S. Judgments

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

Section G: Solvent Schemes of Arrangement

The jurisdiction is requested to provide a description of any legal framework that allows reinsurers domiciled in the jurisdiction to propose or participate in any solvent scheme of arrangement or similar procedure. In addition, the jurisdiction is requested to provide a description of any solvent scheme of arrangement or similar procedure that a domestic reinsurer has proposed or participated in and the outcome of such procedure.
V. Appendices: Specific Guidance with Respect to Section A and Section B

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

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

1. Examination Authority

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

a. Frequency and timing of examinations and reports.

b. Guidelines for examination.

c. Whether the jurisdiction has the authority to examine reinsurers whenever it is deemed necessary.

d. Whether the jurisdiction has the authority to have complete access to the reinsurer’s books and records and, if necessary, the records of any affiliated company.

e. Whether the jurisdiction has the authority to examine officers, employees and agents of the reinsurer when necessary with respect to transactions directly or indirectly related to the reinsurer under examination.

f. Whether the jurisdiction has the authority to share confidential information with U.S. state insurance regulatory authorities, provided that the recipients are required, under their law, to maintain its confidentiality.

2. Capital and Surplus Requirement

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

a. Whether the jurisdiction has the authority to require reinsurers to maintain minimum capital and surplus, including a description of such minimum amounts.

b. Whether the jurisdiction has the authority to require additional capital and surplus based on the type, volume and nature of reinsurance business transacted.

c. Capital requirements for reinsurers, including reports and a description of any specific levels of regulatory intervention.

3. Accounting Practices and Procedures

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

a. Description of the accounting and reporting practices and procedures.

b. Description of any standard financial statement blank/reporting template, including description of content/disclosure requirements and corresponding instructions.

4. Corrective Action

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

a. Identification of specific standards which may be considered to determine whether the continued operation of the reinsurer might be hazardous to the general public.

b. Whether the jurisdiction has the authority to issue an order requiring the reinsurer to take corrective action when it has been determined to be in hazardous financial condition.
5. Regulation and Valuation of Investments

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

a. Whether the jurisdiction has the authority to require a diversified investment portfolio for all domestic reinsurers as to type, issue and liquidity.

b. Whether the jurisdiction has the authority to establish acceptable practices and procedures under which investments owned by reinsurers must be valued, including standards under which reinsurers are required to value securities/investments.

6. Holding Company Systems

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

a. Whether the jurisdiction has access to information via the parent or other regulated group entities about activities or transactions within the group involving other regulated or non-regulated entities that could have a material impact on the operations of the reinsurer.

b. Whether the jurisdiction has access to consolidated financial information of a reinsurer’s ultimate controlling person.

c. Whether the jurisdiction has the authority to review integrity and competency of management.

d. Whether the jurisdiction has approval and intervention powers for material transactions and events involving reinsurers.

e. Whether the jurisdiction has authority to monitor, or has prior approval authority over:
   i. Change in control of domestic reinsurers.
   ii. Dividends and other distributions to shareholders of the reinsurer.
   iii. Material transactions with affiliates.

7. Risk Management

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

a. Whether the jurisdiction has Own Risk and Solvency Assessment (ORSA) requirements and reporting.

b. Any requirements regarding the maximum net amount of risk to be retained by a reinsurer for an individual risk based on the reinsurer’s capital and surplus.

c. Whether the jurisdiction has authority to monitor enterprise risk, including any activity, circumstance, event (or series of events) involving one or more affiliates of a reinsurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the reinsurer or its insurance holding company system as a whole.

d. Whether the jurisdiction has corporate governance requirements for reinsurers.
8. **Liabilities and Reserves**

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

a. Liabilities incurred under reinsurance contracts for policy reserves, unearned premium, claims and losses unpaid, and incurred but not reported (IBNR) claims (including whether discounting is allowed for reserve calculation/reporting).

b. Liabilities related to catastrophic occurrences.

c. Whether the jurisdiction requires an opinion on reserves and loss and loss adjustment expense reserves by a qualified actuary or specialist for all domestic reinsurers, and the frequency of such reports.

9. **Reinsurance Ceded**

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

a. Credit for reinsurance requirements applicable to reinsurance retroceded to domestic and non-domestic reinsurers.

b. Collateral requirements applicable to reinsurance contracts.

c. Whether the jurisdiction requires a reinsurance agreement to provide for insurance risk transfer (i.e., transfer of both underwriting and timing risk).

d. Requirements applicable to special purpose reinsurance vehicles and insurance securitizations.

e. Affiliated reinsurance transactions and concentration risk.

f. Disclosure requirements specific to reinsurance transactions, agreements and counterparties, if such information is not provided under another item.

10. **Independent Audits**

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

a. Requirements for the filing of audited financial statements prepared in conformity with accounting practices prescribed or permitted by the supervisory authority.

b. Contents of annual audited financial reports.

c. Requirements for selection of auditor.

d. Allowance of audited consolidated or combined financial statements.

e. Notification of material misstatements of financial condition.

f. Supervisor’s access to auditor’s workpapers.

g. Audit committee requirements.

h. Requirements for reporting of internal control-related matters.

11. **Receivership**

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

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

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

13. Reinsurance Intermediaries

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

14. Other Regulatory Requirements with respect to Reinsurers

Any other information necessary to adequately describe the effectiveness of the jurisdiction’s laws and regulations with respect to its reinsurance supervisory system.
Appendix B: Regulatory Practices and Procedures

1. Financial Analysis

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

a. Qualified Staff and Resources
   The resources employed to effectively review the financial condition of all domestic reinsurers, including a description of the educational and experience requirements for staff responsible for financial analysis.

b. Communication of Relevant Information to/from Financial Analysis Staff
   The process under which relevant information and data received by the supervisory authority are provided to the financial analysis staff and the process under which the findings of the financial analysis staff are communicated to the appropriate person(s).

c. Supervisory Review
   How the jurisdiction’s internal financial analysis process provides for supervisory review and comment.

d. Priority-Based Analysis
   How the jurisdiction’s financial analysis procedures are prioritized in order to ensure that potential problem reinsurers are reviewed promptly.

e. Depth of Review
   How the jurisdiction’s financial analysis procedures ensure that domestic reinsurers receive an appropriate level or depth of review commensurate with their financial strength and position.

f. Analysis Procedures
   How the jurisdiction has documented its financial analysis procedures and/or guidelines to provide for consistency and continuity in the process and to ensure that appropriate analysis procedures are being performed on each domestic reinsurer.

g. Reporting of Material Adverse Findings
   The process for reporting material adverse indications, including the determination and implementation of appropriate regulatory action.

h. Early Warning System/Stress Testing
   Whether the jurisdiction has an early warning system and/or stress testing methodology that is utilized with respect to its domestic reinsurers.
2. Financial Examinations

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

a. Qualified Staff and Resources
   The resources employed to effectively examine all domestic reinsurers. This should include whether the jurisdiction prioritizes examination scheduling and resource allocation commensurate with the financial strength and position of each reinsurer, and a description of the educational and experience requirements for staff responsible for financial examinations.

b. Communication of Relevant Information to/from Examination Staff
   The process under which relevant information and data received by the supervisory authority are provided to the examination staff and the process under which the findings of the examination staff are communicated to the appropriate person(s).

c. Use of Specialists
   Whether the supervisory authority’s examination staff includes specialists with appropriate training and/or experience or whether the supervisory authority otherwise has available qualified specialists that will permit the supervisory authority to effectively examine any reinsurer.

d. Supervisory Review
   Whether the supervisory authority’s procedures for examinations provide for supervisory review.

e. Examination Guidelines and Procedures
   Description of the policies and procedures the supervisory authority employs for the conduct of examinations, including whether variations in methods and scope are commensurate with the financial strength and position of the reinsurer.

f. Risk-Focused Examinations
   Does the supervisory authority perform and document risk-focused examinations and, if so, what guidance is utilized in conducting the examinations? Are variations in method and scope commensurate with the financial strength and position of the reinsurer?

g. Scheduling of Examinations
   Whether the supervisory authority’s procedures provide for the periodic examination of all domestic reinsurers, including how the system prioritizes reinsurers that exhibit adverse financial trends or otherwise demonstrate a need for examination.

h. Examination Reports
   Description of the format in which the supervisory authority’s reports of examinations are prepared, and how the reports are shared with other jurisdictions under information-sharing agreements.

i. Action on Material Adverse Findings
   What are the jurisdiction’s procedures regarding supervisory action in response to the reporting of any material adverse findings.

3. Information Sharing

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

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

5. **Organization, Licensing and Change of Control of Reinsurers**

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

a. **Licensing Procedure**
   Whether the supervisory authority has documented licensing procedures that include a review and/or analysis of key pieces of information included in a primary licensure application.

b. **Staff and Resources**
   The educational and experience requirements for staff responsible for evaluating company licensing.

c. **Change in Control of a Domestic Reinsurer**
   Procedures for the review of key pieces of information included in filings with respect to a change in control of a domestic reinsurer.

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Summary of Findings and Determination

BERMUDA MONETARY AUTHORITY

Re-Evaluation of Qualified Jurisdiction

Approved By:

Qualified Jurisdiction (E) Working Group
Reinsurance (E) Task Force
Executive (EX) Committee and Plenary

October 7, 2019
December 8, 2019
December 10, 2019

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I. Re-Evaluation of Bermuda Monetary Authority

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to the Bermuda Monetary Authority (BMA), the lead insurance regulatory supervisor for Bermuda. It is the recommendation of the Working Group that the NAIC re-approve the BMA as a Qualified Jurisdiction and continue its designation on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that the BMA’s status as a Qualified Jurisdiction only be applicable to (re)insurers of Class 3A, Class 3B and Class 4, and long-term insurers of Class C, Class D and Class E, which is consistent with the original approval of the BMA as a Qualified Jurisdiction. Finally, the Working Group recommends that Florida be the Lead State for purposes of regulatory cooperation and information sharing with the BMA. These recommendations are based on the following analysis:

II. Procedural History

The NAIC adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.\(^1\)

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved the BMA as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the BMA would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

> Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

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\(^1\) The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. A Qualified Jurisdiction which meets certain additional requirements described in the Credit for Reinsurance Models may be determined to be a Reciprocal Jurisdiction under a separate evaluation by the Working Group.
The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the NAIC List of Qualified Jurisdictions. The Working Group met in regulator-to-regulator session on October 7, 2019, and received a presentation from NAIC staff on whether the BMA should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of the BMA:

2. BMA Power Point Presentation on Group and Commercial Insurer Supervision (Confidential).
3. BMA Power Point Presentation on Legal Entity/Group Supervision Framework (Confidential).
4. BMA NAIC Qualified Jurisdiction Assessment: Summary of Appendices A & B, September 30, 2019 (Confidential).
5. Bermuda Response to Section D—Regulatory Cooperation and Information Sharing (Confidential).
8. Bermuda Response to Section G—Solvent Schemes of Arrangement (Confidential).
9. International Association of Insurance Supervisors Thematic Self-Assessment and Peer Review on Reinsurance and Macroprudential Surveillance (ICPs 13 and 24), September 19, 2016 (Confidential).

III. Standard of Review

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other public documentation that the Working Group would consider to be relevant to this determination. It should be noted that the BMA’s last FSAP report was in 2008; therefore, the BMA supplied additional information (described above) to provide the Working
Group with an accurate understanding of its supervisory regulatory regime deemed equal to the level of an IMF FSAP report. The Working Group also reviewed a confidential self-assessment and peer review on the BMA prepared by the International Association of Insurance Supervisors. In addition, the Working Group considered its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

IV. Summary of Findings and Recommendation

Upon review of the available information, the Working Group has reached the conclusion that the BMA’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency regulation that is acceptable for purposes of reinsurance collateral reduction, that the BMA’s demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize the BMA as a Qualified Jurisdiction and place it on the NAIC List of Qualified Jurisdictions, with such re-evaluation to be effective as of January 1, 2020. Further, the Working Group recommends that the BMA’s status as a Qualified Jurisdiction continues to be only applicable to (re)insurers of Class 3A, Class 3B and Class 4, and long-term insurers of Class C, Class D and Class E.
Summary of Findings and Determination

France: Autorité de Contrôle Prudentiel et de Résolution (ACPR)

Re-Evaluation of Qualified Jurisdiction

Approved By:

Qualified Jurisdiction (E) Working Group August 22, 2019
Reinsurance (E) Task Force October 22, 2019
Executive (EX) Committee and Plenary December 10, 2019
I.  Re-Evaluation of France as a Qualified Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to its re-evaluation of the Autorité de Contrôle Prudentiel et de Résolution (ACPR), the lead insurance regulatory supervisor for France. It is the recommendation of the Working Group that the NAIC re-approve the ACPR as a Qualified Jurisdiction and continue its designation on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that Delaware be the Lead State for purposes of regulatory cooperation and information sharing with the ACPR. These recommendations are based on the following analysis.

II. Procedural History

The NAIC adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.1

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved the ACPR as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the ACPR would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

> Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the NAIC List of Qualified Jurisdictions. The Working Group met in regulator-to-regulator session on August 22, 2019, and heard a presentation by NAIC staff

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1 The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. Because the ACPR’s status as a Reciprocal Jurisdiction arises under a covered agreement under the Dodd-Frank Wall Street Reform and Consumer Protection Act, it is not affected by this re-evaluation of the ACPR as a Qualified Jurisdiction.
on whether the ACPR should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of the ACPR:


3. *Summary of Findings and Determination France: Autorité de Contrôle Prudentiel et de Résolution (ACPR) approved by NAIC Executive (EX) Committee and Plenary on December 16, 2014.*

4. *NAIC Staff Workpapers on Initial Review and Findings dated August 7, 2014 (Confidential).*

### III. Standard of Review

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other documentation that the Working Group would consider to be relevant to this determination. In addition, the Working Group would consider its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

### IV. Summary of Findings and Recommendation

Upon review of the available information, the Working Group has reached the conclusion that the ACPR’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency regulation that is acceptable for purposes of reinsurance collateral reduction, that the ACPR’s demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize the ACPR as a Qualified Jurisdiction and place it on the *NAIC List of Qualified Jurisdictions*, with such re-evaluation to be effective as of January 1, 2020.
Summary of Findings and Determination

Germany: Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin)

Re-Evaluation of Qualified Jurisdiction

Approved By:

Qualified Jurisdiction (E) Working Group  August 22, 2019
Reinsurance (E) Task Force  October 22, 2019
Executive (EX) Committee and Plenary  December 10, 2019
I. Re-Evaluation of Germany as a Qualified Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to its re-evaluation of the Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin), the lead insurance regulatory supervisor for Germany. It is the recommendation of the Working Group that the NAIC re-approve BaFin as a Qualified Jurisdiction and continue its designation on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that California be the Lead State for purposes of regulatory cooperation and information sharing with BaFin. These recommendations are based on the following analysis.

II. Procedural History

The NAIC adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.1

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved BaFin as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which BaFin would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the NAIC List of Qualified Jurisdictions. The Working Group met in regulator-to-regulator session on August 22, 2019, and heard a presentation by NAIC staff

1 The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. Because BaFin’s status as a Reciprocal Jurisdiction arises under a covered agreement under the Dodd-Frank Wall Street Reform and Consumer Protection Act, it is not affected by this re-evaluation of BaFin as a Qualified Jurisdiction.
on whether BaFin should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of BaFin:

3. Summary of Findings and Determination Germany: Federal Financial Supervisory Authority (BaFin) approved by NAIC Executive (EX) Committee and Plenary on December 16, 2014.
5. BaFin Comment Letter (Sept. 30, 2019): “The planned amendment of § 67 (1) VAG with respect to the exemption from the license requirement in cases where the EU has concluded an agreement is now part of another legislative procedure (implementation of the Money Laundering Directive)...the leaflet describes the situation for US reinsurers with the sufficient legal clarity”: https://www.bafin.de/dok/13008940

III. Standard of Review

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other documentation that the Working Group would consider to be relevant to this determination. In addition, the Working Group would consider its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

IV. Summary of Findings and Recommendation

Upon review of the available information, the Working Group has reached the conclusion that BaFin’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency regulation that is acceptable for purposes of reinsurance collateral reduction, that BaFin’s demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.
Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize BaFin as a Qualified Jurisdiction and place it on the *NAIC List of Qualified Jurisdictions*, with such re-evaluation to be effective as of January 1, 2020.
Summary of Findings and Determination

Ireland: Central Bank of Ireland

Re-Evaluation of Qualified Jurisdiction

Approved By:

Qualified Jurisdiction (E) Working Group  August 22, 2019
Reinsurance (E) Task Force  October 22, 2019
Executive (EX) Committee and Plenary  December 10, 2019
I. Re-Evaluation of Ireland as a Qualified Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to its re-evaluation of the Central Bank of Ireland (Central Bank), the lead insurance regulatory supervisor for Ireland. It is the recommendation of the Working Group that the NAIC re-approve the Central Bank as a Qualified Jurisdiction and continue its designation on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that Delaware be the Lead State for purposes of regulatory cooperation and information sharing with the Central Bank. These recommendations are based on the following analysis.

II. Procedural History

The NAIC adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.\(^1\)

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved the Central Bank as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the Central Bank would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

> Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the NAIC List of Qualified Jurisdictions. The Working Group met in regulator-to-regulator session on August 22, 2019, and heard a presentation by NAIC staff.

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\(^1\) The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. Because the Central Bank’s status as a Reciprocal Jurisdiction arises under a covered agreement under the Dodd-Frank Wall Street Reform and Consumer Protection Act, it is not affected by this re-evaluation of the Central Bank as a Qualified Jurisdiction.
on whether the Central Bank should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of the Central Bank:

4. Summary of Findings and Determination Central Bank of Ireland approved by NAIC Executive (EX) Committee and Plenary on December 16, 2014.
5. NAIC Staff Workpapers on Initial Review and Findings dated July 25, 2014 (Confidential).

III. Standard of Review

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other documentation that the Working Group would consider to be relevant to this determination. In addition, the Working Group would consider its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

IV. Summary of Findings and Recommendation

Upon review of the available information, the Working Group has reached the conclusion that the Central Bank’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency regulation that is acceptable for purposes of reinsurance collateral reduction, that the Central Bank’s demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.
Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize the Central Bank as a Qualified Jurisdiction and place it on the *NAIC List of Qualified Jurisdictions*, with such re-evaluation to be effective as of January 1, 2020.
Summary of Findings and Determination

Japan:
Financial Services Agency (FSA)

Re-Evaluation of Qualified Jurisdiction

Approved By:

Qualified Jurisdiction (E) Working Group          October 7, 2019
Reinsurance (E) Task Force                         December 8, 2019
Executive (EX) Committee and Plenary              December 10, 2019
I. Re-Evaluation of Financial Services Agency of Japan

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to its re-evaluation of the Financial Services Agency (FSA), the lead insurance regulatory supervisor for Japan. It is the recommendation of the Working Group that the NAIC re-approve the FSA as a Qualified Jurisdiction and continue its designation on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that California continue to be the Lead State for purposes of regulatory cooperation and information sharing with the FSA. These recommendations are based on the following analysis.

II. Procedural History

The NAIC adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.¹

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved the FSA as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the FSA would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the NAIC List of Qualified Jurisdictions. The Working Group met in regulator-to-regulator session on October 7, 2019, and heard a presentation by NAIC staff.

¹ The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. A Qualified Jurisdiction which meets certain additional requirements described in the Credit for Reinsurance Models may be determined to be a Reciprocal Jurisdiction under a separate evaluation by the Working Group.
on whether the FSA should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of the FSA:


6. *Summary of Findings and Determination Japan: Financial Services Agency (FSA) approved by NAIC Executive (EX) Committee and Plenary on December 16, 2014.*

7. *NAIC Staff Workpapers on Initial Review and Findings dated September 30, 2014 (Confidential).*

III. **Standard of Review**

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other documentation that the Working Group would consider to be relevant to this determination. In addition, the Working Group would consider its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

IV. **Summary of Findings and Recommendation**

Upon review of the available information, the Working Group has reached the conclusion that the JSA’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency
regulation that is acceptable for purposes of reinsurance collateral reduction, that the JSA’s demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize the JSA as a Qualified Jurisdiction and place it on the **NAIC List of Qualified Jurisdictions**, with such re-evaluation to be effective as of January 1, 2020.
Summary of Findings and Determination

Switzerland:
Financial Market Supervisory Authority (FINMA)

Re-Evaluation of Qualified Jurisdiction

Approved By:
Qualified Jurisdiction (E) Working Group  October 7, 2019
Reinsurance (E) Task Force  December 8, 2019
Executive (EX) Committee and Plenary  December 10, 2019
I. Re-Evaluation of Switzerland: Financial Market Supervisory Authority

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to its re-evaluation of the Financial Market Supervisory Authority (FINMA), the lead insurance regulatory supervisor for Switzerland. It is the recommendation of the Working Group that the NAIC re-approve FINMA as a Qualified Jurisdiction and continue its designation on the *NAIC List of Qualified Jurisdictions*, to be effective as of January 1, 2020. Further, the Working Group recommends that Missouri be the Lead State for purposes of regulatory cooperation and information sharing with FINMA. These recommendations are based on the following analysis.

II. Procedural History

The NAIC adopted the *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions* (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.¹

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved FINMA as a Qualified Jurisdiction and placed it on the *NAIC List of Qualified Jurisdictions*, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which FINMA would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

> Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the *NAIC List of Qualified Jurisdictions*. The Working Group met in regulator-to-regulator session on October 7, 2019, and heard a presentation by NAIC staff...

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¹ The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. A Qualified Jurisdiction which meets certain additional requirements described in the Credit for Reinsurance Models may be determined to be a Reciprocal Jurisdiction under a separate evaluation by the Working Group.
on whether FINMA should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of FINMA:

7. *NAIC Staff Workpapers on Initial Review and Findings dated August 5, 2014 (Confidential).*

### III. Standard of Review

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other documentation that the Working Group would consider to be relevant to this determination. In addition, the Working Group would consider its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

### IV. Summary of Findings and Recommendation

Upon review of the available information, the Working Group has reached the conclusion that FINMA’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency
regulation that is acceptable for purposes of reinsurance collateral reduction, that FINMA’s demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize FINMA as a Qualified Jurisdiction and place it on the *NAIC List of Qualified Jurisdictions*, with such re-evaluation to be effective as of January 1, 2020.

W:\National Meetings\2019\Fall\Plenary\15 ReEvaluation_BermudaFranceGermanyIrelandJapanSwitz.pdf
Summary of Findings and Determination

United Kingdom (UK):
Prudential Regulation Authority of the Bank of England

Re-Evaluation of Qualified Jurisdiction

Approved By:

Qualified Jurisdiction (E) Working Group     August 22, 2019
Reinsurance (E) Task Force                   October 22, 2019
Executive (EX) Committee and Plenary        December 10, 2019

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I. Re-Evaluation of the United Kingdom as a Qualified Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to its re-evaluation of the Prudential Regulation Authority of the Bank of England (PRA), the lead insurance regulatory supervisor for the United Kingdom (UK). It is the recommendation of the Working Group that the NAIC re-approve the PRA as a Qualified Jurisdiction and continue its designation on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that New York be the Lead State for purposes of regulatory cooperation and information sharing with the PRA. These recommendations are based on the following analysis.

II. Procedural History

The NAIC adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.¹

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved the PRA as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the PRA would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

> Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the NAIC List of Qualified Jurisdictions. The Working Group met in regulator-to-regulator session on August 22, 2019, and heard a presentation by NAIC staff.

¹ The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. Because the PRA’s status as a Reciprocal Jurisdiction arises under a covered agreement under the Dodd-Frank Wall Street Reform and Consumer Protection Act, it is not affected by this re-evaluation of the PRA as a Qualified Jurisdiction.
on whether the PRA should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of the PRA:


4. *NAIC Staff Workpapers on Initial Review and Findings dated July 22, 2014 (Confidential).*

### III. Standard of Review

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other documentation that the Working Group would consider to be relevant to this determination. In addition, the Working Group would consider its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

### IV. Summary of Findings and Recommendation

Upon review of the available information, the Working Group has reached the conclusion that the PRA’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency regulation that is acceptable for purposes of reinsurance collateral reduction, that the PRA’s demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize the PRA as a Qualified Jurisdiction and place it on the *NAIC List of Qualified Jurisdictions*, with such re-evaluation to be effective as of January 1, 2020.
Summary of Findings and Determination

BERMUDA MONETARY AUTHORITY

Evaluation of Reciprocal Jurisdiction

Issued for Public Comment By:

Qualified Jurisdiction (E) Working Group

November 5, 2019
I. Evaluation of Bermuda Monetary Authority as Reciprocal Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this *Summary of Findings and Determination* with respect to the evaluation of the Bermuda Monetary Authority (BMA), the lead insurance regulatory supervisor for Bermuda, as a Reciprocal Jurisdiction. It is the recommendation of the Working Group that the NAIC approve the BMA as a Reciprocal Jurisdiction and place it on the *NAIC List of Reciprocal Jurisdictions*, to be effective as of January 1, 2020. Further, the Working Group recommends that the BMA’s status as a Reciprocal Jurisdiction only be applicable to (re)insurers of Class 3A, Class 3B and Class 4, and long-term (re)insurers of Class C, Class D and Class E, which is consistent with the approval of the BMA as a Qualified Jurisdiction. Finally, the Working Group recommends that Florida be the Lead State for purposes of regulatory cooperation and information sharing with the BMA. These recommendations are based on the following analysis:

II. Procedural History

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

The NAIC adopted revisions to the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786) (collectively, the “Credit for Reinsurance Models”) on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. A Qualified Jurisdiction which meets certain additional requirements described in the Credit for Reinsurance Models may be determined to be a Reciprocal Jurisdiction under the revised Credit for Reinsurance Models.

A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models.

On October 22, 2019, the Reinsurance (E) Task Force updated and revised the *Process for Evaluating Qualified and Reciprocal Jurisdictions* to specify how Qualified Jurisdictions that recognize key NAIC solvency initiatives, including group supervision and group capital standards, and also meet the other
requirements under the revised Credit for Reinsurance Models, will be recognized as Reciprocal Jurisdictions and receive similar treatment as that provided under the EU and UK Covered Agreements, including the elimination of reinsurance collateral and local presence requirements by the states.

III. BMA’s Status of a Qualified Jurisdiction

A Qualified Jurisdiction may not be reviewed for inclusion on the NAIC List of Reciprocal Jurisdictions unless it remains in good standing with the NAIC as a Qualified Jurisdiction. The NAIC originally designated the BMA as a Conditional Qualified Jurisdiction effective January 1, 2014, with the designation to continue for one year. On December 16, 2014, the NAIC approved the BMA as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the BMA would be re-evaluated.

The Working Group met in regulator-to-regulator session on October 7, 2019 and re-approved the BMA as a Qualified Jurisdiction. The Reinsurance (E) Task Force is expected to approve the re-evaluation of the BMA as a Qualified Jurisdiction, which is expected to be confirmed by the NAIC Executive (EX) Committee and Plenary at its 2019 Fall National Meeting. This Summary of Findings and Determination with respect to the BMA as a Reciprocal Jurisdiction is expressly made contingent upon the NAIC’s re-approval of the BMA as a Qualified Jurisdiction.

IV. Written Confirmation

In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the NAIC List of Reciprocal Jurisdictions, the Qualified Jurisdiction Working Group shall undertake the following analysis in making its evaluation:

1. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in that jurisdiction is received by United States ceding insurers;

2. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

3. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision, including worldwide group
governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the Qualified Jurisdiction;

4. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

5. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in in Section 9C(2) and (3) of Model #786; i.e., must maintain minimum capital and surplus of no less than $250,000,000, and maintains on an ongoing basis the required minimum solvency or capital ratio, as applicable.

The BMA provided the NAIC and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories with this written confirmation by letter dated October 30, 2019. The Qualified Jurisdiction Working Group performed a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate on November 5, 2019.

V. Minimum Solvency or Capital Ratio

The Qualified Jurisdiction Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable equivalency decision made by the European Commission (EC) based on assessments conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

In a Note dated September 27, 2019, the BMA advised the NAIC that Bermuda’s risk-based solvency regime for commercial (re)insurers (Bermuda Enhanced Regime) reached full Solvency II equivalence on 24th March 2016. The regulatory capital requirement for the Bermuda Enhanced Regime is designated Enhanced Capital Requirement (ECR). Full Solvency II equivalence means that the EC and
EIOPA recognize the Bermuda Enhanced Regime as producing equivalent outcomes to Solvency II, namely that a 100% Enhanced Capital Requirement (ECR) ratio is equivalent on an outcome basis to a 100% Solvency II SCR ratio. The BMA also advised the NAIC that it considers a 100% ECR ratio produces results equivalent to a 300% RBC ratio on an outcomes basis. Furthermore, the BMA advised that it had made some enhancements to certain aspects of its Bermuda Enhanced Regime in 2018, which became effective on January 1, 2019. The BMA further reported that in July 2018, the BMA engaged with EIOPA in a series of meetings as part of the monitoring of its Solvency II equivalence status. The overall assessment was “positive” which means that EIOPA confirmed that the Bermuda Enhanced Regime remains fully Solvency II equivalent and that a 100% ECR ratio as calculated under the revised rules remains equivalent on an outcome basis to a 100% Solvency II SCR ratio.

The Qualified Jurisdiction Working Group approved 100% ECR as the minimum solvency or capital ratio for reinsurers domiciled in Bermuda, and the Reinsurance Financial Analysis (E) Working Group approved 100% ECR as the minimum solvency or capital ratio on October 11, 2019.

VI. Summary of Findings and Recommendation

Therefore, it is the recommendation of the Qualified Jurisdiction Working Group that the NAIC recognize the BMA as a Reciprocal Jurisdiction and place it on the NAIC List of Reciprocal Jurisdictions, with such evaluation to be effective as of January 1, 2020. Further, the Working Group recommends that the BMA’s status as a Reciprocal Jurisdiction only apply to (re)insurers of Class 3A, Class 3B and Class 4, and long-term (re)insurers of Class C, Class D and Class E. Finally, the Working Group recommends that the minimum solvency or capital ratio for eligible reinsurers domiciled in Bermuda to be a 100% ECR ratio.
Summary of Findings and Determination

Japan:
Financial Services Agency (FSA)

Evaluation of Reciprocal Jurisdiction

Issued for Public Comment By:

Qualified Jurisdiction (E) Working Group

November 5, 2019
I. Evaluation of Japan as Reciprocal Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to the evaluation of the Financial Services Agency (FSA), the lead insurance regulatory supervisor for Japan, as a Reciprocal Jurisdiction. It is the recommendation of the Working Group that the NAIC approve the FSA as a Reciprocal Jurisdiction and place it on the NAIC List of Reciprocal Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that California be the Lead State for purposes of regulatory cooperation and information sharing with the FSA. These recommendations are based on the following analysis:

II. Procedural History

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

The NAIC adopted revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. A Qualified Jurisdiction which meets certain additional requirements described in the Credit for Reinsurance Models may be determined to be a Reciprocal Jurisdiction under the revised Credit for Reinsurance Models.

A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models.

On October 22, 2019, the Reinsurance (E) Task Force updated and revised the Process for Evaluating Qualified and Reciprocal Jurisdictions to specify how Qualified Jurisdictions that recognize key NAIC solvency initiatives, including group supervision and group capital standards, and also meet the other requirements under the revised Credit for Reinsurance Models, will be recognized as Reciprocal Jurisdictions and receive similar treatment as that provided under the EU and UK Covered Agreements, including the elimination of reinsurance collateral and local presence requirements by the states.
III. Japan’s Status of a Qualified Jurisdiction

A Qualified Jurisdiction may not be reviewed for inclusion on the *NAIC List of Reciprocal Jurisdictions* unless it remains in good standing with the NAIC as a Qualified Jurisdiction. On December 16, 2014, the NAIC approved the FSA as a Qualified Jurisdiction and placed it on the *NAIC List of Qualified Jurisdictions*, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the FSA would be re-evaluated.

The Working Group met in regulator-to-regulator session on October 7, 2019 and re-approved the FSA as a Qualified Jurisdiction. The Reinsurance (E) Task Force is expected to approve the re-evaluation of the FSA as a Qualified Jurisdiction, which is expected to be confirmed by the NAIC Executive (EX) Committee and Plenary at its 2019 Fall National Meeting. This *Summary of Findings and Determination* with respect to the FSA as a Reciprocal Jurisdiction is expressly made contingent upon the NAIC’s re-approval of the FSA as a Qualified Jurisdiction.

IV. Written Confirmation

In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the *NAIC List of Reciprocal Jurisdictions*, the Qualified Jurisdiction Working Group shall undertake the following analysis in making its evaluation:

1. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in that jurisdiction is received by United States ceding insurers;

2. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

3. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision, including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the Qualified Jurisdiction;

4. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if
applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

5. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in in Section 9C(2) and (3) of Model #786; i.e., must maintain minimum capital and surplus of no less than $250,000,000, and maintains on an ongoing basis the required minimum solvency or capital ratio, as applicable.

The FSA provided the NAIC and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories with this written confirmation by letter dated October 31, 2019. The Qualified Jurisdiction Working Group performed a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate on November 5, 2019.

V. Minimum Solvency or Capital Ratio

The Qualified Jurisdiction Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable equivalency assessment conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

In the 2015 EIOPA Advice to the European Commission: Equivalence assessment of the Japanese supervisory system in relation to Article 172 of the Solvency II Directive (EIOPA-CP-14/043), EIOPA made the following observations on the FSA’s capital requirements:

JFSA regulation defines a capital requirement that is named the ‘total risk’ in Ministry of Finance Notice No. 50 “Calculation methods...”. This capital requirement broadly corresponds to the Solvency II Solvency Capital Requirement (SCR) (see below)...JFSA regulation defines a ‘Solvency Margin Ratio’ (hereunder SMR), which equates to double the own funds divided by the ‘total risk’.

JFSA regulation defines three levels of supervisory intervention:
• Even when the SMR is **above 200%**, the JFSA may require insurers to adopt ‘improvement measures’, notably on profitability, credit risk (including a reduction to their credit concentration risk), stability (reduction to their market and interest rate risks) and liquidity risk. The JFSA refers to this ‘early’ supervisory intervention as the “early warning system”.

• When the SMR is **between 100% and 200%**, the JFSA may order insurers to submit and implement an improvement plan for ensuring managerial soundness.

• When the SMR is **between 0% and 100%**, the JFSA may order a series of measures such as reduction of dividends to shareholders, reduction of dividends to policyholders, and contraction of business operations.

• When the SMR is below **0%**, JFSA may order the total or partial suspension of business.

…From the above description, it follows that in terms of supervisory action the JFSA system has at least one supplementary level of intervention, compared to the Solvency II system. It also follows that supervisory actions taken at 200% of the SMR would, broadly speaking, correspond to those taken at the Solvency II SCR level of intervention —even though JFSA may intervene in a legally binding manner even if the SMR is more than 200%—, while supervisory actions taken at 0% of the SMR along with actions taken at the level of 100% of the SMR would, broadly speaking, correspond to possible actions under the Solvency II MCR.

In its consultation e-mail to the NAIC dated October 3, 2019, the FSA advised as follows: “an SMR of 200 percent triggers early remedial action such as submission of a management plan to restore the SMR, as an SCR of 100 percent triggers supervisory action such as submission of a realistic recovery plan. In this regard, we understand supervisory actions taken at 200% of the SMR would correspond to those taken at the Solvency II SCR level of intervention, even though the FSA may take supervisory actions in a proactive manner even if the SMR is more than 200%.”

The Qualified Jurisdiction Working Group approved 200 percent of the SMR as the minimum solvency or capital ratio for reinsurers domiciled in Japan, and the Reinsurance Financial Analysis (E) Working Group approved 200 percent of the SMR as the minimum solvency or capital ratio on October 11, 2019.

VI. **Summary of Findings and Recommendation**

Therefore, it is the recommendation of the Qualified Jurisdiction Working Group that the NAIC recognize the FSA as a Reciprocal Jurisdiction and place it on the *NAIC List of Reciprocal Jurisdictions*, with such evaluation to be effective as of January 1, 2020. Further, the Working Group recommends that the minimum solvency or capital ratio for eligible reinsurers domiciled in Japan to be 200 percent of the SMR.
Summary of Findings and Determination

Switzerland:
Financial Market Supervisory Authority (FINMA)

Evaluation of Reciprocal Jurisdiction

Issued for Public Comment By:
Qualified Jurisdiction (E) Working Group
November 5, 2019
I. Evaluation of Switzerland as Reciprocal Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to the evaluation of the Swiss Financial Market Supervisory Authority FINMA, the lead insurance regulatory supervisor for Switzerland, as a Reciprocal Jurisdiction. It is the recommendation of the Working Group that the NAIC approve FINMA as a Reciprocal Jurisdiction and place it on the NAIC List of Reciprocal Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that Missouri be the Lead State for purposes of regulatory cooperation and information sharing with FINMA. These recommendations are based on the following analysis:

II. Procedural History

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

The NAIC adopted revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. A Qualified Jurisdiction which meets certain additional requirements described in the Credit for Reinsurance Models may be determined to be a Reciprocal Jurisdiction under the revised Credit for Reinsurance Models.

A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models.

On October 22, 2019, the Reinsurance (E) Task Force updated and revised the Process for Evaluating Qualified and Reciprocal Jurisdictions to specify how Qualified Jurisdictions that recognize key NAIC solvency initiatives, including group supervision and group capital standards, and also meet the other requirements under the revised Credit for Reinsurance Models, will be recognized as Reciprocal Jurisdictions and receive similar treatment as that provided under the EU and UK Covered Agreements, including the elimination of reinsurance collateral and local presence requirements by the states.
III. FINMA’s Status of a Qualified Jurisdiction

A Qualified Jurisdiction may not be reviewed for inclusion on the NAIC List of Reciprocal Jurisdictions unless it remains in good standing with the NAIC as a Qualified Jurisdiction. The NAIC originally designated FINMA as a Conditional Qualified Jurisdiction effective January 1, 2014, with the designation to continue for one year. On December 16, 2014, the NAIC approved FINMA as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which FINMA would be re-evaluated.

The Working Group met in regulator-to-regulator session on October 7, 2019 and re-approved FINMA as a Qualified Jurisdiction. The Reinsurance (E) Task Force is expected to approve the re-evaluation of FINMA as a Qualified Jurisdiction, which is expected to be confirmed by the NAIC Executive (EX) Committee and Plenary at its 2019 Fall National Meeting. This Summary of Findings and Determination with respect to FINMA as a Reciprocal Jurisdiction is expressly made contingent upon the NAIC’s re-approval of FINMA as a Qualified Jurisdiction.

IV. Written Confirmation

In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the NAIC List of Reciprocal Jurisdictions, the Qualified Jurisdiction Working Group shall undertake the following analysis in making its evaluation:

1. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in that jurisdiction is received by United States ceding insurers;

2. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

3. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision, including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the Qualified Jurisdiction;
4. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

5. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in in Section 9C(2) and (3) of Model #786; i.e., must maintain minimum capital and surplus of no less than $250,000,000, and maintains on an ongoing basis the required minimum solvency or capital ratio, as applicable.

FINMA provided the NAIC and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories with this written confirmation by letter dated October 29, 2019. The Qualified Jurisdiction Working Group performed a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate on November 5, 2019.

V. Minimum Solvency or Capital Ratio

The Qualified Jurisdiction Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable equivalency assessment conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

In the 2015 EIOPA Advice to the European Commission: Equivalence assessment of the Swiss supervisory system in relation to Articles 172, 227 and 260 of the Solvency II Directive (EIOPA-BoS-15/041), EIOPA made the following observations on Switzerland’s ladder of supervisory intervention:

Under the Swiss Solvency Test (SST), the capital requirement which is more commonly referred to as the Target Capital (TC) under the SST, is calculated to cover unexpected losses arising from existing business that correspond to the Tail Value-at Risk (Tail-VaR) of the Risk Bearing Capital (RBC) subject to a confidence level of 99% over a one-year period….
The SST ratio of an insurer determines its supervisory zone (green, yellow, amber or red) and the corresponding degree of supervisory intervention:

- If the SST ratio is 100% or more, there will be no supervisory intervention – i.e. the insurer will be subject to normal supervisory monitoring. [Emphasis added].

- If the SST ratio falls below 100%, the intensity of supervisory intervention and the intrusiveness of supervisory actions will increase as the SST ratio decreases.

- If the SST ratio falls below 33%, the insurer will be required to take immediate actions to restore the SST ratio, the failure of which will trigger FINMA to revoke its license.

In its consultation letter to the NAIC dated October 2, 2019, FINMA advised as follows:

FINMA would consider in principle 100% SST to be comparable to some extent to 100% SCR under Solvency II. In addition, we would like to make the following comments:

- There is a significant degree of commonalities between the two solvency regimes, but also some different approaches applied.
- The application for the tail value-at-risk with a confidence level of 99% under the SST as opposed to the value-at-at risk with a confidence level of 99.5% leads in the case of a reinsurer typically to more conservative results, i.e. to a higher insurance target capital.
- In this context, one can also refer to recent IMF FSAP Reports.

The Qualified Jurisdiction Working Group approved 100% SST as the minimum solvency or capital ratio for reinsurers domiciled in Switzerland, and the Reinsurance Financial Analysis (E) Working Group approved 100% SST as the minimum solvency or capital ratio on October 11, 2019.

**VI. Summary of Findings and Recommendation**

Therefore, it is the recommendation of the Qualified Jurisdiction Working Group that the NAIC recognize FINMA as a Reciprocal Jurisdiction and place it on the *NAIC List of Reciprocal Jurisdictions*, with such evaluation to be effective as of January 1, 2020. Further, the Working Group recommends that the minimum solvency or capital ratio for eligible reinsurers domiciled in Switzerland to be a 100% SST ratio.

W:\National Meetings\2019\Fall\Plenary\10 ReciprocalJurisdictionFindings.pdf
To: Commissioner Todd E. Kiser (UT), Chair of Financial Regulation Standards and Accreditation (F) Committee

From: Jeff Hunt (TX) and Joel Sander (OK), Co-Chairs of National Treatment and Coordination (E) Working Group

Date: February 15, 2019

Re: Company Licensing Accreditation Standards

Executive Summary

The National Treatment and Coordination (E) Working Group (Working Group) is charged with monitoring usage of the Form A database and implementation of company licensing best practices. As a result of this monitoring, updates and enhancements are made that must also be considered for their impact on the accreditation program and, specifically, Part D: Organization, Licensing and Change of Control of Domestic Insurers (Part D).

On February 14, 2019 the Working Group adopted a recommendation regarding the Part D Accreditation Standards to a) update the guidelines to reflect current practices, b) expand the scope to include redomestications, and c) include Part D in the review team’s recommendation with the result that the outcome can affect a state’s accredited status.

A baseline set of standards for the completion of primary applications for the licensing of new companies and redomestications, and Form A filings promotes reliance on other states in these important functions. Each application requires consideration of financial solvency of the insurers to both strengthen financial regulation and prevent unlicensed or fraudulent activities. The significant reliance on other states combined with the potential solvency impact of non-compliance with the Part D standards result in the recommendation to the Financial Regulation Standards and Accreditation (F) Committee outlined in this referral.

The Working Group recommends that the revisions to the guidelines be adopted with an effective date of January 1, 2020. However, the Working Group also recommends that the effective date for subjecting Part D to Recommendation A or B and thus impacting a state’s accredited status, be effective January 1, 2022. This timeline allows states to adjust to the revised guidelines before elevating the status of the Part D standards. The recommendations are intended to be prospective and applicable to filings received on or after the effective date.
Summary of Changes

Updates to Reflect Current Practices

Following is a summary of the Working Group’s recommended revisions to the Part D accreditation guidelines:

1) update the scope to include primary applications for redomestications,
2) update timing guidelines to rely on department policies along with state statute or regulation or the Company Licensing Best Practices Handbook,
3) add a new standard for the scope and performance of procedures for redomestications which includes elements of a quality review in addition to communication expectations,
4) update the process-oriented guidelines for Form A filings to include documenting an assessment of business plans and the quality and expertise of key persons, and
5) require updates to the Form A database at a minimum every six months for open filings.
6) update the title of Part D to “Primary Licensing, Redomestications and Change of Control”

Expand Scope to Redomestications

Insurance companies redomicile for a variety of reasons. When a redomestication occurs, state regulators take on the responsibility to review the request. The Working Group believes it is key for regulators in both states to communicate, review the information provided, and understand the reasons for the redomestication. In addition, the Working Group received a referral from the Financial Analysis (E) Working Group (FAWG) supporting inclusion of redomestications in the Part D Standards based on their work monitoring troubled and potentially troubled companies. As an example, FAWG has identified situations where companies have sought to take advantage of the redomestication process to achieve regulatory arbitrage. The recommended accreditation guidelines include elements for a quality review of these transactions as well as communication requirements with other regulators.

Subject to Recommendation A or B

In 2016, The Working Group together with the Group Solvency Issues (E) Working Group redesigned the Form A Database to enhance regulatory reviews and provide a more dynamic regulatory tool. The database now captures more information regarding mergers, acquisitions, consolidated hearings and/or coordinated reviews of Form A filings. The Form A is reviewed and analyzed by the state in which the Form A is filed, and the appropriate action is taken by the state to either approve or disapprove the transaction within a specified time frame. Making this information available to regulators in each state via the Form A Database provides awareness of other similar transactions such as a large insurer initiating acquisitions in numerous states or denials/issues with filings from the same ultimate controlling party. The database can also lead to efficiencies in analyzing similar transactions using the Lead State concept incorporated into the database.

To fully realize the regulatory value the Form A Database can provide, all states must effectively use the database for each applicable transaction. The Working Group recommends subjecting the Part D accreditation guidelines to a Recommendation A or B as defined in the accreditation manual to ensure a complete database of information.

In the primary application process for new companies, other states may not immediately rely on the work done by the domiciliary state, but as soon as the insurer begins requesting licenses in other states, heavy reliance is placed on the initial application process done by the domiciliary state. In the primary application process for redomestications, other states rely on the new domestic regulator as discussed above.

Therefore, primary applications for new companies and redomestications, in addition to Form A filings, are equally important and should be encompassed in the Recommendation A or B for the entirety of Part D.
A statement and explanation of how the potential standard is directly related to solvency surveillance and why the proposal should be included in the standards:

The purpose of subjecting primary licensing, redomestications and mergers/acquisitions to Recommendation A or B is to ensure that states have effective processes in place that other states may rely on when these functions are performed. A quality review of each filing includes assessing the financial solvency of the company to ensure the interests of the policyholders are met. These filings promote interstate communication and coordination, which are key elements of effective solvency regulation and an area of increased focused as holding company assessments, supervisory colleges and other coordinated efforts increase the effectiveness of regulation.

In addition, the Form A Database provides a system to communicate whether any similar or related Form A has been approved, denied or withdrawn from another state. The purpose of this database is to: 1) facilitate the communication of actions taken by the states on all Form A filings; and 2) facilitate the coordination of Form A reviews in an attempt to avoid the duplication of regulatory processes via a Web-based application. This database will assist insurance regulators by producing a streamlined regulatory process that maintains the integrity of state holding company laws, while being responsive to a dynamic and evolving industry.

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

States place significant reliance on the work of another state’s review and approval/denial of a primary application for a new company or redomestication or a Form A filing. Elements within the standard such as review of items submitted by the company along with communication between states enhance the system of state-based regulation. Reliance is most effective when states have comfort that other states are in compliance with the minimum uniform standards.

In addition to increasing the uniformity of review, the updated guidelines are designed to enhance the value of the Form A Database. As of December 2018, a substantial number of Form A filings had not been updated in over a year, likely due to delays outside the state’s control. The revised guidelines will require a status update in the Form A Database at least once every six months. With more current information available, states have more tools to avoid fraudulent or questionable acquisitions that could lead to insolvency of an insurer.

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

Part D initially became effective for accreditation in 2012 as an “unscored” section of the accreditation program. This meant that a state could not fail accreditation based solely on the lack of compliance with these standards. If deficiencies were noted, the review team would provide management comments to the state insurance department, requesting the state to consider improvements as needed, but Part D would not factor into a state’s accredited status. Because state’s have been subject to this section since 2012, there is already a base level of compliance. Including the standards in the review team’s recommendation appropriately elevates the importance of the reliance placed on these processes.

Note: The accreditation program moved from a scoring system to a recommendation system effective January 1, 2017.

A statement as to the provisions needed to meet the minimum requirements of the standard:

Revised standards and guidelines for Part D are attached.
Preamble for Part D

The focus of the Part D standards is on strengthening financial regulation and the prevention of unlicensed or fraudulent activities. The scope of this section only includes primary applications for the licensing of new companies and redomestications, and Form A filings. The section applies to traditional life/health and property/casualty companies, and this scope is narrower than that of Part B in that it does not include entities such as health maintenance organizations, health service plans, and captive insurers (including captive risk retention groups). These standards only deal with the department’s analysis of domestic companies or those applying for redomestication, and do not include foreign or alien insurers. The initial company licensing process does not consider the “multi-state” concept since the company is in its initial licensing phase. The standards regarding primary applications for redomestications, and Form A filings deal with only those filings submitted that are related to multi-state insurers, as that term is defined in the Part B Preamble.

Part D: Organization, Licensing and Change of Control of Domestic Insurers

a. Sufficient Qualified Staff and Resources

Standard: The department should have the appropriate staff and resources to effectively and timely review applications for primary licensure of new companies and redomestications, and Form A filings for all domestic insurers.

Results-Oriented Guidelines:

1. The department should have qualified staff with appropriate skill sets, abilities, knowledge and experience levels to satisfactorily and effectively perform a thorough review of applications for primary licensure of new companies and redomestications, and Form A filings. When assessing whether a department has qualified staff and resources, consideration should be given to the quality of work performed by department staff as documented in the files.

2. The review of applications for primary licensure of new companies and redomestications, and Form A filings should be completed timely, as described by department procedures as discussed in the Compliance Guidelines process-oriented guidelines. If the review was not completed timely, the department should document the reasons for such, and the review team may take extenuating circumstances into consideration.

Process-Oriented Guidelines:

1. The department staff responsible for reviewing the applications for primary licensure of new companies and redomestications, and Form A filings should have an accounting, insurance, financial analysis and/or actuarial background. College degrees should focus on accounting,
insurance, finance or actuarial science. Professional designations and credentials may also
demonstrate expertise in insurance and/or financial analysis.

2. The department should have a policy that establishes timing requirements for the review of
applications for primary licensure of new companies and redomestications, and Form A filings.
The policy should include timing expectations for initial review from date of receipt,
notification to the insurer, and completion of the review. The policy should account for any
requirements mandated by the state’s statute or regulation. The use of the Company Licensing
Best Practices Handbook is considered acceptable.

The department should review applications for primary licensure of new companies and
redomestications, and Form A filings within 30 days of receipt. If additional or supplementary
information is needed from the insurer based on the initial review for completeness, the insurer
should be notified of such within 45 days of receipt of the application.

3. For primary applications of new companies and redomestications, the review should be
completed in accordance with timing requirements mandated by the state’s statute or
regulation, unless the state’s statutes or regulations do not specify timing requirements, in
which case, the review should be completed within 90 calendar days of receipt. A review of
an application is complete once the insurer is notified of approval or denial. If additional
information not originally requested in the application is needed to finalize the review of the
application, the review may take longer to complete. Once a request for information is made,
the timing requirement is suspended until the information is received from the applicant.

For Form A filings, the review of the primary application or Form A should be completed in
accordance with timing requirements mandated by the state’s statute or regulation.

b. Scope and Performance of Procedures for Primary Applications

Standard: The department should have documented licensing procedures to provide for
consistency in the review process and to ensure that appropriate procedures are performed on all
primary applications. The use of the Company Licensing Best Practices Handbook is considered
acceptable.

Results-Oriented Guidelines:
1. The review process should adequately assess primary applications and allow the department
to reach appropriate conclusions regarding whether the primary applications are approved or
denied.

Process-Oriented Guidelines:
1. The department should review and document its assessment of each of the following:
   - Business and strategic plans.
   - Pro forma financial projections.
   - Adequacy of proposed reinsurance program.
   - Adequacy of investment policy.
   - Adequacy of short-term and long-term financing arrangements:
- Initial financing of proposed operations or transactions.
- Maintenance of adequate capital and surplus levels.
- Biographical affidavits
- Assessment of the quality and expertise of the following:
  - Ultimate controlling person.
  - Proposed officers and directors.
  - Appointed actuary.
  - Appointed accountant.
- Related party agreements’ compliance with Statement of Statutory Accounting Principles (SSAP) No. 25—Affiliates and Other Related Parties.

2. The department should review the NAIC Form A and Special Activities Database (SAD) Market Action Tracking System (MATS) databases for related information about the primary applicant and other key persons.

c. Scope and Performance of Procedures for Redomestications

Standard: The department should have documented procedures for the review of redomestication applications to provide for consistency in the review process and to ensure that appropriate procedures are performed for all redomestications. The use of the Company Licensing Best Practices Handbook and/or Financial Analysis Handbook are considered acceptable.

Results-Oriented Guidelines:
1. The review process should adequately assess the redomestication application and accompanying information to effectively allow the department to reach appropriate conclusions regarding whether a redomestication application is approved or denied.

2. The department should effectively communicate with the domestic state to gain an understanding of the reasons for redomestication and any concerns of the domestic state. Any concerns raised should be assessed and documented with rationale to support the conclusion.

Process-Oriented Guidelines:
1. The department should review the application and accompanying information and document, at a minimum, its assessment of each of the following:
   - Business and strategic plans of the insurer.
   - Actuarial Opinion
   - Annual and Quarterly statements
   - Risk-based capital (RBC) report
   - Independent CPA audit report
   - Insurance Holding Company System Annual Registration Statement and Exhibits (Form B)
   - Assessment of senior management, board of directors and corporate governance
2. The department should meet with the domestic regulator to obtain, discuss, and conclude on, at a minimum, the items listed below. The meeting should be held via conference call; an email exchange alone is not considered sufficient.
   - Most recent Insurer Profile Summary (IPS) and supervisory plan, including supporting analysis detail for significant risks
   - Reason for redomestication
   - Concerns identified with the insurer/group
   - History of communication with the insurer/group
   - History of regulatory actions
   - Results of recent examinations (financial and market conduct), including findings and resolutions
   - Status of and responsibilities for annual financial analysis and group analysis, if applicable
   - Status of and responsibilities for the financial examinations

3. The department should notify the lead state of the insurance holding company group of receipt of a primary application for redomestication and obtain a copy of the most recent Group Profile Summary (GPS), if applicable.

de. Scope and Performance of Procedures for Form A Filings

Standard: The department should have documented procedures for the review of Form A filings to provide for consistency in the review process and to ensure that appropriate procedures are performed on all Form A filing reviews. The use of the Company Licensing Best Practices Handbook and/or Financial Analysis Handbook is considered acceptable.

Results-Oriented Guidelines:
1. The review process should be designed to adequately assess the Form A filings and accompanying information and to effectively allow the department to reach appropriate conclusions regarding whether the Form A filings are approved or denied.

Process-Oriented Guidelines:
1. The department should review and document its assessment of each of Form A filings should include the following:
   - Business and strategic plans of the insurer.
   - Identity and background of the applicant and individuals associated with the applicant including use of biographical affidavits to assess the quality and expertise of the following:
     - Ultimate controlling person
     - Proposed officers and directors (as listed on Jurat Page of most recent or upcoming financial statement)
     - Other owners of 10% or more of voting securities
   - The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control.
• Fully audited financial information regarding the earnings and financial condition of the acquiring parties for the preceding five years. If fully audited financial information is not available, substantially similar information such as compiled financial statements or tax returns, as deemed acceptable to the commissioner, may be reviewed in lieu of fully audited financial information.

• Unaudited financial information regarding the earnings and financial condition of the acquiring parties as of a date not earlier than 90 days prior to the filing of the Form A.

2. The department should utilize and update the Form A Database for prior filings made by the Form A applicant and the ultimate outcome of such filing(s).

3. Pertinent and relevant information from the Form A filing should be manually entered into the Form A Database within 10 business days of receipt of the Form A.

4. Any changes to the status of the filing or other data elements should be entered into the Form A Database within 10 business days.

4.5. If the progress of a filing stalls, the Form A database should be updated at a minimum every six months to confirm the status of the filing and document the reason the filing has stalled.
State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Executive (EX) Committee

- Adoption of the new Insurance Data Security Model Law (#668)—This model was adopted by the Executive (EX) Committee and Plenary at the 2017 Fall National Meeting. Eight states have enacted this model.

Life Insurance and Annuities (A) Committee

- Amendments to the Standard Nonforfeiture Law for Individual Deferred Annuities (#805)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Summer National Meeting. One state has enacted these revisions to the model.

Health Insurance and Managed Care (B) Committee

- Amendments to the Health Insurance Reserves Model Regulation (#10) (Cancer Expense Table)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Spring National Meeting. Two states have enacted these revisions to the model.

- Amendments to the Health Carrier Prescription Drug Benefit Management Model Act (#22)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2018 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Accident and Sickness Insurance Minimum Standards Model Act (#170), now known as the Supplementary and Short-Term Health Insurance Minimum Standards Model Act—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2019 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Adoption of the Limited Long-Term Care Insurance Model Act (#642)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Adoption of the Limited Long-Term Care Insurance Model Regulation (#643)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

Property and Casualty Insurance (C) Committee

- Adoption of the Travel Insurance Model Act (#632)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. Six states have enacted this model.

Market Regulation and Consumer Affairs (D) Committee

- Amendments to the Privacy of Consumer Financial and Health Information Regulation (#672)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Spring National Meeting. Eleven states have enacted these revisions to the model.

Financial Condition (E) Committee

- Amendments to the Credit for Reinsurance Model Law (#785)—These revisions were adopted by the Executive (EX) Committee and Plenary during the June 26, 2019 conference call. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Credit for Reinsurance Model Regulation (#786)—These revisions were adopted by the Executive (EX) Committee and Plenary during its June 26, 2019 conference call. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Term and Universal Life Insurance Reserve Financing Model Regulation (#787)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2016 Fall National Meeting. Four states have enacted this model.
EXECUTIVE (EX) COMMITTEE

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Executive (EX) Committee
Austin, Texas
December 8, 2019

The Executive (EX) Committee met in Austin, TX, Dec. 8, 2019. The following Committee members participated: Eric A. Cioppa, Chair (ME); Raymond G. Farmer, Vice Chair (SC); David Altmaier, Vice President (FL); Dean L. Cameron, Secretary-Treasurer (ID); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Stephen C. Taylor (DC); Chlora Lindley-Myers (MO); Mike Chaney (MS); Jillian Froment (OH); Andrew R. Stolfi (OR); Jessica Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry Deiter (SD); and Scott A. White (VA).

1. **Adopted the Report of the Executive (EX) Committee and Internal Administration (EX1) Subcommittee Joint Meeting**

Superintendent Cioppa reported the Executive (EX) Committee met Dec. 7 in joint session with the Internal Administration (EX1) Subcommittee. The meeting was held in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings.

During this joint meeting, the Committee and Subcommittee adopted its Nov. 18, Oct. 7 and Summer National Meeting minutes.

The Committee and Subcommittee adopted the Internal Administration (EX1) Subcommittee’s Nov. 26 and Oct. 18 minutes, which included the following action: 1) received an update on the Defined Benefit Plan portfolio as of Sept. 30; 2) received an update on the NAIC long-term investment plan portfolio as of Sept. 30; 3) ratification of the vote to begin restructuring the Defined Benefit Plan portfolio to implement the liability driven investment (LDI) strategy; and 4) approved the 2020 proposed charges for the Internal Administration (EX1) Subcommittee and the Information Systems (EX1) Task Force.

The Committee and Subcommittee adopted the Dec. 3 Audit Committee report, which included the following action: 1) received an overview of the Oct. 31 financial statements; 2) received an update on the 2019/2020 Service Organization Control (SOC) 1 and SOC 2 reviews and reports; 3) received an update on database filing fee payments; and 4) received an update on zone financials.

The Committee and Subcommittee adopted the Dec. 6 Information Systems (EX1) Task Force report, which included the following action: 1) received an update on three draft 2020 fiscals with a technology component; 2) received an operational report for the NAIC’s information technology (IT) activities; 3) received an update on 20 active projects and a summary of three projects completed since the Summer National Meeting; and 4) reaffirmed the Audit Committee Charter.

The Committee and Subcommittee also: 1) approved a recommendation on a vendor and funding to conduct a System for Electronic Rate and Form Filing (SERFF) assessment; 2) approved the release of a fiscal to conduct a principal-based reserve (PBR) yearly renewable term (YRT) reinsurance study for public review and comment; 3) heard a presentation on the NAIC branding project, which includes updating the NAIC logo; 4) received the joint chief executive officer (CEO)/chief operating officer (COO) report; and 5) received a cybersecurity briefing.

Commissioner Altmaier made a motion, seconded by Director Froment, to adopt the report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee. The motion passed.

2. **Adopted its Nov. 18, Oct. 8 and Oct. 7 Interim Meeting Report**

Commissioner Altmaier made a motion, seconded by Director Lindley-Myers, to adopt the Executive (EX) Committee’s Nov. 18, Oct. 8 and Oct.7 interim meeting report (Attachment One). The motion passed.

3. **Adopted the Reports of its Task Forces**

The Committee received reports from the: Financial Stability (EX) Task Force; the Government Relations (EX) Leadership Council; the Innovation and Technology (EX) Task Force and the Long-Term Care Insurance (EX) Task Force.
Commissioner Altmaier made a motion, seconded by Director Wing-Heier, to adopt the reports of the Financial Stability (EX) Task Force, the Government Relations (EX) Leadership Council, the Innovation and Technology (EX) Task Force and the Long-Term Care Insurance (EX) Task Force (Attachment Two). The motion passed.

3. **Adopted its 2020 Proposed Charges**

Director Farmer reported that the Committee’s 2020 proposed charges for consideration are largely the same from year to year. The Executive (EX) Committee Task Forces will be continuing important work on long-term care insurance (LTCI), financial stability, and innovation and technology.

Director Farmer made a motion, seconded by Commissioner Altmaier, to adopt the Committee’s 2020 proposed charges (Attachment Three). The motion passed.

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

Commissioner Altmaier reported that the Request for NAIC Model Law Development to develop amendments to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) is from the Financial Condition (E) Committee and the Group Capital Calculation (E) Working Group. The Working Group has been developing the group capital calculation (GCC) for some time, and while the calculation is not yet complete, testing of the calculation has recently been completed by 32 volunteer insurers and 15 lead states. The goal is to finalize the calculation in 2020 and have the corresponding models ready to go with it.

Commissioner Altmaier made a motion, seconded by Director Farmer, to adopt the Request for NAIC Model Law Development to develop amendments for Model #440 and Model #450 (Attachment Four). The motion passed.

5. **Adopted the Request to Develop Amendments to the Unfair Trade Practices Act (#880)**

Commissioner Godfread reported that the Innovation and Technology (EX) Task Force adopted a Request for NAIC Model Law Development to develop amendments to the Unfair Trade Practices Act (#880) during its Oct. 18 meeting. Anti-rebating laws have existed in some states for a very long time, originally to ensure company solvency while also leveling the playing field for insurers and preventing unfair trade practices and discrimination. The intent was to prevent insurers and producers from providing an insured or a prospective insured with anything of value not specified or contained in the policy that may act as an inducement to purchase insurance.

The Innovation and Technology (EX) Task Force began discussing rebating issues in 2018 during the Summer National Meeting particularly because of the increased interest in offering value-added products and services such as risk mitigation devices and related services that are not necessarily addressed within the applicable insurance policy language.

After finding that state interpretation and application of anti-rebating laws varies and reviewing the history of Model #880 along with the history and the intent of the anti-rebating portion, it became clear to the Task Force that applying the anti-rebating laws to the innovation of new insurance products and services could be challenging.

During the Summer National Meeting, the Task Force voted to move forward with the Request for NAIC Model Law Development to open Model #880 to amend the language in Section 4(H)(1) - Unfair Trade Practices Defined-Rebates.

Commissioner Altmaier made a motion, seconded by Director Wing-Heier, to adopt the Request for NAIC Model Law Development to develop amendments to Model #880 (Attachment Five). The motion passed.

7. **Received a Status Report on the NAIC State Ahead Strategic Plan Implementation**

Superintendent Cioppa provided an update on the NAIC State Ahead implementation efforts (Attachment Six) highlighting the projects completed and underway in the themes of safe, solvent and stable markets; consumer protection and education; and superior member services and resources. Through State Ahead, the NAIC has made significant enhancements in regulator training and tools, consumer education, member engagement and support, technology, and NAIC talent development.
8. **Received a Report of Model Law Development Efforts**

Superintendent Cioppa presented a written report on the progress of ongoing model law development efforts (Attachment Seven).

9. **Heard a Report from the NIPR Board of Directors**

Director Deiter reported the National Insurance Producer Registry (NIPR) Board of Directors met Dec. 6 and heard a report from the NIPR Audit Committee regarding NIPR’s financials through October 2019. The Board also heard a report of the Investment Committee. The NIPR Long-Term Investment Portfolio climbed +0.4% for the third quarter.

The NIPR Board approved NIPR’s 2020 budget, with projected revenues of $46.1 million and projected expenses of $43.3 million. The NIPR Board also heard on update on the progress of implementing NIPR’s strategic plan, which will be completed in 2020. In addition to the general progress on the plan, two major strategic initiatives have been accomplished this year.

In September, NIPR added Florida for resident licensing for individual insurance producers, and it is anticipated that Florida’s resident and non-resident business entities will be available before the end of 2019. This leaves only five remaining states to add for NIPR’s major licensing services.

Another major accomplishment this year was a joint NAIC/NIPR security infrastructure initiative, Data De-identification. The joint project was part of the *State Ahead* initiative and involved extensive work to protect Personally Identifiable Information (PII) by masking or de-identifying the PII data in a consistent manner for all NAIC and NIPR non-production technical environments.

NIPR will launch a new and improved website in January, designed to provide easier navigation and improve the user experience.

In addition to the progress on the strategic plan, the Board also received a report on the NAIC and NIPR’s ongoing cybersecurity initiatives. Finally, the Board heard from KC Tech Council CEO, Ryan Weber, on current employment trends in the Kansas City technical industry.

NIPR anticipates that it will have processed more than $726 million in producer licensing-related fees on behalf of the states by yearend. This represents an 8% increase over fees collected on behalf of the states last year.

10. **Heard a Report from the Compact**

Director Froment reported the Interstate Insurance Product Regulation Commission (Compact) will meet Dec. 9. The Compact members have spent this past year engaged in a member-driven strategic planning process. The Compact has conducted member surveys and had four in-person discussions. This effort has culminated in a draft strategic plan, available on its website, that the Compact will discuss during its meeting and hopefully finalize. The Compact is planning to refer to it as the Insurance Compact Compass as it will guide the course of the Compact over the next three years.

The Compact will also consider the adoption of three group annuity standards; this is a new product line the Compact will have available for filing in 2020.

The Compact will consider the annual budget package for adoption, which includes a request for a new position dedicated to member services in support of the strategic plan initiatives.

The Compact will put in place the Management Committee for next year and hold its annual election of officers.

The Compact will also be releasing a report on Compact-Approved Individual Long-Term Care Rate Schedule Certifications. The purpose of the report is to share the aggregate information with respect to the review of the 2018 annual and triennial rate certifications for Compact-approved individual LTCI rate schedules.

The Compact is experiencing another record year of growth in terms of the number of companies using the Compact and in the volume of filing submissions. The Compact exceeded its budgeted revenue as of the end of September and expects to come in under budget in expenses. This is a unique set of circumstances for this year as every life company must prepare for the...
implementation of principle-based reserving (PBR) by updating their life products to the 2017 Commissioners’ Standard Ordinary (CSO) Mortality Tables.

Regarding the $3.4 million line of credit the NAIC made available to the Compact (2007 to 2012 that has been in a deferred status), the Compact will meet one of the repayment triggers this year as its net positive revenue will exceed $250,000 by yearend.

The Compact officers and NAIC officers are restructuring the terms of repayment, which currently require repayment of the entire amount within five years and expect the organizations to reach an agreement on a restructuring of the Compact debt by the time the first payment is due at the end of the first quarter in 2020.

Having no further business, the Executive (EX) Committee adjourned.
The Executive (EX) Committee met Nov. 18, Oct. 8 and Oct. 7, 2019. These meetings were held in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During these meetings, the Committee:

1. Approved the NAIC 2020 proposed budget, and recommended the budget be adopted by the full NAIC membership at the Fall National Meeting.

2. Approved recommendations for the NAIC’s Defined Benefit Plan Fund Investments.

3. Adopted the investment policy statement (IPS) for the NAIC’s Long-Term Funds.

4. Adopted the IPS for the NAIC’s defined benefit plan and the defined contribution plan.


6. Adopted the Internal Administration (EX1) Subcommittee’s 2020 proposed charges.

7. Approved the NAIC 2020 proposed budget, including five fiscals, for a public comment period ending Nov. 7.
REPORT OF THE EXECUTIVE (EX) COMMITTEE TASK FORCES

Financial Stability (EX) Task Force—The Financial Stability (EX) Task Force plans to meet Dec. 9 to: 1) consider adoption of its Summer National Meeting minutes; 2) consider adoption of the minutes of the Liquidity Assessment (EX) Subgroup; 3) hear an update on Financial Stability Oversight Council (FSOC) developments; 4) consider a joint exposure of the 2019 proposed liquidity stress test with the Liquidity Assessment (EX) Subgroup; 5) receive an update from the Receivership and Insolvency (EX) Task Force on its work to address the Financial Stability (EX) Task Force’s referral letter to undertake analysis relevant to the NAIC Macroprudential Initiative (MPI); 6) hear an update on collateralized loan obligations (CLO) stress tests; and 7) hear an update on macroprudential surveillance.

Government Relations (EX) Leadership Council—The Government Relations (EX) Leadership Council did not meet at the Fall National Meeting. The Leadership Council meets weekly via conference call in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss federal legislative and regulatory developments affecting insurance regulation.

Innovation and Technology (EX) Task Force—The Innovation and Technology (EX) Task Force plans to meet Dec. 9 to: 1) consider adoption of its Oct. 18 minutes; 2) consider adoption of its working group reports and hear a report on the activities of the Innovation and Technology State Contact Group; 3) discuss a draft bulletin from North Dakota addressing a specific interpretation of its statutory language considering anti-rebating issues and whether to pursue an NAIC model bulletin; 4) discuss the next steps for developing model law language to amend the Unfair Trade Practices Act (#880); 5) hear an update on cybersecurity activity, including a legislative update and briefing on data privacy activity from the Privacy Protections (D) Working Group chair, Director Chlora Lindley-Myers (MO); and 6) discuss working on an educational document on insurance products and regulation for InsurTech startups; and 7) hear a report from the National Conference of Insurance Legislators (NCOIL) on its insurance modernization activity.

The Artificial Intelligence (EX) Working Group met Sept. 5 and decided to take comments on if it would be appropriate to base artificial intelligence (AI) principles for the insurance industry on the Organisation for Economic Co-operation and Development (OECD) AI principles, and if so, how they might be revised to be more relevant for the insurance industry. The Working Group also met Dec. 7 and discussed those comments and next steps for continuing the development of principles for the insurance industry.

The Big Data (EX) Working Group met Oct. 7 and took the following action: 1) adopted its Summer National Meeting minutes; and 2) heard presentations from the Insurance Services Office (ISO) on the use of data to detect fraud and settle property/casualty (P/C) claims. The Working Group also met Dec. 7 and took the following action: 1) adopted its Oct. 7 minutes; 2) discussed the use of data in fraud detection and claim settlements; 3) received an update from the Casualty Actuarial and Statistical (C) Task Force regarding its draft white paper on best practices for the review of predictive models and analytics filed by insurers to justify rates, the development of state guidance (e.g., information and data) for rate filings that are based on complex predictive models, and the development of training for the sharing of expertise through predictive analytics webinars; 4) received an update on the work of the Accelerated Underwriting (A) Working Group; 5) received an update on NAIC technical and non-technical rate review trainings; and 6) received a presentation on entities not licensed as advisory organizations.

The Speed to Market (EX) Working Group did not meet at the Fall National Meeting. The Working Group met via conference call Dec. 3 and Sept. 12. During its Sept. 12 meeting, the Working Group: 1) heard and discussed a presentation by Joy E. Morrison (NAIC), Bridget Kieras (NAIC) and Brandy Woltkamp (NAIC) regarding prioritization of the System for Electronic Rate and Form Filing (SERFF) enhancements regarding submission validations, review tools, workload management, performance and reliability, search, document management, reporting and data export, streamlined correspondence, and user experience. After the meeting, a survey was sent to all the states seeking feedback on which SERFF enhancement capabilities were the most important to them. During its Dec. 3 meeting, the Working Group: 1) adopted its Sept. 12 minutes; and 2) received an update from Ms. Kieras regarding an upcoming business and technical assessment of SERFF, as well as the survey sent in September. Survey results have been received and continue to be reviewed. Some items from the survey are already being worked into the SERFF analysis and development process, and some are being moved through the development pipeline.
Long-Term Care Insurance (EX) Task Force—The Long-Term Care Insurance (EX) Task Force plans to meet Dec. 9 to:
1) consider adoption of its Oct. 31 and Summer National Meeting minutes; 2) receive a progress report on the activities of each of the Task Force’s six workstreams: a) the rate review practices workstream is refining a set of selection principles and criteria for guiding the development of a recommended rate review methodology; b) the restructuring techniques workstream is developing its strategic plan; c) the reduced benefit options and consumer notices workstream completed a survey of the states and is reviewing results with plans to develop best practices; d) the valuation of reserve issues workstream continues to monitor actuarial review work and solvency monitoring of long-term care insurance (LTCI) companies, and to develop additional state insurance regulator guidance related to reserve assumptions; e) the non-actuarial considerations workstream completed a limited scope survey of the states and is reviewing results with plans to develop best practices; and f) the data call design and oversight workstream has issued a request for proposal to develop a data call; and 3) hear from consumer and industry representatives on the progress of workstream activity.
2020 Proposed Charges for Executive (EX) Committee consideration

Draft: 10/16/19
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Executive (EX) Committee, Dec. 8, 2019

2020 Proposed Charges

EXECUTIVE (EX) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Executive (EX) Committee will:
   A. Identify the goals and priorities of the organization and make recommendations to achieve such goals and priorities based on input of the membership. Make recommendations by the 2020 Commissioners Conference.
   B. Create/terminate task force(s) and/or Executive (EX) Committee-level working groups to address special issues and monitor the work of these groups. Create necessary task force(s) and/or Executive (EX) Committee-level working groups throughout 2020 as necessary.
   C. Submit reports and recommendations to NAIC members concerning the activities of its subcommittee and the standing committees. Submit a report at each national meeting.
   D. Consider requests from NAIC members for friend-of-the-court briefs.
   E. Establish and allocate functions and responsibilities to be performed by each NAIC zone.
   F. Pursuant to the Bylaws, oversee the NAIC offices to assist the organization and the individual members in achieving the goals of the organization.
   G. Conduct strategic planning on an ongoing basis.
   H. Plan, implement and coordinate communications and activities with the Federal Insurance Office (FIO).
   I. Plan, implement and coordinate communications and activities with other state, federal, local and international government organizations to advance the goals of the NAIC and promote understanding of state insurance regulation.
   J. Review and approve requests for the development of model laws and/or regulations. Coordinate the review of existing model laws and/or regulations.
   K. Select NAIC national meeting sites five and six years in advance of the meeting date to ensure efficient and economical locations and facilities.
   L. Review and revise, as necessary and appropriate, the criteria and categories for registrants at NAIC national meetings.

NAIC Support Staff: Andrew J. Beal/Kay Noonan
2020 Proposed Charges for Executive (EX) Committee consideration

Draft: 10/4/19
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Executive (EX) Committee, Dec. 8, 2019
Adopted by the Financial Stability (EX) Task Force, Oct. 2, 2019

2020 Proposed Charges

FINANCIAL STABILITY (EX) TASK FORCE

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

Ongoing Support of NAIC Program, Products or Services

1. The Financial Stability (EX) Task Force will:
   A. Consider issues concerning domestic and global financial stability as they pertain to the role of state insurance regulators and make recommendations to the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council, and/or the Executive (EX) Committee, as appropriate.
      1. Analyze existing post-financial crisis regulatory reforms for their application in identifying macroeconomic trends, including identifying possible areas of improvement or gaps, and propose to the Financial Condition (E) Committee or other relevant committee enhancements and/or additions to further improve the ability of state insurance regulators and the industry to address macroprudential impacts; consult with such committees on implementation, as needed.
   B. Consider state insurance regulators’ input to national and international discussions on macroeconomic vulnerabilities affecting the insurance sector.
      1. Monitor international macroprudential activities at forums like the International Association of Insurance Supervisors (IAIS).
      2. Implement the Macroprudential Initiative (MPI) domestically, which includes enhancements to the U.S. regulatory toolkit as part of the State Ahead initiative.
   C. Serve as a forum to coordinate state insurance regulators’ perspectives on a wide variety of issues arising from the designation of a U.S. insurance group as “systemically important” and “internationally active” both pre- and post-designation, including:
      1. Where appropriate, develop policy recommendations and/or guidance regarding the role, responsibilities and activities of state insurance regulators in the context of consolidated supervision resulting from designation.
      2. Analyze proposed rules by the federal agencies that relate to financial stability.
      3. Analyze proposed policy measures regarding supervisory standards for global systemically important insurers and internationally active insurance groups.
      4. Develop comment letters on such analysis for further consideration by the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council, and/or the Executive (EX) Committee, as appropriate.

2. The Liquidity Assessment (EX) Subgroup will:
   A. Review existing public and regulator-only data related to liquidity risk, identify any gaps based on regulatory needs and propose the universe of companies to which any recommendations may apply.
   B. Refine and implement a liquidity stress testing framework proposal for consideration by the Financial Condition (E) Committee, including the proposed universe of companies to which the framework will apply (e.g., large life insurers).

NAIC Support Staff: Elise Liebers/John Hopman/Mark Sagat/Todd Sells/Tim Nauheimer
2020 Proposed Charges for Executive (EX) Committee consideration

Draft: 10/7/19
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Executive (EX) Committee, Dec. 8, 2019
Adopted by the Government Relations (EX) Leadership Council, Oct. 11, 2019

2020 PROPOSED CHARGES
GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

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

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Ethan Sonnichsen/Mark Sagat/Brian R. Webb
2020 Proposed Charges for Executive (EX) Committee consideration

Draft: 10/18/19
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Executive (EX) Committee, Dec. 8, 2019
Adopted by the Innovation and Technology (EX) Task Force, Oct. 18, 2019

2020 PROPOSED CHARGES

INNOVATION AND TECHNOLOGY (EX) TASK FORCE

The mission of the Innovation and Technology (EX) Task Force is to provide a forum for regulator education and discussion of innovation and technology in the insurance sector, to monitor technology developments that affect the state insurance regulatory framework, and to develop regulatory guidance, as appropriate.

Ongoing Support of NAIC Programs, Products or Services

1. The Innovation and Technology (EX) Task Force will:
   A. Provide forums, resources and materials for the discussion of innovation and technology developments in the insurance sector, including the collection and use of data by insurers and state insurance regulators—as well as new products, services and distribution platforms—in order to educate state insurance regulators on how these developments affect consumer protection, privacy, insurer and producer oversight, marketplace dynamics and the state-based insurance regulatory framework.
   B. Develop regulatory guidance, model laws or model law revisions, and white papers or make other recommendations to the Executive (EX) Committee, as appropriate.
   C. Monitor and discuss regulatory issues that arise with the development of autonomous vehicles. Study and, if necessary, develop recommendations for changes needed to the state-based insurance regulatory framework.
   D. Discuss emerging issues related to companies or licensees leveraging new technologies to develop products for on-demand insurance purposes—in addition to potential implications on the state-based insurance regulatory structure—including, but not limited to, reviewing new products and technologies affecting the insurance space and the associated regulatory implications.
   E. Monitor developments in the area of cybersecurity, including the implementation of the Insurance Data Security Model Law (#668) and representing the NAIC and communicating with other entities/groups, including sharing information as may be appropriate.
   F. Coordinate with other NAIC committees and task forces, as appropriate, on technology, innovation, cybersecurity issues and data privacy.

2. The Big Data (EX) Working Group will:
   A. Review current regulatory frameworks used to oversee insurers’ use of consumer and non-insurance data. If appropriate, recommend modifications to model laws and/or regulations regarding marketing, rating, underwriting and claims, regulation of data vendors and brokers, regulatory reporting requirements, and consumer disclosure requirements.
   B. Propose a mechanism to provide resources and allow the states to share resources to facilitate their ability to conduct technical analysis of, and data collection related to, the review of complex models used by insurers for underwriting, rating and claims. Such a mechanism shall respect and in no way limit the states’ regulatory authority.
   C. Assess data needs and required tools for state insurance regulators to appropriately monitor the marketplace and evaluate underwriting, rating, claims and marketing practices. This assessment shall include gaining a better understanding of currently available data and tools, as well as recommendations for additional data and tools, as appropriate. Based on this assessment, propose a means to collect, house and analyze needed data.
2020 Proposed Charges for Executive (EX) Committee consideration

INNOVATION AND TECHNOLOGY (EX) TASK FORCE (continued)

3. The **Speed to Market (EX) Working Group** will:
   A. Consider proposed System for Electronic Rate and Form Filing (SERFF) features or functionality presented to the Working Group by the SERFF Advisory Board, likely originating from the SERFF Product Steering Committee. Upon approval and acquisition of any needed funding, direct the SERFF Advisory Board to implement the project. Receive periodic reports from the SERFF Advisory Board, as needed.
   B. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed to market operational efficiencies related to product filing needs, efficiencies and effective consumer protection. This includes the following activities:
      1. Provide a forum to gather information from the states and the industry regarding tools, policies and resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency issues for state insurance regulators and the industry, particularly with regard to uniformity. In 2020, evaluate the state survey results compiled in 2019 regarding the usefulness of existing tools and potential new tools and propose a plan to make improvements.
      2. Use SERFF data to develop, refine, implement, collect and distribute common filing metrics that provide a tool to measure the success of the speed to market modernization efforts as measured by nationwide and individual state speed to market compliance, with an emphasis on monitoring state regulatory and insurer responsibilities for speed to market for insurance products.
      3. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal document (UTD) on an annual basis, including the review, approval and notification of changes. Monitor, assist with and report on state implementation of any PCM changes.
      4. Facilitate the review and revision of the *Product Filing Review Handbook*, which contains an overview of all of the operational efficiency tools and describes best practices for industry filers and state reviewers with regard to the rate and form filing and review process. In 2020, develop and implement a communication plan to inform states about the *Product Filing Review Handbook*.
   C. Provide direction to NAIC staff regarding SERFF functionality, implementation, development and enhancements. Direct NAIC staff to provide individual state speed to market reports to each commissioner at each national meeting. Receive periodic reports from NAIC staff, as needed.
   D. Conduct the following activities as desired by the Interstate Insurance Product Regulation Commission:
      1. Provide support to the Compact as the speed to market vehicle for asset-based insurance products, encouraging the states’ participation in, and the industry’s usage of the Compact.
      2. Receive periodic reports from the Compact, as needed.

4. The **Artificial Intelligence (EX) Working Group** will:
   A. Study the development of artificial intelligence (AI), its use in the insurance sector, and its impact on consumer protection and privacy, marketplace dynamics, and the state-based insurance regulatory framework. The Working Group will develop regulatory guidance, beginning with guiding principles, and make other recommendations to the Innovation and Technology (EX) Task Force as appropriate by the 2020 Summer National Meeting.

NAIC Support Staff: Scott Morris/Denise Matthews
2020 Proposed Charges for Executive (EX) Committee consideration

Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Executive (EX) Committee, Dec. 8, 2019
Adopted by the Long-Term Care Insurance (EX) Task Force, Oct. 31, 2019

2020 Proposed Charges

LONG-TERM CARE INSURANCE (EX) TASK FORCE

The Long-Term Care Insurance (EX) Task Force will:

A. Recognizing the gravity of the threat posed by the current long-term care insurance (LTCI) environment both to consumers and our state-based system of insurance regulation, this Task Force is charged to:
   1. Develop a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.
   2. Identify options to provide consumers with choices regarding modifications to LTCI contract benefits where policies are no longer affordable due to rate increases.
   3. Deliver such a proposal to the Executive (EX) Committee by the 2020 Fall National Meeting.

B. Provide periodic reporting to the Long-Term Care Insurance (E/B) Task Force to help ensure coordination between the two task forces on LTCI issues.

Unless otherwise affirmatively extended or modified by the Executive (EX) Committee, the Task Force and its charges will expire Jan. 31, 2021.

NAIC Support Staff: Jeffrey C. Johnston
2020 Proposed Charges for Executive (EX) Committee consideration

Draft: 8/22/19
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Executive (EX) Committee, Dec. 8, 2019
Adopted by the Internal Administration (EX1) Subcommittee, Oct. 8, 2019

2020 Proposed Charges

INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Andrew J. Beal/Jim Woody
2020 Proposed Charges for Executive (EX) Committee consideration

Draft: 6/7/19
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Executive (EX) Committee, Dec. 8, 2019
Adopted by the Internal Administration (EX1) Subcommittee, Oct. 9, 2019
Adopted by the Information Systems (EX1) Task Force, Aug. 2, 2019

2020 PROPOSED CHARGES

INFORMATION SYSTEMS (EX1) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Cheryl McGee/Sherry Stevens
2020 Proposed Charges for Executive (EX) Committee consideration

Draft: 7/24/19
Reaffirmed by the Executive (EX) Committee and Plenary, TBD
Reaffirmed by the Executive (EX) Committee, Dec. 8, 2019
Reaffirmed by the Internal Administration (EX1) Subcommittee, Nov. 26, 2019
Reaffirmed by the Audit Committee, Aug. 2, 2019

2020 PROPOSED NAIC AUDIT COMMITTEE

Committee Charter

1. The Audit Committee will:
   A. Provide continuous audit oversight, including:
      1. Provide an open avenue of communication between the independent auditor and the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.
      2. Confirm and ensure the independence of the independent auditor.
      3. Inquire of management and the independent auditor about significant risks or exposures and assess the steps management has taken to minimize such risk.
      4. Consider and review with the independent auditor:
         a. Significant findings during the year, including the status of previous audit recommendations.
         b. Any difficulties encountered in the course of audit work, including any restrictions on the scope of activities or access to required information.
         c. The adequacy of internal controls, including computerized information system controls and security, as documented in the Statement on Auditing Standards (SAS) 115 letter from the independent auditor.
         d. Related findings and recommendations of the independent auditor with management’s responses, as documented in the SAS 114 letter from the independent auditor.
      5. Meet periodically with the independent auditor in separate executive sessions to discuss any matters the Committee believes should be discussed privately with the Committee.
      6. Report periodically to the Executive (EX) Committee and Internal Administration (EX1) Subcommittee on significant results of the foregoing activities.
      7. Instruct the independent auditor that the Executive (EX) Committee and Internal Administration (EX1) Subcommittee are the auditor’s clients.
   B. Provide continuous oversight of reporting policies, including:
      1. Advise financial management and the independent auditor that they are expected to provide a timely analysis of significant current financial reporting issues and practices.
      2. Inquire as to the auditor’s independent qualitative judgments about the appropriateness, not just the acceptability, of the accounting principles and the clarity of the financial disclosure practices.
      3. Inquire as to the auditor’s views about whether management’s choices of accounting principles are conservative, moderate or aggressive from the perspective of income, asset and liability recognition, and whether those principles are common practices or are minority practices.
      4. Inquire as to the auditor’s views about how choices of accounting principles and disclosure practices may affect NAIC members, the insurance industry, and public views and attitudes.
   C. Provide continuous oversight of financial management, including:
      1. Review the monthly consolidated financial statements and receive regular reports from executive management on the financial operations of the association.
      2. Meet prior to, or at, each national meeting, or more frequently as circumstances require. The Committee may ask members of management or others to attend meetings and provide pertinent information, as necessary.
      3. Report on significant results of the foregoing activities to the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee on a regular basis.
2020 Proposed Charges for Executive (EX) Committee consideration

D. Conduct scheduled audit activities, including:
   1. Recommend the selection of the independent auditor for approval by the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, approve the compensation of the independent auditor, and review and approve the discharge of the independent auditor.
   2. Review annually the audit scope and plan of the independent auditor with management and the independent auditor, including:
      a. The independent auditor’s audit of the financial statements, accompanying footnotes and its report thereon.
      b. Any significant changes required in the independent auditor’s audit plans.
      c. Any difficulties or disputes with management encountered during the course of the year under audit.
      d. Other matters related to the conduct of the audit, which are to be communicated to the Committee under generally accepted auditing standards (GAAS).
   3. Review and approve needs-based funding allocations, as needed.
   4. Review and update the Committee charter, on at least an annual basis.

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

NAIC Support Staff: Jim Woody
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

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

   Group Capital Calculation (E) Working Group

2. NAIC staff support contact information:

   Dan Daveline
ddaveline@naic.org
(816) 783-8134

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

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

   In 2015, the NAIC adopted the following charge to the Financial Condition (E) Committee who subsequently formed the Group Capital Calculation (E) Working Group to carry out such a change.

   “Construct a U.S. group capital calculation using an RBC aggregation methodology; liaise as necessary with the Comframe Development and Analysis (G ) Working Group on international capital developments and consider group capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation.”

   The Group Capital Calculation (E) Working Group has been developing the group capital calculation (GCC) since receiving its charge and in May, with the assistance of 33 insurance groups and 15 lead states, began testing the current construction. The lead states are currently reviewing the completed templates and take aways from the testing are expected to be summarized and discussed at the Fall National Meeting in Austin. Upon completion of the field-testing, state regulators will use the results to further improve the construction of the calculation and at this junction, the Working Group is striving to adopt the calculation sometime in 2020. In order to allow states to be able to adopt the GCC, the Working Group is seeking approval to modify the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). While the Working Group has not concluded the exact construct of such changes, the Working Group expects Section 4 of #440 will need to be revised to require a new filing and #450 will need to be revised to add the new filing and a related new section (Form G).
4. Does the model law meet the Model Law Criteria? ☑ Yes or ☐ No (Check one)

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

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

If yes, please explain why:

State insurance regulators currently perform group analysis on all U.S. insurance groups, including assessing the risks and financial position of the insurance holding company system based on currently available information. However, state regulators currently do not have the benefit of a consolidated statutory accounting system and financial statements to assist them in these efforts. The GCC is expected to fill this void since it requires an aggregation and display of the individual company’s available capital and operating figures. More specifically, the GCC and related reporting will provide more transparency to insurance regulators regarding the insurance group and make risks more identifiable and more easily quantified. In this regard, the tool will assist regulators in holistically understanding the financial condition of non-insurance entities, how capital is distributed across an entire group, and whether and to what degree insurance companies may be subsidizing the operations of non-insurance entities, potentially undermining the insurance company’s financial condition and/or placing upward pressure on premiums to the detriment of insurance policyholders. It is envisioned that this calculation will provide an additional early warning signal to regulators so they can begin working with a company to resolve any concerns in a manner that will ensure that policyholders will be protected. Importantly, the GCC will complement existing group supervisory tools already available to state insurance regulators, such as the Form F Enterprise Risk Report1, the Own Risk and Solvency Assessment Summary Report2 and the Form B Holding Company Filings3. As such, we would expect it to be a national standard

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

☑ Yes or ☐ No (Check one)

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

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:

As previously noted, the Working Group is striving to adopt the calculation sometime in 2020 and it is expected that revisions to the model be adopted by the NAIC within that same time period so that states can begin to implement through changes to state law.

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1 Insurance Holding Company System Regulatory Act (#440) and supporting Insurance Holding Company System Model Regulation (#450) require the annual filing of an Enterprise Risk Report (Form F) which requires the disclosure on material risks within the insurance holding company system that could pose enterprise risk to the insurer.

2 Risk Management and Own Risk and Solvency Assessment (ORSA) Model Act (#505) require the annual filing of an ORSA Summary report that includes 1) Description of the Insurer’s Risk Management Framework; 2) Insurer’s Assessment of Risk Exposure; and 3) Group Assessment of Risk Capital and Prospective Solvency Assessment.

3 Insurance Holding Company System Regulatory Act (#440) and supporting Insurance Holding Company System Model Regulation (#450) require the annual filing of a Registration Statement (Form B) which includes, among other items, the annual financial statements of the ultimate controlling person in the insurance holding company system and all of its affiliates and subsidiaries.
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary: See previous discussion.

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

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:

At this juncture, the changes to the NAIC models are expected to 1) require the filing of the GCC with the state; 2) provide important confidentiality protections; 3) provide exemptions for who is not expected to file the GCC. As such, variations by states related to these elements are not expected.

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

The Group Capital Calculation (E) Working Group has not discussed whether the GCC should be an accreditation standard. However, because the GCC is expected to be required of the largest and most complex U.S. insurance group who operate in all states, a national standard is appropriate.

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

Yes. Under Title V of the Dodd-Frank Act, the U.S. Department of the Treasury and the Office of the U.S. Trade Representative are authorized to jointly negotiate covered agreements, defined under the Dodd-Frank Act as written bilateral or multilateral agreements between the United States and one or more foreign governments, authorities or regulators regarding prudential measures with respect to insurance or reinsurance, on the condition that the prudential measures subject to a covered agreement achieve a level of protection for insurance or reinsurance consumers that is “substantially equivalent” to the level of protection achieved under U.S. state insurance laws. On Sept. 22, 2017, the U.S. Department of the Treasury and the Office of the U.S. Trade Representative signed the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement). On December 18, 2018, a separate Covered Agreement was signed between the U.S. and the United Kingdom, which is mirrors the language from the agreement with the EU, and has the same timing requirements for implementation.

The Covered Agreement includes requirements on reinsurance collateral, group supervision and group capital. Specifically, Article 4(h) provides that the host supervisor (i.e., a supervisory authority from the territory in which an insurance group has operations but which is not the territory where the worldwide parent is domiciled or headquartered) may not impose a group capital assessment or requirement at the level of the worldwide parent, but only if the insurance group is subject to a group capital assessment imposed by the home supervisor. The group capital assessment of the home supervisor must include a worldwide group capital calculation capturing risk at the level of the entire group, and the home supervisor must have the authority to impose preventive, corrective or otherwise responsive measures on the basis of the assessment, including the authority to impose capital measures where appropriate.

Under Article 10(e) of the Covered Agreement, supervisory authorities in the European Union shall not impose a group capital requirement at the level of the worldwide parent undertaking of the insurance or reinsurance group, with regard to
A U.S. insurance or reinsurance group with operations in the European Union, for 60 months after the date of provisional application of the Covered Agreement; i.e., Nov. 7, 2022. The NAIC is developing a group capital calculation intended to serve as an analytical tool for evaluating an insurer’s capital position at the group level, but which is not intended to be applied as a group-level capital requirement or standard. The *Statement of the United States on the Covered Agreement with the European Union* provides further clarification with respect to this group capital assessment:

The Agreement limits the worldwide application of EU prudential group insurance measures on U.S. insurers operating in the EU. The Agreement provides that U.S. insurers and reinsurers can operate in the EU without the U.S. parent being subject to the group level governance, solvency and capital, and reporting requirements of Solvency II, and reinforces that the EU system of prudential insurance supervision is not the system in the United States. The Agreement does not require development of a group capital standard or group capital requirement in the United States. Article 4(h) contemplates that the states will develop a group-wide capital assessment. Through the National Association of Insurance Commissioners (NAIC), the states are in the process of developing a group capital calculation which is intended to serve as an analytical tool for evaluating a firm’s capital position at the group level. The *United States expects that the NAIC’s group capital calculation will satisfy the “group capital assessment” condition of Article 4(h)*, provided that the work is completed and implemented within five years of the date on which the Agreement is signed. [Emphasis added].

Any state with U.S. groups operating in either the European Union or the United Kingdom will need to adopt these legislative changes by Nov. 7, 2022 in order to effectuate compliance with the Covered Agreement.
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:
   Innovation and Technology (EX) Task Force

2. NAIC staff support contact information:
   Denise Matthews
dmatthews@naic.org
   816-783-8007

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

   NAIC Unfair Trade Practices Act (Model #880)
   Section 4(H)(1)

   The Innovation and Technology (EX) Task Force will draft amendments to the NAIC Unfair Trade Practices Act (Model #880), focusing on Section 4H, to clarify what is considered a “rebate” or “inducement”.

4. Does the model law meet the Model Law Criteria? ☑ Yes or ☐ No (Check one)
   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).
   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? ☑ Yes or ☐ No (Check one)
      If yes, please explain why: Inconsistency in the interpretation of the Model language necessitates revisions to clarify the intent and ensure necessary consumer protections remain in place in light of technologies being deployed to add value to existing insurance products and services.
   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?
      ☑ Yes or ☐ No (Check one)
5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

   X 1  □ 2  □ 3  □ 4  □ 5  (Check one)

   High Likelihood  Low Likelihood

   Explanation, if necessary: A significant amount of time and discussion has already been devoted to this topic including presentations from all stakeholders and discussion around draft guideline language. That should help in accelerating the development process related to this model language.

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

   □ 1  X 2  □ 3  □ 4  □ 5  (Check one)

   High Likelihood  Low Likelihood

   Explanation, if necessary:

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

   □ 1  X 2  □ 3  □ 4  □ 5  (Check one)

   High Likelihood  Low Likelihood

   Explanation, if necessary:

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

   No

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

   No.
Model Law Development Report

Amendments to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)—Amendments to Model #171 are required for consistency with the federal Affordable Care Act (ACA) and, therefore, did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee. At the 2015 Fall National Meeting, the Regulatory Framework (B) Task Force discussed the proposed revisions to this model. The Task Force requested additional comments by Jan. 22, 2016. The Task Force met Feb. 11, 2016 and appointed the Accident and Sickness Insurance Minimum Standards (B) Subgroup to work on revisions to this model. The Subgroup has been meeting on a regular basis since the 2016 Spring National Meeting and plans to continue meeting via conference call until it completes its work. During its meetings, the Subgroup has discussed a number of issues, including its approach for revising the model’s disability income insurance coverage provisions, and decided preliminarily to review the Interstate Insurance Product Regulation Commission’s (Compact) approach. After pausing its work due to the ACA’s potential repeal, replacement or modification—and the possible impact on the provisions of this model, as well as the Subgroup’s preliminary proposed revisions to the model—the Subgroup began meeting again via conference call in May 2018. Revisions to Model #170, now known as the Supplementary and Short-Term Health Insurance Minimum Standards Model Act, were adopted by the full NAIC membership at the Spring National Meeting. The Subgroup has begun meeting via conference call to consider revisions to Model #171 for consistency with the revised Model #170 since the Summer National Meeting discussing comments received on Sections 1-5 of Model #171. The Subgroup plans to meet via conference call following the Fall National Meeting to complete its review of the Section 1-5 comments and establish public comment period ending in mid-January 2020 for additional Model #171 sections. The Subgroup hopes to complete its work by the 2020 Summer National Meeting.

Amendments to the Annuity Disclosure Model Regulation (#245)—The Executive (EX) Committee met June 19, 2017 and approved a Request for NAIC Model Law Development to amend Model #245. The amendments will revise Section 6—Standards for Illustrations. The purpose of the revision is to address issues identified by the Life Insurance and Annuities (A) Committee’s Annuity Disclosure (A) Working Group related to innovations in annuity products that are not addressed, or not addressed adequately, in the current standards. Revisions addressing participating income annuities were adopted by the Life Insurance and Annuities (A) Committee during its July 19, 2018, conference call and held pending the resolution of the Working Group’s discussions regarding illustrating indexes in existence for less than 10 years. The Working Group continues to discuss additional revisions on the index issue. The Working Group made progress during discussions via conference call on Sept. 19 and Dec. 2, and it received an extension from the Life Insurance and Annuities (A) Committee at the Fall National Meeting to continue its work. The Working Group hopes to complete its work by the 2020 Spring National Meeting.

Amendments to the Suitability in Annuity Transactions Model Regulation (#275)—Amendments to Model #275 are being drafted for consistency with federal rules and, therefore, did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee. The Life Insurance and Annuities (A) Committee’s Annuity Suitability (A) Working Group is drafting amendments to Model #275 that would raise the standard of conduct requirement for insurers and producers offering annuity products. The Working Group held an in-person meeting in June to consider the comments received on the draft proposed revisions exposed for a public comment period ending Feb. 15. The Working Group continued its discussion July 23 and July 29 via conference call, as well as during its meeting at the Summer National Meeting. Following the Summer National Meeting, the Working Group developed a new draft of proposed revisions incorporating a best interest standard of conduct and set a comment period ending Sept. 30 to receive comments on the draft. The Working Group discussed the comments received by the Sept. 30 comment deadline via conference calls Nov. 5, Oct. 29, Oct. 15 and Oct. 8. At the end of its Nov. 5 conference call, the Working Group agreed that it had completed its work as directed by the Life Insurance and Annuities (A) Committee at the Spring National Meeting and sent the revised draft to the Life Insurance and Annuities (A) Committee for its consideration. The Life Insurance and Annuities (A) Committee chair set a public comment period ending Nov. 26 to receive comments on the revised draft. The Life Insurance and Annuities (A) Committee plan to discuss the comments received by the public comment deadline during its meeting at the Fall National Meeting.

Amendments to the Health Maintenance Organization Model Act (#430)—The Executive (EX) Committee approved the Request for NAIC Model Law Development to amend Model #430 at the 2019 Summer National Meeting. The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force is drafting the amendments to address conflicts and redundancies with provisions in the *Life and Health Insurance Guaranty Association Model Act* (#520). Following the Summer National Meeting, the Working Group met via conference call to consider recommendations from the Virginia Insurance Bureau on revising Model #430 consistent with its charge. During its Nov. 21 conference call, the Working Group decided to move forward with revising Model #430 based on recommendations from the Maine Bureau of Insurance (BOI). It is anticipated the
Subgroup will meet via conference call sometime after the Fall National Meeting to review an initial draft of revisions to Model #430 based on the Maine BOI’s recommendations.

Amendments to the Life Insurance Disclosure Model Regulation (#580)—The Executive (EX) Committee met June 19, 2017, and approved the Request for NAIC Model Law Development to incorporate a policy overview document requirement into Model #580 and the Life Insurance Illustrations Model Regulation (#582), in order to improve the understandability of the life insurance policy summary and narrative summary already required by Section 5A(2) of Model #580 and Section 7B of Model #582. While the Life Insurance and Annuities (A) Committee’s Life Insurance Illustration Issues (A) Working Group was originally planning to revise both Model #580 and Model #582, it will now revise only Model #580. The Working Group has been meeting via conference call to develop language to add a requirement for a one- to two-page consumer-oriented policy overview. The Working Group continued to make progress during its discussions Oct. 21, Sept. 17 and Sept. 3 via conference call and received an extension from the Life Insurance and Annuities (A) Committee at the Fall National Meeting to continue its work. The Working Group hopes to complete its work by the 2020 Spring National Meeting.

Amendments to the Mortgage Guaranty Insurance Model Act (#630)—The Executive (EX) Committee and Plenary approved the Request for NAIC Model Law Development to amend Model #630 on July 26, 2013. The Financial Condition (E) Committee’s Mortgage Guaranty Insurance (E) Working Group developed substantial changes to the model but continues to discuss those changes. The Working Group’s focus has shifted to working with a consultant to produce a capital model that will serve as the basis for levels of intervention included in Model #630, with significant progress made in this area since the Spring National Meeting. The Working Group received an extension from the Financial Condition (E) Committee until the 2020 Spring National Meeting.

New Model: Real Property Lender-Placed Insurance Model Act—The Executive (EX) Committee approved the Request for NAIC Model Law Development, submitted by the Property and Casualty Insurance (C) Committee, to draft the new Real Property Lender-Placed Insurance Model Act at the 2017 Summer National Meeting. The Property and Casualty Insurance (C) Committee’s Lender-Placed Insurance Model Act (C) Working Group exposed a draft of this proposed new model focusing on lender-placed insurance related to mortgage loans for a public comment period ending Oct. 31, 2018. At the 2019 Fall National Meeting, the Working Group received an extension of time to continue drafting the new model.

New Model: Pet Insurance Model Act—The Executive (EX) Committee approved the Request for NAIC Model Law Development at the 2019 Summer National Meeting. The Pet Insurance (C) Working Group is drafting the model law to define a regulatory structure for pet insurance and to address issues, such as: producer licensing; policy terms; coverages; claims handling; premium taxes; disclosures; arbitration and preexisting conditions.

New Model: Pharmacy Benefit Manager (PBM) Model Law—The Executive (EX) Committee approved the Request for NAIC Model Law Development at the 2019 Summer National Meeting to draft a new model law addressing licensure or registration of pharmacy benefit managers (PBMs). The Regulatory Framework (B) Task Force’s Pharmacy Benefit Manager Regulatory Issues (B) Subgroup is drafting the model as a result of discussions that began during the Health Insurance and Managed Care (B) Committee’s work to revise the Health Carrier Prescription Drug Benefit Management Model Act (#22). Following the Summer National Meeting, the Working Group held a number of information-gathering sessions to gather information to assist it in working on its charge. The Working Group is currently considering its next steps.

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FINANCIAL STABILITY (EX) TASK FORCE

Financial Stability (EX) Task Force Dec. 9, 2019, Minutes ................................................................. 4-29
Liquidity Assessment (EX) Subgroup Nov. 26, 2019, Minutes (Attachment One) ........................................ 4-33
2019 NAIC Liquidity Stress Test Framework, Nov. 26, 2019, Draft (Attachment Two) ................................. 4-35
Valuation Analysis (E) Working Group Memorandum Regarding Response
   Related to Economic Scenario Generators, Nov. 27, 2019 (Attachment Three) .................................. 4-71
The Financial Stability (EX) Task Force met in Austin, TX, Dec. 9, 2019. The following Task Force members participated: Marlene Caride, Chair (NJ); Eric A. Cioppa, Vice Chair (ME); Andrew N. Mais and Kathy Belfi (CT); David Altmaier and Ray Spudeck (FL); Doug Ommen represented by Jim Armstrong (IA); Dean L. Cameron represented by Nathan Faragher (ID); Gary Anderson (MA); Chlora Lindley-Myers represented by John Rehagen (MO); Bruce R. Ramge represented by Justin Schrader (NE); Jessica Altman represented by Kim Rankin (PA); Raymond G. Farmer (SC); Hodgen Mainda and Trey Hancock (TN); Kent Sullivan represented by Mike Boerner and James Kennedy (TX); and Scott A. White represented by Doug Stolte (VA).

1. **Adopted its Summer National Meeting Minutes**

Commissioner Altmaier made a motion, seconded by Director Farmer, to adopt the Task Force’s Aug. 5 minutes (*see NAIC Proceedings – Summer 2019, Financial Stability (EX) Task Force*). The motion passed.

2. **Adopted the Nov. 26 Minutes of the Liquidity Assessment (EX) Subgroup**

Mr. Schrader made a motion, seconded by Commissioner Altmaier, to adopt the Subgroup’s Nov. 26 minutes (Attachment One). The motion passed.

3. **Heard an Update on FSOC Developments**

Superintendent Cioppa reported that since the Summer National Meeting, the Financial Stability Oversight Council (FSOC) has met three times. During last week’s meeting, the FSOC approved the final revisions to the Nonbank Designations guidance. He summarized that the final version, like the initial proposal, prioritizes an activities-based approach to the identification and mitigation of risks to financial stability. He added that the new guidance also makes changes to the designations process, including increasing transparency around the process. He also said that there is now a clearer off-ramp to designation, with both a pre-designation off-ramp and a robust post-designation off-ramp.

Superintendent Cioppa praised the new framework, which he said represents a sensible shift in approach and is consistent with approaches the NAIC has been advocating for the past several years. He added that the FSOC’s annual report is now available on the FSOC website.

4. **Exposed the Proposed 2019 NAIC Liquidity Stress Test Framework**

Mr. Schrader reported that state insurance regulators have been working diligently toward delivering an initial proposal of a 2019 liquidity stress test and is pleased that today they are in a position to do just that. He highlighted the key design element recommendations made since the last Task Force meeting at the Summer National Meeting.

Mr. Schrader said that for the 2019 liquidity stress test, a baseline normal operations scenario, two liquidity stress scenarios and an insurer-specific information request will be required. For each stress scenario, there will be a regulator-provided narrative for companies to use in their internal modeling. The assumptions underlying the modeled narrative will be a combination of regulator prescribed assumptions and company specific assumptions, the latter of which must be consistent with the prescribed narrative.

The first liquidity stress test is a Severely Adverse Scenario, where market conditions are similar to the 2008 financial crisis. The state insurance regulator prescribed narrative and assumptions are primarily extracted from the Federal Reserve Board’s Supervisory Scenarios for Annual Stress Tests Required under the Dodd-Frank Act Stress Testing Rules and the Capital Plan Rule. He said there is also a “what if” modification to the Severely Adverse Scenario that limits the insurer to curing any liquidity deficiency through expected asset sales amounts. He clarified that under that assumption, there are no internal and external funding sources to satisfy any liquidity deficiency under stress such as no new Federal Home Loan Bank (FHLB) draws or holding company contributions.
Mr. Schrader said the second liquidity stress test is a scenario that includes an interest rate spike, a market-wide decrease in equities and a credit spread stress. Additionally, the nationally recognized statistical rating organization (NRSRO) insurance industry outlook goes from stable to negative, with many insurers experiencing a downgrade. A “what if” modification changing the equities decrease to an increase and removing the credit spread stress to this stress scenario is also required. He noted that while some elements of this narrative would also be relevant for performing a Sovereign Debt stress scenario, state insurance regulators are not ready to implement it for the 2019 liquidity stress test.

Mr. Schrader noted that for the insurer-specific information request, state insurance regulators also require the insurers to report their severe worst-case stress scenario in a detailed narrative, including any assumptions needed for state insurance regulators to gain greater insight to the drivers of liquidity risk and to inform future prescribed stress scenarios.

Mr. Schrader explained that if the insurer reported a liquidity deficiency, where liquidity uses exceed sources, then the insurer would need to disclose in the reporting templates the expected asset sales involved with meeting that shortfall. He added that the insurer will be requested to provide:

- The expected asset sales amounts generated by the system prior to any review or modification by the portfolio manager.
- The final expected asset sales amounts after review or modification by portfolio manager.

Mr. Schrader mentioned that the holding company and life insurance legal entities in the group are required to perform the stress tests. Additionally, non-life insurance and non-insurance legal entities within the group with material liquidity risks should also be required to perform the stress tests. He mentioned that the definition of materiality should be flexible, based on the insurer’s Own Risk and Solvency Assessment (ORSA) and internal liquidity stress testing.

Mr. Schrader mentioned that subsequent to insurer reporting of liquidity stress testing results and aggregation of data, the Liquidity Assessment (EX) Subgroup will also focus on the mapping of industry aggregated sales to market data. The NAIC aims to compare the aggregated results against various benchmarks, potentially including normal and/or stressed trading volumes and asset values for various asset classes, to determine the impact such sales may have on the capital markets in times of stress.

Mr. Schrader requested that the Task Force, together with the Liquidity Assessment (EX) Subgroup, expose the proposed 2019 NAIC Liquidity Stress Test Framework for a 60-day public comment period ending Feb. 7, 2020.

Mr. Schrader made a motion, seconded by Ms. Belfi, to expose the proposed 2019 NAIC Liquidity Stress Test Framework jointly by the Task Force and the Subgroup for a 60-day public comment period (Attachment Two). The motion passed.

5. Received an Update from the Receivership and Insolvency (E) Task Force on its Work to Address the Financial Stability (EX) Task Force’s Referral Letter to Undertake Analysis Relevant to the MPI

Mr. Kennedy reported that the Receivership and Insolvency (E) Task Force continues to work to address the Financial Stability (EX) Task Force’s referral letter to undertake an analysis of resolution and recovery concerns important to financial stability as part of the Macroprudential Initiative (MPI). He said the current Insurer Receivership Model Act (#555) substantially conforms with the International Association of Insurance Supervisors’ (IAIS) Insurance Core Principles (ICPs) and its Common Framework for the Supervision on Internationally Active Insurance Groups (ComFrame), as well as the Financial Stability Board’s (FSB) Key Attributes of Effective Resolution Regimes for Financial Institutions.

Mr. Kennedy cautioned that most states have laws based on prior NAIC models, so the NAIC will encourage adoption, including a request to amend the Financial Regulation Standards and Accreditation Program. He also noted that a bridge institution might be useful in a receivership to address an early termination on qualified financial contracts (QFCs) but would require the use of a temporary stay on termination rights, which is prohibited in many states.

Mr. Kennedy added that the Receivership Model Law (E) Working Group will explore if a bridge could be implemented under regulatory oversight before receivership to address the early termination of QFCs. He also reported that the Financial Condition (E) Committee has adopted amendments to the Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (#1556), which will be considered for adoption by the Executive (EX) Committee and Plenary at this national meeting.
6. Heard an Update on CLO Stress Tests

Eric Kolchinsky (NAIC) reported that the stress thesis is based on the concern about U.S. insurer holdings of collateralized loan obligations (CLOs) that stem from lax underwriting on the underlying leveraged loans. He added that the loose underwriting falls into three areas: covenant-lite; lack of subordination; and weaker earnings before interest, tax, depreciation and amortization (EBITDA) multiples. He concluded that these developments will result in substantially lower recovery rates on leveraged loans during the next recession. He forecast that loan recoveries will deteriorate from the historical norms to levels comparable to unsecured debt. He added that recovery stresses were run in both historical and moderately stressful default environments.

Mr. Kolchinsky said that about 85% of CLOs outstanding were modeled in three scenarios, which is approximately $527 billion. He noted that insurance companies hold a total of $130 billion of CLOs based on year-end 2018 data, which was published in the NAIC’s Special Report, “U.S. Insurers’ Exposure to CLOs,” on June 19, 2019. He added that these exposures were classified into five categories:

- Mapped and modeled “normal” ($96 billion)
- Mapped and modeled “atypical” ($1 billion)
- Ready to map ($6 billion)
- Out of scope ($12 billion)
- Need information ($15 billion)

Mr. Kolchinsky concluded that, based on results, CLOs do not appear to be a significant risk to the insurance sector as a whole, but a few companies have concentrated investments in combo notes, which are securities that pay off quickly in good times but take significant losses in stressed environments. He reported that NAIC staff has requested that the Valuation of Securities (E) Task Force exclude combo notes from filing exemption treatment because their risk is not captured by ratings.

7. Heard an Update on Macroprudential Surveillance

Mr. Nauheimer reported that the IAIS has adopted a framework for a holistic approach to assessing and mitigating systemic in the insurance sector, with implementation beginning in 2020. He summarized that the holistic framework consists of the following elements:

- An enhanced set of supervisory policy measures for macroprudential purposes.
- The global monitoring exercise that is both individual and sector wide.
- Mechanisms to allow for a collective assessment of potential global systemic risk and a coordinated supervisory response.
- An assessment by the IAIS of the consistent implementation of the enhanced supervisory policy measures and powers of intervention.

He also reported that the IAIS Macro-prudential Surveillance Working Group (MPSWG) will be disbanded and two new groups will be formed in its place. They are the “Macroprudential Monitoring Working Group” or MMWG and the “Macroprudential Supervision Working Group” or MSWG. The work related to macroprudential supervision will move to the MSWG. In the immediate future the MSWG will be tasked with developing and finalizing two application papers: The Application Paper on Liquidity Risk Management; and the macroprudential supervision paper to support implementation of ICP 24 – Macroprudential Surveillance and Insurance Supervision.

Mr. Nauheimer reported that the IAIS issued the Application Paper on Liquidity Risk Management for public consultation with comments due by Jan. 18, 2020, and he encouraged interested parties to submit comments before the deadline. He also said the FSB has accepted the IAIS recommendation to suspend global systemically important insurer (G-SII) identification and, in 2022, the FSB will consider whether to discontinue or re-establish an annual identification of G-SIIs.

Mr. Nauheimer also reported that as the IAIS takes a deeper dive into the Holistic Framework’s domestic impact with its four key elements and numerous workstreams, the NAIC is reviewing any areas where state insurance regulators may want to ramp up work in progress and/or bring new proposals forward under the domestic Macroprudential initiatives. Many initiatives updated earlier in the meeting such as the Liquidity Stress Testing and Resolution initiatives address Holistic Framework workstreams. The creation of a U.S. risk assessment is another example of a relatively new initiative motivated by the Holistic Framework.
8. Received a Response from the Valuation Analysis (E) Working Group Regarding the Academy’s ESGs

Todd Sells (NAIC) reported that the Task Force received a status report regarding Commissioner Caride’s request to the Valuation Analysis (E) Working Group (VAWG) to assess a potential concern related to economic scenario generators (ESGs) developed by the American Academy of Actuaries (Academy). The VAWG’s status report is included in a memo dated Nov. 27 (Attachment Three). Mr. Boerner summarized the report and indicated the VAWG will continue addressing issues of concern. He added that though the process of implementing a new ESG is expected to take several years once a vendor has been selected, the Life Actuarial (A) Task Force (LATF) is pursuing an aggressive timeline. The details can be found on a report posted on the LATF’s NAIC webpage.

Having no further business, the Financial Stability (EX) Task Force adjourned.

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Liquidity Assessment (EX) Subgroup
Conference Call
November 26, 2019

The Liquidity Assessment (EX) Subgroup of the Financial Stability (EX) Task Force met via conference call Nov. 26, 2019. The following Task Force members participated: Justin Schrader, Chair (NE); Kathy Belfi (CT); Philip Barlow (DC); Carrie Mears (IA); Bruce Sartain and Vincent Tsang (IL); Bill Carmello (NY); and Mike Boerner (TX). Also participating was: John Rehagen (MO).

1. Discussed its Progress on the Liquidity Stress Test Proposal

Mr. Schrader stated that a draft of the 2019 liquidity stress test proposal will be jointly exposed for a 60-day public comment period by the Financial Stability (EX) Task Force and the Subgroup during the Task Force’s Dec. 9 meeting at the Fall National Meeting.

Mr. Schrader noted that the draft 2019 liquidity stress test proposal does not address all aspects of liquidity risk concerns, but rather focuses on key risks from the 2019 stress test results to further refine the methodology. Mr. Schrader highlighted the key design element recommendations made since the last Task Force meeting at the Summer National Meeting.

Mr. Schrader said that for the 2019 liquidity stress test, a baseline normal operations scenario, two liquidity stress scenarios and an insurer-specific information request should be required. For each stress scenario, there will be a state insurance regulator-provided narrative and state insurance regulator-prescribed assumptions that must be used in the insurer’s internal modeling. For these stress scenarios, there will be company assumptions to be generated and used by the insurer based upon the state insurance regulator-provided narrative and state insurance regulator-prescribed assumptions that exist.

The first liquidity stress test is a Severely Adverse Scenario, where market conditions are similar to the 2008 financial crisis. The state insurance regulator prescribed narrative and assumptions are primarily extracted from the Federal Reserve Board’s Supervisory Scenarios for Annual Stress Tests Required under the Stress Testing Rule of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act. He said that additionally, there is a “what if” modification to the Severely Adverse Scenario that limits the insurer to curing any liquidity deficiency through expected asset sales amounts. He clarified that under that assumption, there are no internal and external funding sources to satisfy any liquidity deficiency under stress such as no new FHLB draws or holding company contributions. Mr. Schrader added that the values of assumptions such as market capacity, swaption volatility, structured spreads, swap spreads and credit default assumptions being suggested in the draft exposure document will be finalized in the first quarter of 2020 and to also reflect an update from the Federal Reserve Board.

Mr. Schrader said the second liquidity stress test is a scenario that contemplates whether an interest rate spike, equities decrease and credit spread stress exist. Additionally, the nationally recognized statistical rating organization (NRSRO) insurance industry outlook goes from stable to negative with many insurers experiencing a downgrade. A “what if” modification to this stress scenario is also required. State insurance regulators see value in performing a Sovereign Debt stress scenario but are not ready to implement it for the 2019 liquidity stress test. This stress scenario and “what if” modification will accomplish some of the dynamics that would be included in a Sovereign Debt stress, and state insurance regulators will utilize those results to build out a Sovereign Debt stress scenario in the future. The “what-if” modification to this stress scenario includes the state insurance regulator-provided narrative and all state insurance regulator-prescribed assumptions as per above except that instead of a decrease in equities, insurers should assume an increase in equities. Additionally, no credit spread stress should be assumed.

Mr. Schrader noted that for the insurer-specific information request, state insurance regulators also require the insurers to report their severe worst-case stress scenario in a detailed narrative, including any assumptions needed for state insurance regulators to gain greater insight to the drivers of liquidity risk for specific insurers and to inform future prescribed stress scenarios.

Mr. Schrader explained that if the insurer reported a liquidity deficiency, where liquidity uses exceed sources, then the insurer would need to disclose in the reporting templates the expected asset sales involved with meeting that short fall. He added that the insurer will be requested to provide:

- The expected asset sales amounts generated by the system prior to any review or modification by the portfolio manager.
The final expected asset sales amounts after review or modification by portfolio manager.

Mr. Schrader mentioned that the holding company and life insurance legal entities in the group are required to perform the stress tests. For the remaining non-life insurance and non-insurance legal entities within the group, those with material liquidity risks should be required to perform the stress tests. He mentioned that the definition of materiality should be flexible, based on the insurer’s Own Risk and Solvency Assessment (ORSA) and internal liquidity stress testing. He also mentioned that based on the results of the 2019 initial stress test exercise, the Subgroup will determine if additional materiality criteria should be developed to help ensure better comparability among insurers.

As to the next steps, Mr. Schrader noted that the study group still needs to address other types of disclosures to be captured in the 2019 liquidity stress test results—for example, some of the key company assumptions utilized by the insurers. These disclosures will be finalized in the first quarter of 2020.

Mr. Schrader mentioned that the timing of the 2019 liquidity stress test is proposed to be early third quarter of 2020.

Mr. Schrader mentioned that subsequent to insurer reporting of liquidity stress testing results and aggregation of data, the Subgroup will also focus on the mapping of industry aggregated sales to market data. The NAIC aims to compare the aggregated results against various benchmarks, potentially including normal and/or stressed trading volumes and asset values for various asset classes, to determine the impact such sales may have on the capital markets in times of stress. Findings from this analysis may also inform expected asset sale assumptions utilized in future runs of the liquidity stress test. As part of its macroprudential surveillance, state insurance regulators and/or the NAIC may reach out to other regulatory agencies to discuss aggregate results that may affect other regulated industries such as banks, securities brokers and asset managers. State insurance regulators may also coordinate with other agencies to identify appropriate and perhaps coordinated action they may take to prevent or minimize the effect large asset sales may have on the financial markets and overall economy.

Mr. Schrader said that for the 2019 liquidity stress test exercise, lead state insurance regulators will utilize their examination authority to collect the reporting results from insurers identified by the scope criteria to ensure confidentiality. He added that the Task Force will be developing a long-term solution to confidentiality, possibly in coordination with the needs from the group capital calculation (GCC) project.

Mr. Tsang (IL) asked if an executive summary to the draft exposure document would be good to have to better understand the purpose, to which Mr. Schrader responded that the background section of the document covers this aspect.

Mr. Rehagen (MO) asked for a confirmation of which firms are on the list based on the scope criteria. Mr. Schrader responded that 23 firms are in the scope, noting that he had checked with all lead state insurance regulators if those firms were informed.

Having no further business, the Liquidity Assessment (EX) Subgroup adjourned.
2019 NAIC LIQUIDITY STRESS TEST FRAMEWORK
For Life Insurers Meeting the Scope Criteria
December 2019
DRAFT
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1. Introduction

1.1 Macroprudential Implications of a Liquidity Stress

Beginning mid-year 2017, the NAIC embarked on a project to develop a liquidity stress test (LST) framework. While the NAIC has existing tools and processes for assessing liquidity risk at a legal entity level (i.e., “inward” impacts to the insurer), there was recognition that the NAIC toolbox could be further enhanced with the addition of more granular data in the annual statement and a tool that would enable an assessment of macroprudential impacts on the broader financial markets (i.e., “outward” impacts) of a liquidity stress affecting a number of insurers simultaneously.

Post-financial crisis, there were several attempts to assess potential market impacts emanating from a liquidity stress in the insurance sector. Many of these analyses relied heavily on anecdotal assumptions and observations from behaviors of other financial sectors. In order to provide more evidence-based analyses, the NAIC decided to develop an LST for large life insurers that would aim to capture the impact on the broader financial markets (i.e., outward impacts) of aggregate asset sales under a liquidity stress.

The stress test will be run annually and the findings, on an aggregate basis, reported annually as part of the NAIC’s continuous macroprudential monitoring efforts. The NAIC’s pursuit of the LST should not suggest any pre-judgement of the outcomes. The NAIC believes there is value to the exercise whether it points to vulnerabilities of certain asset classes or markets or, alternatively, suggests that even a severe liquidity stress affecting the insurance sector is unlikely to have material impacts on financial markets. The NAIC LST is intended to supplement, not replace, a firm-specific liquidity risk management framework. The NAIC has not yet discussed steps that might be taken to address any identified vulnerabilities but acknowledges that any recommendations may require collaboration with other financial regulators.

This initial exposure document focuses on the LST itself which is one component of a broader LST framework. A more comprehensive framework, still to be developed, will additionally address model laws to establish regulatory authority, confidentiality and other policy considerations.
Once the LST framework is further developed by the Subgroup and Task Force, a proposal will be sent to the Financial Condition (E) Committee as per the adopted charges.

The NAIC’s proposed 2019 LST is contained in the pages that follow and is exposed for a public comment period ending Feb. 10, 2020. The NAIC recognizes that, at least in the early years, the stress testing process and analyses will be iterative. We expect refinements to the LST as the framework is developed, especially after the first year’s implementation.

2. Background

2.1 NAIC Macroprudential Initiative

The NAIC’s Macroprudential Initiative (MPI) commenced in 2017. It recognized the post-financial crisis reforms that became part of our Solvency Modernization Initiative (SMI) that continue to serve us well today. However, in the ensuing years since those reforms, insurers have had to contend with sustained low interest rates, changing demographics and rapid advancements in communication and technology. They have responded by offering new products, adjusting investment strategies, making structural changes and expanding into new global markets. There are new market players, new distribution channels, and a complex web of interconnections between financial market players.

What has not changed since the financial crisis is the scrutiny on the insurance sector in terms of understanding how insurers react to financial stress, and how that reaction can affect, via various transmission channels, policyholders, other insurers, financial market participants and the broader public.

The proposed work on macroprudential measures is reflective of state insurance regulators’ commitment to ensure that the companies they regulate remain financially strong for the protection of policyholders, while serving as a stabilizing force to contribute to financial stability, including in stressed financial markets. To that end, the NAIC’s three-year strategic plan (2018-2020), State Ahead, reflects the objective of evaluating gaps and regulatory opportunities arising from macroprudential surveillance, and develop appropriate regulatory responses.
The NAIC’s work on macroprudential surveillance is overseen by the Financial Stability (EX) Task Force of the Executive (EX) Committee. In April 2017, the Task Force was asked to consider new and improved tools to better monitor and respond to both the impact of external financial and economic risks on supervised firms, as well as the risks emanating from or amplified by these firms that might be transmitted externally. The Task Force, in turn, focused its efforts on potential enhancements to liquidity risk, among other areas. More specifically, the Task Force was requested to further develop the U.S. regulatory framework on liquidity risk with a focus on life insurers due to the long-term cash-buildup involved in many life insurance contracts and the potential for large-scale liquidation of assets.

2.2 Liquidity Assessment Subgroup

To carry out its work on liquidity, the Task Force established the Liquidity Assessment (EX) Subgroup mid-year 2017.

2.2.1 Mandate

The Subgroup’s charges and workplan reflect the following assignments:

- Review existing public and regulator-only data related to liquidity risk, identify any gaps based on regulatory needs and determine the scope of application, and propose recommendations to enhance disclosures.
- Develop an LST framework proposal for the Financial Condition (E) Committee’s consideration, including the proposed universe of companies to which the framework will apply (e.g., large life insurers).
- Once the stress testing framework is completed, consider potential further enhancements or additional disclosures.

In addition, a small informal study group comprised of state insurance regulators, industry participants and NAIC staff was formed to consider the specific data needs and technical aspects of the project. The study group is NOT an official NAIC working group. All recommendations from the study group must be vetted and considered by the Liquidity Assessment (EX) Subgroup and/or the Financial Stability (EX) Task Force according to NAIC procedures.
2.2.2 Data Gaps

Prior to undertaking work on the LST, the Subgroup constructed an inventory list of existing life insurer disclosures as of 2018 that contribute to an understanding of liquidity risk. When assessing the current state, the Subgroup recognized the availability of significant detailed investment-related disclosures but contrasted it to the relatively sparse liability-related disclosures. To remedy this imbalance, a blanks proposal was constructed to significantly increase the disclosures for life insurance products.

Specifically, the Analysis of Operations by Line of Business schedule was expanded from a single exhibit to five exhibits, one each for Individual Life, Group Life, Individual Annuity, Group Annuity, and Accident and Health (A&H). The Analysis of Increase in Reserves schedule was similarly expanded. Within each of the five new exhibits, columns were added for more detailed product reporting. For example, columns were added to the Individual and Group Life exhibits to capture universal life insurance and universal life insurance with secondary guarantees (ULSG), and columns were added to the Individual and Group Annuity exhibits to capture variable annuities and variable annuities with guaranteed benefits. In addition, two new lines were added to the now five exhibits of the Analysis of Increase in Reserves schedule: one capturing the cash surrender value of the products outstanding and another capturing the amount of policy loans available (less amounts already loaned).

A new addition was also proposed to the Life Notes to Financial Statement. The new Note 33 considered the type of liquidity concerns disclosed in Note 32 for annuities and deposit-type contracts and added disclosures for life insurance products not covered in Note 32.

These proposals were exposed and commented upon several times by the Liquidity Assessment (EX) Subgroup, the Financial Stability (EX) Task Force and the Blanks (E) Working Group. Ultimately, they were adopted by NAIC Plenary for inclusion in the 2019 life annual statement blank. As an interim step, The Financial Stability (EX) Task Force performed a data call requesting a few key lines of information from the newly adopted 2019 format of the Analysis of Operations
by Line of Business schedule and the Analysis of Increase in Reserves schedule, as well as the new Note 33, but populated with 2018 year-end data. This data call was completed in July 2019.

2.2.3 Discussions with Insurers

During the latter part of 2017 and the first quarter of 2018, the Subgroup conducted calls with several large life insurers who agreed to share their internal liquidity risk assessment processes. The dialogue provided extremely helpful input and informed the establishment of the initial direction of the LST framework.

Feedback from these discussions include:

- Scope criteria should be risk-focused, not solely based on size.
- The stress test should align with internal management reporting and leverage the Own Risk and Solvency Assessment (ORSA).
- The stress test should be principle-based and complement a company’s internal stress testing methodology.
- Regulatory guidance should be provided to help define liquidity sources and uses, products/activities with liquidity risk, time horizons, level of aggregation, reporting frequency, and establishing stress scenarios.
- Public disclosure of results should be carefully considered to avoid exacerbating a liquidity crisis.

Regarding the specifics of liquidity assessments/stress test approaches, significant diversity in practice existed. Key observations in this regard included:

- Liquidity tests are performed at the material entity level and at the holding company level. Definitions of material entities differ.
- Most firms determine some sort of coverage ratio (Liquidity Sources)/(Liquidity Uses) for base and stress scenarios and monitor results to ensure they align with the firm’s (internal) risk appetite. Categories of liquidity sources and uses differ across firms, and assumptions vary depending on time horizon. Some insurers determine coverage ratios using balance sheet values, applying different haircuts by asset class, time horizon and type of stress. Other
insurers determine liquidity coverage gaps (Liquidity Inflows – Liquidity Outflows) using a cash-flow approach.

• Stress scenarios vary by company, reflecting a combination of market-driven, as well as idiosyncratic and insurer-specific, scenarios.

• Time horizons tested also varied, typically ranging from seven days to one year.

3. Scope Criteria for Determining Groups Subject to Stress Test

In determining the scope of companies subject to the LST, consideration was given to activities assumed to be correlated with liquidity risk. Another consideration was the desirability of tying data used in the criteria back to the statutory financial statements. Ultimately, six activities were identified: 1) fixed and indexed annuities; 2) funding agreements; 3) derivatives; 4) securities lending; 5) repurchase agreements; and 6) borrowed money. Minimum thresholds were established for each of these six activities. A life insurance legal entity or life insurance group exceeding the threshold for any of the six activities is subject to the stress test. (See Annex 1 for more details.) For 2019, 23 insurance groups met the criteria.

While the scope criteria only uses statutory annual statement data, the stress test is not similarly limited. Thus, the stress test will consider many more liquidity risk elements than the scope criteria, and internal company data will be the source for many of those liquidity risk elements.

Just as the LST structure and methodology may change over time, the scope criteria may also be modified, for example, in response to new data points in the NAIC annual statement blank.

Using the agreed criteria, NAIC staff obtained the amounts for all life insurance legal entities from the 2018 annual statutory financial statements (filed by March 1, 2019). If two or more life insurers are part of an insurance group with an NAIC group code, then the numbers for each of those legal entity life insurers will be summed together to represent an insurance group result. Thus, a legal entity life insurer not in an insurance group can meet the threshold on its own, or the sum of legal entity life insurers in a group can meet the threshold.
In establishing whether an insurer or group met or exceeded the threshold criteria, the Subgroup members supported using the most current single year activity rather than a multi-year average. This resulted in coverage amounts ranging from 60% to 80% of the industry total for each activity based on 2018 data. In the future, regulatory judgment will be used to address an insurer’s exit from or entry to the scope of insurers subject to the LST.

4. Stress Testing Structure

4.1 Liquidity Stress Test Summary

The stress test employs a company cash-flow projection approach incorporating liquidity sources and uses over various time horizons under a baseline assumption and some number of stress scenarios (For 2019, there are two stress scenarios and also an insurer-specific request for information.) The available assets are then recorded by asset category. The LST then calls for identification of expected asset sales by category to cure any cash-flow deficits (liquidity uses exceed liquidity sources) under the stress scenarios.

The stress scenarios may vary from year-to-year and contain variations referred to as “what-if” scenarios. The following sections provide a further description of the LST’s key components.

4.2 Entities to Be Included in Stress Tests

The scope of entities included within an insurance group for the purposes of LST to assess the potential for large-scale liquidation of assets should include:

- Life insurance legal entities.
- Where applicable, their holding companies that could be a source of liquidity to the life insurance legal entities.
- Non-life insurance entities and non-insurance entities with material sources of liquidity, or that carry out material liquidity risk-bearing activities and could, directly or indirectly, pose similar risk of large-scale liquidation of assets.

For 2019, the legal entities identified in the bullets above, per a company’s ORSA, must be considered as material or identified as carrying out material liquidity risk-bearing activities and,
hence, subject to internal LST requirements. Although a legal entity in the group may not be required to perform the stress test due to materiality considerations, those entities’ cash impacts on entities performing the stress test must be captured in the sources and uses templates. Based on the results of the 2019 initial stress test exercise, the Subgroup will determine if additional materiality criteria should be developed to ensure better comparability amongst insurers.

4.3 Cash-Flow Approach

The LST is anchored by a cash-flow approach, using companies’ actual cash-flow projections of sources and uses of liquidity over various time horizons based upon experience and expectations. This contrasts with a balance sheet approach, which employs static balance sheet amounts and generic assumptions about asset liquidity. While a balance sheet approach is easier to apply and provides calculation consistency (and thus the perception of increased comparability), its “one-size-fits-all” approach could result in a misleading assessment of liquidity risk and fail to capture certain asset activities or product features under different stress scenarios and time horizons. The cash-flow approach is deemed more dynamic and may capture liquidity risk impacts more precisely.

4.4 Liquidity Sources and Uses

The insurer should produce cash-flow projections for sources of liquidity and uses of liquidity that cover: operating items, investment and derivatives, capital items, and funding arrangements. (See Annex 2: Sources and Uses template.) To clarify an issue regarding funding arrangements, the projected cash flows for liquidity sources and uses should include already existing funding arrangements, such as Federal Home Loan Bank (FHLB) draws outstanding in the current time period. Also, specific to the holding company, these projected cash flows for liquidity sources and uses should include non-U.S. impacts as well.

The insurer will produce these liquidity sources and uses cash-flow projections in a baseline, normal course of business scenario, for each time horizon. The insurer will also produce these cash flows based upon a specific number of required stress scenarios for each time horizon. (For 2019, there are two stress scenarios and also an insurer-specific request for information.)
Baseline Assumptions for Cash Flows

Baseline (pre-stress) cash flows are the insurer-specific cash flows from normal expected operations. Insurers should prepare cash-flow projections under normal operating conditions and report the net cash flows (projected liquidity sources less uses) for each time horizon. These cash-flow projections should be consistent with those used for internal financial planning and analysis (FP&A), risk management data sets, etc. A positive net cash-flow is presumed in the baseline cash flows since companies are not expected to be operating in a net cash-flow deficiency state.

4.5 Stress Scenarios and Their Assumptions

For year-end 2019, there are two liquidity stress scenarios: 1) a 2008 financial crisis-like scenario; and 2) an interest rate shock/downgrade scenario and the insurers most adverse scenario. There is also an insurer-specific information request. The 2008 financial crisis-like scenario and interest rate shock/downgrade scenario contains a state insurance regulator-provided narrative, state insurance regulator-prescribed assumptions and company-specific assumptions. The insurer-specific information request contains a company-provided narrative. The state insurance regulator-provided narrative will be a qualitative description of the economic scenario in place to highlight the particular risks and sensitivities associated with that stress scenario. The state insurance regulator-prescribed assumptions are specific parameters insurers should incorporate into their modeling for a particular scenario. Company-specific assumptions should be consistent with the information provided in the state insurance regulator-provided narrative and state insurance regulator-prescribed assumptions, and represent the detailed assumptions needed for a specific company’s internal model. Examples include debt issuance, lapse sensitivity, new business sensitivity and mortality sensitivity. All key business activities and product types’ impact to liquidity should be considered. If the insurer’s internal model does not utilize a specific economic and/or example of company-specific assumption included in this document, the internal model does not need to be modified to utilize it. However, if the insurer’s internal model does utilize a specific economic and/or example of company-specific assumption included in this document, the insurer must utilize the specific value for that assumption provided in this document. For example, if an insurer’s internal model uses Structured Spreads over Treasuries,
the company must use the value for that 3-month assumption as presented in the final regulator-prescribed assumptions in quarter 1 of 2020. If there is no specific value for a certain time horizon, the company should use the values for the other time horizon to interpolate a value. For example, if the state insurance regulator-provided assumptions in quarter 1 of 2020 include values for three-month, six-month, nine month and one year, the insurer should use those values to extrapolate the one-month value. The company is not to utilize its own values for any item provided in the regulator prescribed assumptions.

4.5.1 2008 Financial Crisis-like Severely Adverse Scenario

State Insurance Regulator-Provided Narrative

Insurers are required to apply a 2008 financial crisis-like scenario as one of the stress scenarios. The following is a summary of market conditions extracted from the Federal Reserve Board’s (FRB) 2018 Supervisory Scenarios for Annual Stress Tests Required under the Dodd-Frank Act Stress Testing Rules and the Capital Plan Rule.

This scenario is characterized by a severe global recession that is accompanied by a global aversion to long-term fixed-income assets. As a result, long-term rates do not fall, and yield curves steepen in the U.S. In turn, these developments lead to a broad-based and deep correction in asset prices, including in the corporate bond and real estate markets.

- Macroeconomic
  - The real gross domestic product (GDP) begins to decline in the first quarter of 2018 and reaches a trough in the third quarter of 2019 that is 7.5% below the pre-recession peak.
  - The unemployment rate approaches 10%
  - The headline Consumer Price Index (CPI) falls below 1% at an annual rate in the second quarter of 2018 and rises to about 1.5% at an annual rate by the end of the scenario

- Interest Rates and Credit Spreads
  - Short-term Treasury rates fall and remain near zero throughout the stress
  - 10-year Treasury yields remain unchanged through the scenario period.
Investment grade (IG) corporate credit spreads widen to 5.75%

- Asset Valuations
  - Equity prices decline by roughly 65%
  - The Volatility Index (VIX) moves above 60%
  - Housing prices and commercial real estate prices decline by 30% and 40% respectively, through eight quarters.

- Description of International Market Conditions
  - Severe recessions and slowdowns in growth are experienced in the Euro area, United Kingdom (UK), Japan, and developing Asia economies.
  - All foreign economies experience a decline in consumer prices.
  - The U.S. dollar appreciates against the Euro, British pound, and developing Asia currencies.
  - The U.S. dollar depreciates modestly against the Japanese yen, driven by flight-to-safety capital flow.

State Insurance Regulator-Prescribed Assumptions

Insurers should utilize the specific values for the economic indicators from the FRB’s annual Supervisory Scenarios for Annual Stress Tests Required under the Dodd-Frank Act Stress Testing Rules and the Capital Plan Rule, Table 1.A. Historical data and Table 4.A. Supervisory severely adverse scenario. For the first year of the stress test, insurers should use the version published in February 2020. (Refer to the tables in Annex 4i.) Specifically, insurers should run the 2008 stress scenario using the values for the Treasury curve, corporate spreads, GDP, unemployment, U.S. inflation (CPI), Housing Price Index (HPI), S&P 500 Index (SPX SPOT), Commercial Real Estate Index (CREI) and VIX index. Q4 2019 values should be used for the baseline and projected values should be used for the 30-day, 90-day and one-year horizons.

In addition, other market indicators are necessary for insurers to apply to stressed cash-flows and to assess the impact on expected asset sales. These are as follows (with details to be found in Annex 4):
Market capacity assumption.

Structured spreads over Treasuries.

SWAP spreads

Swaption volatility.

Credit assumptions: Moody’s Transition Matrix/Migration rates.

Credit assumptions: Moody’s Default table.

Credit assumptions: Moody’s Recovery Rate table.

**Market Capacity Assumption**

Insurers should use the table in Annex 4ii to assist in determining asset values and the quantity of assets to be sold in stressed markets. The table incorporates average daily trading volumes from the Securities Industry and Financial Markets Association (SIFMA) for certain assets classes. Insurers should assume 80% of current volumes for stressed scenarios to calculate the price at which they can sell as well as the quantity to sell. Insurers should make their own assumptions for asset categories where no trading volume data is available using other categories as a proxy.

**Structured Spreads over Treasuries**

Insurers should use the table in Annex 4iii to assist in determining asset values and the quantity of assets to be sold in stressed markets. For baseline values, the industry shall submit year-end spreads to the state insurance regulators shortly after year-end. The state insurance regulators will review and approve the values for use in the table for LST purposes. State insurance regulators shall use structured spread data from the 2007-2009 period provided by JP Morgan added to baseline values to calculate stressed amounts for the 30-day, 90-day and one-year horizons to complete the table.

**Swap Spreads**

Insurers should use the table in Annex 4iv to assist in determining asset values and the quantity of assets to be sold in stressed markets. Swap spread source data from the FRB’s H.15 FRED data should be incorporated into the swap spread table. Stressed spread levels may affect assets prices for expected sales calculations necessary for the stress scenarios.
Swaption Volatility

Insurers should use the table in Annex 4v to assist in determining asset values and the quantity of assets to be sold in stressed markets. Insurers should obtain the information to populate the table from Bloomberg on swaption volatility for various time horizons and expiry. For consistency, insurers should use the table found on Bloomberg at NSV [Go].

Moody’s Transition Matrix/Migration Rates

Insurers should use the table in Annex 4vi to assist in determining credit migrations, asset values and the quantity of assets to be sold in stressed markets. The table is imported from Moody’s Corporate-Global: Annual default study, Exhibit 36 – Average one-year alphanumeric rating migration rates, 1983–2018. Insurers should use the equivalent Moody’s tables for U.S. Public Finance for municipal bonds.

Moody’s Default Table

Insurers should use the table in Annex 4vii to assist in determining asset values and the quantity of assets to be sold in stressed markets. The table is imported from Moody’s Corporate-Global: Annual default study, Exhibit 43 – Average cumulative issuer-weighted global default rates by letter rating, 1983–2018. Insurers should use the equivalent Moody’s tables for U.S. Public Finance for municipal bonds.

Moody’s Recovery Rate Table

Insurers should use the table in Annex 4viii to assist in determining asset values and the quantity of assets to be sold in stressed markets. The table is imported from Moody’s Corporate-Global: Annual default study, Exhibit 9 – Average corporate debt recovery rates measured by ultimate recoveries, 1987–2018. Insurers should use the equivalent Moody’s tables for U.S. Public Finance for municipal bonds.

Additionally, the 2008 stress scenario should be run considering sources other than expected asset sales (e.g., FHLB credit line draws, bank lines of credit and holding company contributions). The insurer must identify the expected asset sales for remaining liquidity deficiencies.
“What-if” Variation

The “what-if” modification to the severely adverse scenario eliminates the ability of the insurer to use other internal and external funding sources to satisfy any liquidity deficiency under stress—for example, no new FHLB draws or other loans, no holding company contributions, and no inter-affiliate contributions. Thus, expected asset sales will be the primary source of meeting any liquidity deficiency for the “what-if” scenario.

Company-Specific Assumptions

Insurers must construct the assumptions needed for their internal models to run the above 2008 stress scenario. Company-specific assumptions should be consistent with the above scenario as narrative and state insurance regulator-prescribed assumptions. Examples include the inability to roll or issue new debt, potential increases in lapse rates, new business sensitivity and mortality experience.

4.5.2 Interest Rate Spike/Industry Outlook and Downgrade Scenario

State Insurance Regulator-Provided Narrative

This scenario contemplates an interest rate spike, equities decrease, and the existence of credit spread stress. Additionally, the nationally recognized statistical rating organization (NRSRO) insurance industry outlook goes from stable to negative with many insurers experiencing a downgrade. A “what-if” modification to this stress scenario is also required. State insurance regulators see value in performing a sovereign debt stress scenario but are not ready to implement it for the 2019 LST. This stress scenario and “what-if” modification will accomplish some of the dynamics that would be included in a sovereign debt stress, and state insurance regulators will utilize those results to build out a sovereign debt stress scenario in the future. In the meantime, insurers should only assume as shocks to their baseline, the interest rate change, equity shock, credit spread and downgrade notches provided in this document for the 2019 LST.

State Insurance Regulator-Prescribed Assumptions

Insurers should run a scenario that considers the immediate impact of the following interest rate spikes. For the initial exercise, these would be implemented as parallel shifts to the baseline curve:
In addition to the rate spike, the scenario should incorporate the following assumptions:

- A one notch down grade after one month of the insurer’s senior debt or financial strength rating.
- A 25% decrease in equities.
- A one in 10 credit spread stress (reflecting the 90th percentile of the biggest annual credit spread increase over one year observed historically).

“What-If Variation”

The “what-if” modification to the interest rate spike/industry outlook and downgrade scenario includes all state insurance regulator-prescribed assumptions as per above except:

- Instead of a 25% decrease in equities, insurers should assume a 25% increase in equities.
- No credit spread stress should be assumed.

Company-Specific Assumptions

Insurers must construct the assumptions needed for their internal models to run the above stress scenario. Company-specific assumptions should be consistent with the above narrative and state insurance regulator-prescribed assumptions.

4.5.3 Insurer-Specific Information Request

Narrative

This information request requires insurers to provide a detailed narrative of their most severe liquidity stress scenario to obtain greater insight to the drivers of liquidity risk for specific insurers. The most severe scenario should be one that results in the largest liquidity deficiency (sources less uses) from their existing internal LST process. State insurance regulators may use this information to inform future prescribed stress scenarios.
Insurers should provide a comprehensive narrative describing the stress scenario and the economic environment. This stress scenario could be a combination of multiple stressors.

4.6 Available and Expected Asset Sales: 2019 Methodology

Once the stressed sources and uses of liquidity have been established, and the net cash-flows calculated, insurers then project the assets available at the end of the time horizon by asset category. (Please refer to Annex 3: Expected Asset Sales Categories) The valuation of available assets for the baseline scenario utilizes current and projected asset values for a normal operating environment. The valuation of available assets for a stress scenario will be based upon fair value haircuts per the specific stress scenario narrative, its regulatory-prescribed assumptions, or the company assumptions based on the narrative and regulatory-prescribed assumptions (e.g., fair market value haircuts and capacity indicators).

To the extent that stressed cash inflows are insufficient to meet the required cash outflows, the insurer must provide for cash-flows to meet the deficiency. Unless a stress scenario (or “what-if” modification of a stress scenario) indicates otherwise, the insurer can utilize internal and external funding sources (e.g., FHLB new draws), as well as asset sales, to satisfy a liquidity deficiency. Any expected asset sales must be reported in the appropriate column(s) of the template. Insurers decide which categories of available assets to sell, as well as the quantity to sell.

The expected asset sales amounts calculated based on the insurer’s own models should also be subject to portfolio manager and/or chief investment officer (CIO) feedback. The intent is for these asset sales to most accurately represent what actions the insurer could reasonably take in the given scenario, in light of market conditions and the company’s anticipated investment policy and/or strategy. This feedback may take the form of “topside” adjustments to the expected asset sales. To accommodate this, there is an initial expected asset sales column and a final expected asset sales column to highlight how the internal model process generates expected assets sale vs. the final expected asset sales which incorporates the investment portfolio manager’s insights and input.
5. Reporting

Insurers should submit data in the reporting template for sources and uses, available assets and expected asset sales. These templates utilize categories for 30-day, 90-day and one-year time horizons. The template further illustrates available assets, expected asset sales and final expected asset sales by asset sub-category to cover any liquidity deficiency (negative amounts of net sources less uses over the prescribed time horizons). Final asset sales should take into consideration portfolio manager input and market conditions that may require an adjustment to the expected asset sales values. A report should be submitted for each legal entity within the group that was subjected to LST.

Additional reporting disclosures (e.g., some of the company assumptions based on the stress scenario narrative and regulatory metrics) will be finalized in early 2020.

The reporting templates and other to-be-determined disclosures are anticipated to be submitted in third quarter 2020 (to be finalized in the future).

6. Data Aggregation

Given the NAIC’s primary focus on macroprudential impacts of a liquidity stress affecting the life insurance sector, the NAIC will aggregate final expected asset sales data across the insurance groups subject to the LST. The aggregation will be done by asset category. The NAIC aims to compare the aggregated results against various benchmarks, potentially including normal and/or stressed trading volumes and asset values for various asset classes, to determine the impact such sales may have on the capital markets in times of stress. Findings from this analysis may also inform expected asset sale assumptions utilized in future runs of the LST.

As part of its macroprudential surveillance, the state insurance regulators and/or NAIC may reach out to other regulatory agencies to discuss aggregate results that may affect other regulated industries, such as banks, securities brokers and asset managers. State insurance regulators may also coordinate with other agencies to identify appropriate and perhaps coordinated action they
may take to prevent or minimize the effect large asset sales may have on the financial markets and overall economy.

7. Regulatory Authority and Confidentiality

7.1 Regulatory Authority

For the 2019 LST, lead state insurance regulators will utilize their examination authority to collect the reporting results from insurers and to keep the data confidential. A long-term solution will be developed at the Financial Stability (EX) Task Force, possibly in coordination with the needs from the group capital calculation (GCC) project.

7.2 Protocols for Protecting Individual Firm’s Results

For the 2019 LST, lead state insurance regulators will utilize their examination authority to collect the reporting results from insurers identified by the scope criteria. Existing protocols for collecting confidential/sensitive data for each state and insurer will be utilized. A long-term solution will be developed at the Financial Stability (EX) Task Force, possibly in coordination with the needs from the group capital calculation (GCC) project.
8. Timeline

LST: Milestone Chart: 2019

- July: Expected asset sales
- Aug.: Severely adverse scenario and "what-if"
- Sept.: LAS call
- Oct.: Framework proposal for LST
- Nov.: Assumptions grid
- Int spike/downgrade
- Dec.: Dec 9 FSTF: Framework for comment

LST: Draft Milestone Chart: 2020 (tentative)

- Jan.: March 21 FSTF
- Feb.: Early April finalize instructions and template
- Mar.: April
- April: May
- May: July
- June: Early July data collection
- July: Aug.
- Aug.: Aug 8 FSTF
- Sept.: Data analysis
- Oct.: Nov.
- Nov.: Nov 14 FSTF
- Dec.:
Annex 1: Scope Criteria with Annual Statement Reference

The Subgroup proposes to include in the scope of the LST any insurer/group that exceeds the following thresholds for any of the noted activities (or account balance as a proxy for that activity). The thresholds have been established taking into consideration both the account balance of the insurer/group to the total balance for the life insurance sector, as well as the aggregate account balance of insurers/groups within scope to the aggregate account balance for the life insurance sector.

<table>
<thead>
<tr>
<th>Account Balances</th>
<th>Threshold in $B “Greater than”</th>
<th>Reference to 2017 NAIC Life/Accident and Health (A&amp;H) Annual Financial Statement Blank</th>
</tr>
</thead>
</table>
| Fixed and Indexed Annuities | 25 | Analysis of Increase in Annuity Reserves  
| | | Page: Supplement 62  
| | | Line: Reserves December 31, current year (15)  
| | | Column: Sum of Individual Fixed Annuities, Individual Indexed Annuities, Group Fixed Annuities and Group Indexed Annuities |
| Funding Agreements and Guaranteed Investment Contracts (GICs)i | 10 | Deposit-Type Contracts  
| | | Page: Exhibit 7 – Deposit-Type Contracts  
| | | Line: 9  
| | | Column: Guaranteed Investment Contracts (Column 2)  
| | | Column: Premium and Other Deposit Funds (Column 6) IF the amount of FHLB Funding Reserves from Note 11.B(4)(b) suggests funding agreements are not reported in Column 2 of Exhibit 7  
| | | Synthetic GICS  
| | | Page: Exhibit 5 – Interrogatories  
| | | Line: 7.1 |
| Derivatives – Notional Value (absolute value) | 75 | Derivatives – Notional Value (absolute value)  
| | | Pages: Schedule DB, Part A; Schedule DB, Part B, Section 1  
| | | Column: Notional Value (sum all) |
| Securities Lending | 2 | Securities Lending Collateral Assets  
| | | Pages: Schedule DL, Part 1; Schedule DL, Part 2  
| | | Line: Total (9999999)  
| | | Column: Fair Value |
| Repurchase Agreements | 1 | Repurchase Agreements  
| | | Page: Notes to Financial Statement Investments Restricted Assets  
| | | Line: Sum of 05L1C, 05L1D, 05L1E, 05L1F  
| | | Column: Total (General Account Plus Separate Account) |
| Borrowed Money (includes commercial papers, letters of credit, etc.) | 1 | Borrowed Money  
| | | Page: Liabilities  
| | | Line: Borrowed Money (22)  
| | | Column: Current Year |
In performing the addition of the FHLB funding agreement amount to the GICs amount, NAIC staff discovered that the reporting of FHLB funding agreements is not consistent in Exhibit 7, Deposit-Type Contracts. The source of the FHLB amount is Note 11.B(4)(b):

Line: Funding agreements, current year, amount as of the reporting date, borrowing from FHLB, collateral pledged to FHLB Column: Funding Agreement Reserves Established

For some insurers, we were able to match amounts from the FHLB funding agreement footnote to the exact same amount in Exhibit 7, either Column 2 (GICs) or Column 6 (Premiums and Other Deposit Funds). For those insurers where the FHLB amount matched Exhibit 7, Column 2, we did not add the FHLB funding agreement amount to the GICs amount, because that would be double-counting the FHLB funding agreements. For other insurers, even though the amounts did not match exactly, we were able to assume the FHLB funding agreements were reported in either Column 2 or Column 6 (e.g., the amount in Exhibit 7, Column 2 was zero or much smaller than the FHLB note, while the Column 6 amount was larger). However, for several insurers, we were not able to make an informed assumption (e.g., both Column 2 and Column 6 amounts were larger than the FHLB funding agreement amount). To be conservative in these instances, we added the FHLB funding agreement amount to the GICs amount. Overall, for the $10 billion threshold, adding FHLB funding agreements to GICs does not result in a different list of insurance groups from the list with GICs of more than $10 billion.
Annex 2: Sources and Uses

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<tr>
<th>Cash Flow</th>
<th>CF Type</th>
<th>CF Category</th>
<th>1 Month</th>
<th>3 Months</th>
<th>12 Months</th>
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<td>Dividends / Distributions</td>
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<th>3 Months</th>
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<tr>
<td>Capital</td>
<td>Shareholder / Policyholder Dividends</td>
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<tr>
<td></td>
<td>Capital Contributions to Subsidiaries</td>
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<td>✔️</td>
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<tr>
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<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Funding</td>
<td>Debt Maturities / Debt Servicing</td>
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<td>✔️</td>
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<tr>
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<td>GICs Benefits / Maturities</td>
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<td>✔️</td>
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</tbody>
</table>

Note: Certain flows could be settled in securities (e.g. margins on derivatives, capital contributions/dividends, etc.). Alternatively, eligible securities could be pledged to FHLB (or REPO with the street) to raise short-term funding.
Annex 3: Expected Asset Sales Categories

<table>
<thead>
<tr>
<th>Asset Category</th>
<th>Asset Sub-Category</th>
<th>1 Month</th>
<th>3 Months</th>
<th>12 Months</th>
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<tbody>
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<td>Cash</td>
<td>Cash &amp; Cash Equivalents</td>
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<td>Treasury &amp; Agency Bonds</td>
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<td></td>
<td>Other IG Sovereigns &amp; Regional Government</td>
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<td>Below IG Sovereigns &amp; Regional Government</td>
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<td></td>
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<tr>
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<td>Agency MBS</td>
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<td>Agency CMBS</td>
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<td>Agency ABS</td>
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<td>Public Bonds</td>
<td>IG Public Corporate Bonds</td>
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<tr>
<td></td>
<td>IG Municipal Bonds</td>
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<td>Below IG Public Corporate Bonds</td>
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<tr>
<td></td>
<td>Below IG Municipal Bonds</td>
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<td>IG 144As</td>
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<td>Below IG Private Placement Bonds</td>
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<tr>
<td></td>
<td>Below IG 144As</td>
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<tr>
<td>Non-Agency Structured Debt</td>
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<tr>
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<tr>
<td></td>
<td>IG CLO</td>
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<td>Below IG CMO</td>
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<tr>
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<td>Below IG CMBS</td>
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<td>Below IG CLO</td>
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<tr>
<td>Equity</td>
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<td>Other</td>
<td>Commercial, Residential, Agricultural</td>
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<td>Bank and Other Loans</td>
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<td>Other</td>
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<tr>
<td><strong>Total Expected Asset Sales</strong></td>
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</tbody>
</table>

Note: Any securities pledged as part of institutional funding agreements (e.g. FHLB) should be excluded and considered encumbered. However, any pre-pledged assets that are not securing credit that has been extended and remains outstanding (i.e., excess) should be considered unencumbered.
## Annex 3i. Example (reconciliation to portfolio manager review/feedback)

<table>
<thead>
<tr>
<th>Asset Category</th>
<th>Asset Sub-Category</th>
<th>1 Month</th>
<th>3 Months</th>
<th>12 Months</th>
<th>1 Month</th>
<th>3 Months</th>
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<th>Comments</th>
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<tr>
<td>Other Equity and Alternative Investments</td>
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<td>Other</td>
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<tr>
<td>Total</td>
<td></td>
<td>6,283</td>
<td>7,235</td>
<td>9,689</td>
<td>1,676</td>
<td>1,682</td>
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<td>1,493</td>
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<td>(1,676)</td>
<td>(1,682)</td>
<td>(9,013)</td>
<td>(1,676)</td>
<td>(1,682)</td>
<td>(9,013)</td>
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<tr>
<td>Cash</td>
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<td>488</td>
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<td>488</td>
<td>488</td>
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<tr>
<td>Total Assets Available for Sale</td>
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<td>7,235</td>
<td>9,689</td>
<td>1,676</td>
<td>1,682</td>
<td>9,013</td>
<td>1,676</td>
<td>1,682</td>
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<tr>
<td>% Asset Sales</td>
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<td>20.50%</td>
<td>17.70%</td>
<td>92.65%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
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<tr>
<td>Coverage Ratio</td>
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<td>311.91%</td>
<td>274.90%</td>
<td>104.51%</td>
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NAIC Proceedings – Fall 2019
Attachment Two
Financial Stability (EX) Task Force
12/9/19

DRAFT 2019 LST 11-26-2019

Annex 4: Regulatory Prescribed Assumptions
Annex 4i. Economic and Market Variables: Federal Reserve’s 2008 Severely Adverse Scenario
Placeholder-Illustrative Example only
Table 1.A. Historical data: Domestic variables, Q1:2000–Q4:2017
Percent, unless otherwise indicated.
Level

Date

Q1 2000
Q2 2000
Q3 2000
Q4 2000
Q1 2001
Q2 2001
Q3 2001
Q4 2001
Q1 2002
Q2 2002
Q3 2002
Q4 2002
Q1 2003
Q2 2003
Q3 2003
Q4 2003
Q1 2004
Q2 2004
Q3 2004
Q4 2004
Q1 2005
Q2 2005
Q3 2005
Q4 2005
Q1 2006
Q2 2006
Q3 2006
Q4 2006
Q1 2007
Q2 2007
Q3 2007
Q4 2007
Q1 2008
Q2 2008
Q3 2008
Q4 2008
Q1 2009
Q2 2009

Real GDP
growth

Nominal
GDP
growth

Real
disposable
income
growth

1.2
7.8
0.5
2.3
-1.1
2.1
-1.3
1.1
3.7
2.2
2.0
0.3
2.1
3.8
6.9
4.8
2.3
3.0
3.7
3.5
4.3
2.1
3.4
2.3
4.9
1.2
0.4
3.2
0.2
3.1
2.7
1.4
-2.7
2.0
-1.9
-8.2
-5.4
-0.5

4.3
10.2
3.1
4.5
1.4
5.1
0.0
2.3
5.1
3.8
3.8
2.4
4.6
5.1
9.3
6.8
5.9
6.6
6.3
6.4
8.3
5.1
7.3
5.4
8.2
4.5
3.2
4.6
4.8
5.4
4.2
3.2
-0.5
4.0
0.8
-7.7
-4.5
-1.2

8.1
4.2
4.8
1.4
3.5
-0.3
9.8
-4.9
10.1
2.0
-0.5
1.9
1.1
5.9
6.7
1.6
2.9
4.0
2.1
5.1
-3.8
3.2
2.1
3.4
9.5
0.6
1.2
5.3
2.6
0.8
1.1
0.3
2.9
8.7
-8.9
2.6
-0.8
2.9

Nominal
CPI
BBB
dispo- Unem3-month 5-year 10-year
Mortgage
sable ployment inflation Treasury Treasury Treasury corporate
rate
rate
yield
income
rate
rate
yield
yield
growth

11.8
6.1
7.4
3.6
6.3
1.6
10.1
-4.6
10.9
5.2
1.5
3.8
4.0
6.3
9.3
3.3
6.1
7.0
4.5
8.5
-1.8
6.0
6.6
6.6
11.5
3.7
4.1
4.6
6.5
4.0
3.4
4.4
6.5
13.3
-5.1
-3.2
-3.0
4.7

4.0
3.9
4.0
3.9
4.2
4.4
4.8
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5.7
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2.9
3.9
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-0.3
1.3
3.2
2.2
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4.2
-0.7
3.0
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4.3
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1.5
0.3
0.2
0.2

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6.6
6.5
6.1
5.6
4.9
4.9
4.6
4.2
4.5
4.5
3.4
3.1
2.9
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3.2
3.7

28

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8.1
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7.3
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6.4
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6.5
6.4
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8.2

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8.0
7.6
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6.8
7.0
6.8
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6.1
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6.2
6.6
6.6
6.2
6.2
6.4
6.6
6.2
5.9
6.1
6.3
5.9
5.1
5.0

Prime
rate

8.7
9.2
9.5
9.5
8.6
7.3
6.6
5.2
4.8
4.8
4.8
4.5
4.3
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4.0
4.0
4.4
4.9
5.4
5.9
6.4
7.0
7.4
7.9
8.3
8.3
8.3
8.3
8.2
7.5
6.2
5.1
5.0
4.1
3.3
3.3

Dow
Jones
Total
Stock
Market
Index

House
Price
Index

14,296
13,619
13,613
12,176
10,646
11,407
9,563
10,708
10,776
9,384
7,774
8,343
8,052
9,342
9,650
10,800
11,039
11,145
10,894
11,951
11,637
11,857
12,283
12,497
13,122
12,809
13,322
14,216
14,354
15,163
15,318
14,754
13,284
13,016
11,826
9,057
8,044
9,343

102
105
107
110
112
114
116
118
120
123
127
129
132
135
139
143
148
154
159
165
172
179
185
191
194
193
192
191
189
184
178
172
165
157
150
142
138
138

Commercial
Market
Real
Volatility
Estate
Index
Price
Index
127
125
139
144
143
142
143
139
140
140
142
144
151
151
149
147
153
164
175
178
179
185
190
199
204
213
220
222
230
239
247
249
236
224
231
219
208
180

27.0
33.5
21.9
31.7
32.8
34.7
43.7
35.3
26.1
28.4
45.1
42.6
34.7
29.1
22.7
21.1
21.6
20.0
19.3
16.6
14.7
17.7
14.2
16.5
14.6
23.8
18.6
12.7
19.6
18.9
30.8
31.1
32.2
24.1
46.7
80.9
56.7
42.3


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NAIC Proceedings – Fall 2019

Attachment Two
Financial Stability (EX) Task Force
12/9/19

DRAFT 2019 LST 11-26-2019

Table 1.A.—continued
Level
Real
disposable
income
growth

Nominal
CPI
BBB
dispo- Unem3-month 5-year 10-year
Mortgage
sable ployment inflation Treasury Treasury Treasury corporate
rate
rate
yield
income
rate
rate
yield
yield
growth

Dow
Jones
Total
Stock
Market
Index

House
Price
Index

3.3
3.3
3.3
3.3
3.3

10,813
11,385
12,032
10,646
11,814

138
139
139
138
135

160
160
152
165
165

31.3
30.7
27.3
45.8
32.9

4.4
4.8
4.7
4.3

3.3
3.3
3.3
3.3

13,131
13,909
13,843
11,677

134
133
132
133

167
172
173
172

23.5
29.4
22.7
48.0

5.0
4.7
4.5
4.2
3.9
4.0
4.1
4.9
4.8
4.6
4.3
4.2

4.0
3.9
3.8
3.6
3.4
3.5
3.7
4.4
4.3
4.4
4.2
4.1

3.3
3.3
3.3
3.3
3.3
3.3
3.3
3.3
3.3
3.3
3.3
3.3

13,019
14,627
14,100
14,895
14,835
16,396
16,771
17,718
19,413
19,711
20,569
20,459

133
134
138
140
143
147
151
155
158
160
161
163

178
180
181
187
187
190
199
208
212
211
220
223

45.5
23.0
26.7
20.5
22.7
19.0
20.5
17.0
20.3
21.4
17.0
17.0

2.3
2.0
2.2
2.3

4.2
4.0
4.2
4.5

4.0
3.7
3.8
4.0

3.3
3.3
3.3
3.3

21,425
21,708
21,631
19,959

166
168
170
172

234
249
251
257

26.3
22.4
18.9
40.7

1.6
1.4
1.3
1.2

2.2
2.0
1.8
1.6

4.6
4.6
4.1
3.7

3.9
3.7
3.6
3.4

3.3
3.5
3.5
3.5

21,101
21,179
21,621
22,469

175
177
179
182

254
245
248
266

24.4
28.1
25.8
18.1

1.7
2.0
1.8
1.8
2.1

2.2
2.5
2.3
2.3
2.4

4.1
4.2
4.0
3.9
4.0

3.8
4.2
4.0
3.9
3.9

3.5
3.8
4.0
4.3
4.3

23,277
24,508
25,125
26,149
27,673

184
187
190
193
194

269
262
272
275
279

22.5
13.1
16.0
16.0
13.1

Real GDP
growth

Nominal
GDP
growth

Q3 2009
Q4 2009
Q1 2010
Q2 2010
Q3 2010

1.3
3.9
1.7
3.9
2.7

1.2
5.2
3.2
5.8
4.6

-4.3
-0.5
0.4
5.3
2.0

-1.9
2.2
1.8
5.8
3.2

9.6
9.9
9.8
9.6
9.5

3.5
3.2
0.6
-0.1
1.2

0.2
0.1
0.1
0.1
0.2

2.5
2.3
2.4
2.3
1.6

3.8
3.7
3.9
3.6
2.9

6.8
6.1
5.8
5.6
5.1

5.2
4.9
5.0
4.9
4.4

Q4 2010
Q1 2011
Q2 2011
Q3 2011

2.5
-1.5
2.9
0.8

4.7
0.2
6.0
3.3

2.8
5.0
-0.6
2.1

5.0
8.2
3.5
4.3

9.5
9.0
9.1
9.0

3.3
4.3
4.6
2.6

0.1
0.1
0.0
0.0

1.5
2.1
1.8
1.1

3.0
3.5
3.3
2.5

5.0
5.4
5.1
4.9

Q4 2011
Q1 2012
Q2 2012
Q3 2012
Q4 2012
Q1 2013
Q2 2013
Q3 2013
Q4 2013
Q1 2014
Q2 2014
Q3 2014

4.6
2.7
1.9
0.5
0.1
2.8
0.8
3.1
4.0
-0.9
4.6
5.2

5.2
4.9
3.8
2.7
1.7
4.4
1.6
5.1
6.1
0.7
7.0
7.1

0.2
6.7
3.1
-0.2
10.9
-15.7
2.4
2.4
0.9
4.3
5.3
4.2

1.6
9.2
4.4
1.1
13.3
-14.5
2.5
3.9
2.6
6.5
7.1
5.5

8.6
8.3
8.2
8.0
7.8
7.7
7.5
7.2
6.9
6.7
6.2
6.1

1.8
2.3
0.8
1.8
2.7
1.6
-0.5
2.2
1.6
2.6
1.9
1.0

0.0
0.1
0.1
0.1
0.1
0.1
0.1
0.0
0.1
0.0
0.0
0.0

1.0
0.9
0.8
0.7
0.7
0.8
0.9
1.5
1.4
1.6
1.7
1.7

2.1
2.1
1.8
1.6
1.7
1.9
2.0
2.7
2.8
2.8
2.7
2.5

Q4 2014
Q1 2015
Q2 2015
Q3 2015

2.0
3.2
2.7
1.6

2.6
3.2
5.0
3.0

5.9
4.3
3.8
1.8

5.7
2.6
5.6
3.2

5.7
5.6
5.4
5.1

-0.7
-2.5
2.4
1.5

0.0
0.0
0.0
0.0

1.6
1.5
1.5
1.6

Q4 2015
Q1 2016
Q2 2016
Q3 2016

0.5
0.6
2.2
2.8

1.3
0.8
4.7
4.2

2.9
0.2
1.9
0.7

3.1
0.9
4.0
2.5

5.0
4.9
4.9
4.9

0.4
0.1
2.3
1.8

0.1
0.3
0.3
0.3

Q4 2016
Q1 2017
Q2 2017
Q3 2017
Q4 2017

1.8
1.2
3.1
3.2
2.7

3.8
3.3
4.1
5.3
5.0

-1.8
2.9
2.7
0.5
1.9

0.1
5.2
3.0
2.1
5.6

4.7
4.7
4.3
4.3
4.1

3.0
3.1
-0.3
2.0
3.7

0.4
0.6
0.9
1.0
1.2

Date

Prime
rate

Commercial
Market
Real
Volatility
Estate
Index
Price
Index

Note: Refer to Notes Regarding Scenario Variables for more information on the definitions and sources of historical observations of the variables in the table.

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Table 4.A. Supervisory severely adverse scenario: Domestic variables, Q1:2018–Q1:2021
Percent, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Date</th>
<th>Real GDP growth</th>
<th>Nominal GDP growth</th>
<th>Real disposable income growth</th>
<th>Nominal disposable income growth</th>
<th>Unemployment rate</th>
<th>CPI inflation rate</th>
<th>3-month Treasury yield</th>
<th>5-year Treasury yield</th>
<th>10-year Treasury yield</th>
<th>BBB corporate yield</th>
<th>Mortgage rate</th>
<th>Prime rate</th>
<th>Dow Jones Total Stock Market Index</th>
<th>House Price Index</th>
<th>Commercial Real Estate Price Index</th>
<th>Market Volatility Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2018</td>
<td>-4.7</td>
<td>-2.3</td>
<td>1.4</td>
<td>3.0</td>
<td>5.0</td>
<td>1.4</td>
<td>0.1</td>
<td>1.9</td>
<td>2.4</td>
<td>7.1</td>
<td>5.3</td>
<td>3.3</td>
<td>13,466</td>
<td>186</td>
<td>262</td>
<td>50.7</td>
</tr>
<tr>
<td>Q2 2018</td>
<td>-8.9</td>
<td>-7.1</td>
<td>-4.2</td>
<td>-3.1</td>
<td>6.5</td>
<td>0.9</td>
<td>0.1</td>
<td>1.9</td>
<td>2.4</td>
<td>7.7</td>
<td>5.7</td>
<td>3.3</td>
<td>11,631</td>
<td>171</td>
<td>234</td>
<td>62.4</td>
</tr>
<tr>
<td>Q3 2018</td>
<td>-6.8</td>
<td>-5.1</td>
<td>-5.1</td>
<td>-3.8</td>
<td>7.6</td>
<td>1.2</td>
<td>0.1</td>
<td>1.9</td>
<td>2.4</td>
<td>7.9</td>
<td>5.8</td>
<td>3.3</td>
<td>10,575</td>
<td>159</td>
<td>212</td>
<td>59.5</td>
</tr>
<tr>
<td>Q4 2018</td>
<td>-4.7</td>
<td>-3.0</td>
<td>-3.9</td>
<td>-2.5</td>
<td>8.5</td>
<td>1.3</td>
<td>0.1</td>
<td>1.9</td>
<td>2.4</td>
<td>8.0</td>
<td>5.9</td>
<td>3.3</td>
<td>10,306</td>
<td>151</td>
<td>195</td>
<td>52.8</td>
</tr>
<tr>
<td>Q1 2019</td>
<td>-3.6</td>
<td>-1.8</td>
<td>-2.9</td>
<td>-1.5</td>
<td>9.3</td>
<td>1.5</td>
<td>0.1</td>
<td>1.9</td>
<td>2.4</td>
<td>8.1</td>
<td>6.0</td>
<td>3.2</td>
<td>9,689</td>
<td>143</td>
<td>181</td>
<td>47.4</td>
</tr>
<tr>
<td>Q2 2019</td>
<td>-1.3</td>
<td>0.3</td>
<td>-2.4</td>
<td>-1.0</td>
<td>9.7</td>
<td>1.5</td>
<td>0.1</td>
<td>1.9</td>
<td>2.4</td>
<td>7.9</td>
<td>6.0</td>
<td>3.2</td>
<td>10,100</td>
<td>139</td>
<td>173</td>
<td>37.9</td>
</tr>
<tr>
<td>Q3 2019</td>
<td>-0.2</td>
<td>1.4</td>
<td>-1.4</td>
<td>-0.1</td>
<td>10.0</td>
<td>1.5</td>
<td>0.1</td>
<td>1.9</td>
<td>2.4</td>
<td>7.5</td>
<td>5.8</td>
<td>3.2</td>
<td>10,949</td>
<td>136</td>
<td>167</td>
<td>29.7</td>
</tr>
<tr>
<td>Q4 2019</td>
<td>2.8</td>
<td>4.3</td>
<td>-0.1</td>
<td>1.5</td>
<td>9.9</td>
<td>1.8</td>
<td>0.1</td>
<td>1.9</td>
<td>2.4</td>
<td>7.1</td>
<td>5.7</td>
<td>3.2</td>
<td>12,031</td>
<td>136</td>
<td>167</td>
<td>23.5</td>
</tr>
<tr>
<td>Q1 2020</td>
<td>3.5</td>
<td>4.8</td>
<td>1.9</td>
<td>3.4</td>
<td>9.7</td>
<td>1.8</td>
<td>0.1</td>
<td>1.9</td>
<td>2.4</td>
<td>6.7</td>
<td>5.5</td>
<td>3.2</td>
<td>13,234</td>
<td>136</td>
<td>167</td>
<td>19.8</td>
</tr>
<tr>
<td>Q2 2020</td>
<td>4.0</td>
<td>5.2</td>
<td>2.3</td>
<td>3.7</td>
<td>9.5</td>
<td>1.7</td>
<td>0.1</td>
<td>1.9</td>
<td>2.4</td>
<td>6.3</td>
<td>5.3</td>
<td>3.2</td>
<td>14,713</td>
<td>137</td>
<td>170</td>
<td>17.5</td>
</tr>
<tr>
<td>Q3 2020</td>
<td>4.2</td>
<td>5.3</td>
<td>2.7</td>
<td>4.1</td>
<td>9.2</td>
<td>1.6</td>
<td>0.1</td>
<td>1.9</td>
<td>2.4</td>
<td>5.9</td>
<td>5.1</td>
<td>3.2</td>
<td>16,323</td>
<td>139</td>
<td>172</td>
<td>16.0</td>
</tr>
<tr>
<td>Q4 2020</td>
<td>4.5</td>
<td>5.5</td>
<td>3.1</td>
<td>4.3</td>
<td>8.9</td>
<td>1.6</td>
<td>0.1</td>
<td>1.9</td>
<td>2.4</td>
<td>5.5</td>
<td>4.9</td>
<td>3.2</td>
<td>18,143</td>
<td>141</td>
<td>176</td>
<td>15.0</td>
</tr>
<tr>
<td>Q1 2021</td>
<td>4.5</td>
<td>5.4</td>
<td>3.3</td>
<td>4.5</td>
<td>8.6</td>
<td>1.5</td>
<td>0.1</td>
<td>1.9</td>
<td>2.4</td>
<td>5.0</td>
<td>4.7</td>
<td>3.2</td>
<td>20,188</td>
<td>143</td>
<td>180</td>
<td>14.4</td>
</tr>
</tbody>
</table>

Note: Refer to Notes Regarding Scenario Variables for more information on the definitions and sources of historical observations of the variables in the table.

ANNEX 4ii. MARKET CAPACITY ASSUMPTION

**Placeholder-Illustrative Example only**

<table>
<thead>
<tr>
<th>Asset Category</th>
<th>Asset Sub-Category</th>
<th>Name in 2010 SIFMA Factbook</th>
<th>Year in 2019 SIFMA Factbook</th>
<th>Average Daily Trading Volume ($ billions)</th>
<th>Volume - Assume 80% Haircut</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government Securities</td>
<td>Treasury &amp; Agency Bonds</td>
<td>16; U.S. BOND MARKET AVERAGE DAILY TRADING VOLUME; Treasury + Federal Agency Securities</td>
<td>2008</td>
<td>657.51</td>
<td>526.01</td>
</tr>
<tr>
<td>Other IG Sovereigns &amp; Regional Government</td>
<td>Below IG</td>
<td>Agency CMO</td>
<td>16; U.S. BOND MARKET AVERAGE DAILY TRADING VOLUME; Agency CMO</td>
<td>2008</td>
<td>344.92</td>
</tr>
<tr>
<td>Agency MBS</td>
<td>16; U.S. BOND MARKET AVERAGE DAILY TRADING VOLUME; Agency MBS</td>
<td>2008</td>
<td>344.92</td>
<td>275.94</td>
<td></td>
</tr>
<tr>
<td>Agency CMBS</td>
<td>16; U.S. BOND MARKET AVERAGE DAILY TRADING VOLUME; Municipal Bonds</td>
<td>2008</td>
<td>19.37</td>
<td>15.50</td>
<td></td>
</tr>
<tr>
<td>Agency ABS</td>
<td>16; U.S. BOND MARKET AVERAGE DAILY TRADING VOLUME</td>
<td>2008</td>
<td>14.32</td>
<td>11.46</td>
<td></td>
</tr>
<tr>
<td>Public Bonds</td>
<td>IG Public Corporate Bonds</td>
<td>16; U.S. BOND MARKET AVERAGE DAILY TRADING VOLUME; Corporate Bonds</td>
<td>2008</td>
<td>14.32</td>
<td>11.46</td>
</tr>
<tr>
<td>IG Municipal Bonds</td>
<td>16; U.S. BOND MARKET AVERAGE DAILY TRADING VOLUME; Municipal Bonds</td>
<td>2008</td>
<td>19.37</td>
<td>15.50</td>
<td></td>
</tr>
<tr>
<td>Private Bonds</td>
<td>IG Private</td>
<td>16; U.S. BOND MARKET AVERAGE DAILY TRADING VOLUME; Non-Agency MBS</td>
<td>2011</td>
<td>4.44</td>
<td>3.55</td>
</tr>
<tr>
<td>IG 144As</td>
<td>16; U.S. BOND MARKET AVERAGE DAILY TRADING VOLUME; IG 144As</td>
<td>2011</td>
<td>4.44</td>
<td>3.55</td>
<td></td>
</tr>
<tr>
<td>Below IG Private</td>
<td>Below IG 144As</td>
<td>IG CMO</td>
<td>16; U.S. BOND MARKET AVERAGE DAILY TRADING VOLUME; IG CMO</td>
<td>2011</td>
<td>1.47</td>
</tr>
<tr>
<td>Non-Agency Structured Debt</td>
<td>IG MBS</td>
<td>IG CMBS</td>
<td>16; U.S. BOND MARKET AVERAGE DAILY TRADING VOLUME; IG CMBS</td>
<td>2011</td>
<td>1.47</td>
</tr>
<tr>
<td>IG ABS</td>
<td>16; U.S. BOND MARKET AVERAGE DAILY TRADING VOLUME</td>
<td>2011</td>
<td>1.47</td>
<td>1.18</td>
<td></td>
</tr>
<tr>
<td>IG CLO</td>
<td>16; U.S. EQUITY MARKETS AVERAGE DAILY TRADING VOLUME - CHART; U.S. equity</td>
<td>2009</td>
<td>220.47</td>
<td>176.37</td>
<td></td>
</tr>
<tr>
<td>Equity</td>
<td>Common Stock</td>
<td>Preferred Stock</td>
<td>Other Equity and Other</td>
<td>16; U.S. EQUITY MARKETS AVERAGE DAILY TRADING VOLUME - CHART; U.S. equity</td>
<td>2009</td>
</tr>
<tr>
<td>Other</td>
<td>Commercial, Residential, Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Annex 4iii. Structured spreads over Treasuries

**Placeholder-Illustrative Example only**

<table>
<thead>
<tr>
<th>Asset Type</th>
<th>Baseline</th>
<th>1 Mo.</th>
<th>3 Mo.</th>
<th>6 Mo.</th>
<th>9 Mo.</th>
<th>12 Mo.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency MBS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Non-Agency MBS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CMBs</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CLO/CDO</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ABS-Cards</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ABS-Auto</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

### Annex 4iv. Swap Spreads

**Placeholder-Illustrative Example only**

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Baseline</th>
<th>1 Mo.</th>
<th>3 Mo.</th>
<th>6 Mo.</th>
<th>9 Mo.</th>
<th>12 Mo.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Mo.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5 Yr</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>10 Yr</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>20 Yr</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>30 Yr</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

1. (Nominal) Swap Spreads (in BPS)
2. IR Par Swap Spreads for USD, EUR, JPY, GBP, AUD and CAD
Timeseries of Swap Rates, Treasury Rates, and Swap Spreads

1 Years
- Swap
- Treasury
- Spread

2 Years
- Swap
- Treasury
- Spread

3 Years
- Swap
- Treasury
- Spread

5 Years
- Swap
- Treasury
- Spread

7 Years
- Swap
- Treasury
- Spread

10 Years
- Swap
- Treasury
- Spread

30 Years
- Swap
- Treasury
- Spread

Date

Swap and Treasury rates from H.15 (via FRED).
Spread paid by fixed-rate payer on an interest rate swap over constant maturity Treasury at the given maturities.

Source: Federal Reserve
Annex 4v. Implied Volatility of IR Swaptions

**Placeholder-Illustrative Example only**

<table>
<thead>
<tr>
<th>Time Horizon 0</th>
<th>3Y</th>
<th>7Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenor/Expiry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Mo.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3Y</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5Y</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>7Y</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>10Y</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
### Exhibit 36. Average one-year alphanumeric rating migration rates, 1983-2018

| From | Aaa | Aa1 | Aa2 | Aa3 | A1  | A2  | A3  | Baa1 | Baa2 | Baa3 | Ba1 | Ba2 | Ba3 | B1  | B2  | Ca1 | Ca2 | Ca3 | Ca-C | WR | Dw1 |
|------|-----|-----|-----|-----|-----|-----|-----|------|------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Aaa  | 86.92% | 4.31% | 1.49% | 0.15% | 0.12% | 0.29% | 0.02% | 0.06% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 4.25% | 0.00% |
| Aa1  | 1.70% | 76.66% | 8.04% | 5.90% | 1.43% | 0.91% | 0.18% | 0.12% | 0.08% | 0.01% | 0.04% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 4.82% | 0.00% |
| Aa2  | 1.04% | 4.33% | 73.29% | 10.31% | 3.52% | 1.65% | 0.41% | 0.06% | 0.03% | 0.02% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 5.01% | 0.00% |
| Aa3  | 0.15% | 1.07% | 4.18% | 75.15% | 8.79% | 3.60% | 0.64% | 0.24% | 0.12% | 0.03% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 5.48% | 0.04% |
| A1   | 0.05% | 0.10% | 1.06% | 5.12% | 75.75% | 7.71% | 7.24% | 0.62% | 0.45% | 0.10% | 0.10% | 0.05% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 5.56% | 0.07% |
| A2   | 0.00% | 0.03% | 0.21% | 1.05% | 5.83% | 76.17% | 7.37% | 2.60% | 1.02% | 0.38% | 0.18% | 0.14% | 0.17% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 4.61% | 0.01% |
| A3   | 0.04% | 0.04% | 0.10% | 0.30% | 1.52% | 6.39% | 75.08% | 6.84% | 2.74% | 0.89% | 0.30% | 0.10% | 0.11% | 0.04% | 0.02% | 0.00% | 0.00% | 0.00% | 5.15% | 0.05% |
| Baa1 | 0.15% | 0.08% | 0.12% | 0.25% | 0.73% | 7.50% | 6.75% | 2.34% | 0.30% | 0.22% | 0.07% | 0.03% | 0.03% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 5.05% | 0.14% |
| Baa2 | 0.04% | 0.04% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 5.34% | 0.35% |
| Baa3 | 0.03% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 6.00% | 0.23% |
| Ba1  | 0.00% | 0.00% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 7.46% | 0.43% |
| Ba2  | 0.00% | 0.00% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 0.02% | 8.54% | 0.71% |
| Ba3  | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 10.05% | 1.88% |
| B1   | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 15.46% | 4.62% |
| B2   | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 12.48% | 4.62% |
| Ca1  | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 14.09% | 4.62% |
| Ca2  | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 15.48% | 8.82% |
| Ca3  | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 12.46% | 4.62% |
| Ca-C | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 14.75% | 18.17% |

Source: Moody's
**Annex 4vii. Credit Assumptions: Moody’s Default Table**

**Placeholder-Illustrative Example only**

<table>
<thead>
<tr>
<th>Emergence Year</th>
<th>Default Year</th>
<th>1987-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>2017</td>
<td>85.0%</td>
</tr>
<tr>
<td>2018</td>
<td>2017</td>
<td>85.0%</td>
</tr>
</tbody>
</table>

Source: Moody’s

**Annex 4viii. Credit Assumptions: Moody’s Recovery Rate Table**

**Placeholder-Illustrative Example only**

<table>
<thead>
<tr>
<th>Priority Corporate Debt Recovery Rates Measured by Ultimate Recoveries, 1987-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loans</td>
</tr>
<tr>
<td>Senior Secured Bonds</td>
</tr>
<tr>
<td>Senior Unsecured Bonds</td>
</tr>
<tr>
<td>Subordinated Bonds</td>
</tr>
<tr>
<td>85.0% 83.3% 80.3% 85.0% 84.3% 80.3% 55.0% 65.7% 62.2% 35.5% 58.3% 47.7% 0.0% 51.2% 28.0% 62.9% 28.0%</td>
</tr>
</tbody>
</table>

Source: Moody’s
To: Commissioner Marlene Caride, Chair of the Financial Stability (EX) Task Force  
From: Mike Boerner, Chair of the Valuation Analysis (E) Working Group  
Date: November 27, 2019  
Re: Response to Request from the Financial Stability (EX) Task Force

Executive Summary

On 6/17/19, you made a request to the Valuation Analysis (E) Working Group (VAWG) to assess a potential concern related to Economic Scenario Generators (ESGs) developed by the American Academy of Actuaries (Academy). These ESGs are currently prescribed (or encouraged) for the following calculations: (1) Risk-Based Capital for Variable Annuities (C-3 Phase II) and certain annuities or single premium life insurance products (C-3 Phase 1); (2) Statutory Reserves for Variable Annuities (Actuarial Guideline 43 and VM-21 of the Valuation Manual); and (3) Statutory Reserves for Life & Variable Life Insurance (VM-20 of the Valuation Manual). One insurer suggested that there is a deficiency in the current ESG in that it doesn’t adequately consider a very low or negative interest rate environment, and more specifically that this raises a material risk at the macro prudential level in the U.S., particularly for variable annuities.

The Life Actuarial (A) Task Force (LATF) has begun a process to replace the Academy ESGs. However, to allay any concerns during the interim period until a new ESG is in place, you requested that the VAWG assess this insurer’s concern and provide assurance that any issues either have been addressed, or will be able to be addressed.

To assess the concern during the interim period (which is expected to be several years), the VAWG sent an information request to companies representing over 90% of the U.S. variable annuity business inforce. The responses indicate that overall, companies are aware of the significance of variable annuity interest rate risk, and have taken various actions to measure and manage it. However, there were findings for individual companies that will require further review and follow-up. The VAWG also sees a need for continued monitoring via coordinated reviews of companies’ future variable annuity filings, similar to those currently performed for LTC AG51 reports and the VM-31 Life PBR Actuarial Reports.

The VAWG plans to take the following actions to provide assurance that any issues regarding companies’ variable annuity interest rate risk will be addressed: 1) Questions regarding findings of concern and informational questions for individual companies will be developed, for referral to domestic state regulators for review and follow-up; 2) A communication will be sent to state regulators to alert them to the concern raised regarding interest rate risk for variable annuities, and to encourage them to focus on this as they assess risks, conduct financial reviews, and review companies’ asset adequacy testing; 3) A recommendation will be made to review and consider enhancements to the Financial Condition Examiner’s Handbook to address review of proprietary ESGs used for hedging and other purposes; and 4) A coordinated review of the VM-31 Variable Annuity PBR Actuarial Reports and C3 Phase II reports will be performed for all early adopters of the new variable annuity framework for reserves and capital. The framework becomes mandatory for all inforce business in 2020. However, companies may elect to early adopt as of 12/31/19.

This report provides key findings from the information request, including materiality of variable annuity interest rate risk and the approaches companies have taken to measure and manage it. The report concludes with information on current usage of the Academy ESGs, the status of the RFP for a new ESG, and the potential length of the interim period before the new ESG will be implemented.
Industry VA Information Request

To assess the concern raised regarding variable annuity interest rate risk in the interim period before a new ESG is implemented, an information request was sent to 24 companies representing over 90% of the U.S. variable annuity business in force. Companies were asked to provide the following information:

2. A discussion on how the company is addressing the risks to variable annuities from an extended period of low interest rates, including commentary on actions taken and planned beyond the use of the Academy ESG, if applicable. As part of this discussion companies were asked to include: a) a description of the types of guarantees provided on their variable annuities; b) information on how the company measures and manages interest rate risk from variable annuities and associated guarantees; and c) an assessment of the materiality of this risk to the company.

Key Findings

Summarized below are some of the key findings from the VAWG’s review of industry responses.

Types of Guarantees Provided on Variable Annuities

Nearly all companies offered a Guaranteed Minimum Death Benefit (GMDB) on their products. Most companies also offered one or more of the following types of guaranteed living benefits:
- Guaranteed Minimum Income Benefit (GMIB)
- Guaranteed Minimum Withdrawal Benefit (GMWB)
- Guaranteed Minimum Accumulation Benefit (GMAB)
- A fixed account with or without a market value adjustment, with a guaranteed minimum interest rate

Materiality of Interest Rate Risk

The vast majority of companies acknowledged that interest rate risk from VA guarantees represents a material risk for their company. For the few remaining companies, this risk was not viewed as material either because the VA block represents a relatively small percentage of total in force business, or because the risk was completely or largely transferred to a reinsurer.

Measurement and Management of Interest Rate Risk

ESGs produce stochastic interest rate scenarios which are used to measure and manage risk. However, ESGs are not the only tools used for this purpose. Pre-defined deterministic scenarios, such as the NY7 scenarios commonly used in asset adequacy testing, can be effective as well. Many companies also monitor earnings volatility (e.g. economic, Statutory, GAAP).

The vast majority of companies have a hedging program in place to manage interest rate risk, and typically other risks as well, such as equity risk. Many of these companies have a Clearly Defined Hedging Strategy, meaning that specific criteria defined in the Valuation Manual have been met. Some companies noted that they have recently made changes to their hedging approach, such as increasing the amount of interest rate hedging.

Some companies disclosed the results of their hedging programs and reported high hedge effectiveness. This information was not specifically requested and was not provided by most companies.
Nearly all companies with a hedging program indicated that they do not rely on the Academy ESGs for hedging. Proprietary ESGs are commonly used for this, as well as other purposes (e.g. economic capital, and day-to-day risk management).

Management Actions

In addition to the activities mentioned above, many companies have taken actions to further address interest rate risk. Actions cited in the survey include but are not limited to those listed below.

- Discontinuing sales - About a third of the companies surveyed are no longer selling variable annuities. Of those currently issuing new business, some have discontinued sales of one or more of their guaranteed living benefits.
- Lowering the guaranteed minimum interest rates offered on fixed accounts for new sales, or discontinuing fixed accounts altogether
- De-risking guaranteed living benefits, e.g. by adjusting fees and/or benefits
- Offering a lump sum to certain contract holders in exchange for termination of a guaranteed living benefit
- Some companies hold additional reserves beyond the minimum requirements

Use of Academy ESGs for Statutory Reserves and Capital

Nearly all companies provided information on the type of ESG used in calculating 2018 statutory reserves and capital. Approximately 75% used an Academy ESG, with or without modifications. Of these companies, many used the Academy VM-20 ESG, which will be prescribed in 2020 under the new VA framework. Some used an older Academy C-3 Phase 1 ESG, which has a higher, less conservative long-term interest rate assumption. However, some companies adjusted this assumption to bring it closer to that used in the Academy VM-20 ESG. Other companies did not specifically state which Academy ESG they used. The remaining 25% of the companies used a proprietary ESG, and about half of these appear to be more conservative than the Academy VM-20 ESG. Companies may continue to use these ESGs under the new VA framework, since the Academy VM-20 ESG is prescribed as the minimum standard.

ESG RFP Status and Potential Length of Interim Period

The process of implementing a new ESG is expected to take several years. There is agreement that the Academy ESGs must be replaced and that various enhancements will be necessary, including adequate consideration of a prolonged low interest rate environment. However, many steps will be needed prior to implementation, since the intent is to consider prescribing the new ESG for all of the calculations noted in the first paragraph of this report.

Progress has been made on this initiative. At the time of your request to the VAWG, an informal subgroup of LATF was considering various alternatives to replace the Academy ESGs. On 7/16/19, an open meeting of the Life RBC Working Group (LRBC WG) and LATF was held to discuss the alternatives, and a request was made that NAIC staff move forward with the RFP process to select an ESG vendor to develop and maintain a new prescribed ESG.
A group consisting of regulators, NAIC staff, Academy representatives, and other industry subject matter experts has been formed and has met several times to work on a draft RFP. The target timeframe for completion is Q1, 2020, although it may take longer. The RFP will then need to be adopted by LATF and the Life Insurance and Annuities (A) Committee and presented to the NAIC Executive (EX) Committee for final approval, including a request for appropriate funding. The NAIC will then issue the RFP, and submissions will be reviewed based upon weighted criteria as specified within the issued RFP. A recommendation for award will then be submitted to the NAIC Executive (EX) Committee for final approval.

Once an ESG vendor has been selected, implementation of the ESG will require additional steps such as the following: 1) consideration and adoption of any potential ESG parameter modifications desired by regulators; 2) an impact study to assess the results; 3) drafting, exposure, and adoption of any Valuation Manual amendments and RBC instruction changes necessary to incorporate prescription of the new ESG; 4) documentation on the ESG methodology and parameters; and 5) training on the use of the ESG. This entire process is expected to be completed no sooner than 2022 (i.e. effective for the 2022 Valuation Manual).
GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

The Government Relations (EX) Leadership Council did not meet at the Fall National Meeting.
INNOVATION AND TECHNOLOGY (EX) TASK FORCE

Innovation and Technology (EX) Task Force Dec. 9, 2019, Minutes .................................................................4-77
    Big Data (EX) Working Group Dec. 7, 2019, Minutes (Attachment One). ............................................................4-84
    Big Data (EX) Working Group Oct. 7, 2019, Minutes (Attachment One-A).........................................................4-87
    Speed to Market (EX) Working Group Dec. 3, 2019, Minutes (Attachment Two)..............................................4-90
    Speed to Market (EX) Working Group Sept. 12, 2019, Minutes (Attachment Two-A) ......................................4-92
    Artificial Intelligence (EX) Working Group Dec. 7, 2019, Minutes (Attachment Three) .................................4-93
Innovation and Technology (EX) Task Force Oct. 18, 2019, Minutes (Attachment Four) .......................................4-95
    Artificial Intelligence (EX) Working Group Sept. 5, 2019, Minutes (Attachment Four-A) ..............................4-100
Innovation and Technology (EX) Task Force 2020 Proposed Charges (Attachment Four-B) ..................................4-103
Center for Economic Justice (CEJ) Comments Regarding Suggested InsurTech Bulletin,
    April 19, 2019 (Attachment Four-C) ...............................................................................................................4-105
Request for NAIC Model Law Development: Amendments to Unfair Trade Practices
    Act (#880) (Attachment Four-D) ......................................................................................................................4-107
The Innovation and Technology (EX) Task Force met in Austin, TX, Dec. 9, 2019. The following Task Force members participated: Jon Godfred, Chair, and Chris Aufenthie (ND); Keith Schraad, Vice Chair (AZ); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Jerry Workman (AL); Allen W. Kerr represented by Letty Hardee (AR); Michael Conway represented by Peg Brown (CO); Andrew N. Mais (CT); Stephen C. Taylor (DC); Trinidad Navarro represented by Leslie Ledogar (DE); David Altmaier represented by Mike YaVorsky (FL); Colin M. Hayashida (HI); Doug Ommen and Travis Grassel (IA); Dean L. Cameron represented by Weston Trexler (ID); Robert H. Muriel represented by CJ Metcalf (IL); Vicki Schmidt represented by LeAnn Crow (KS); Nancy G. Atkins (KY); James J. Donelon represented by Rich Piazza and Warren Byrd (LA); Al Redmer Jr. and Robert Baron (MD); Gary Anderson represented by Rachel M. Davison (MA); Anita G. Fox represented by Chad Arnold (MI); Steve Kelley represented by Tammy Lohmann and Phil Vigliaturo (MN); Chlora Lindley-Myers represented by Angela Nelson and Cynthia Amann (MO); Mike Causey represented by Tracy Biehn and Kathy Shortt (NC); John Elias represented by Christian Citarella (NH); John G. Francini and Anna Krylova (NM); Jillian Froment (OH); Glen Mulready (OK); Andrew Stolfi (OR); Jessica Altman and Michael Humphreys (PA); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer (SC); Larry Deiter (SD); Hodgen Mainda represented by Carter Lawrence (TN); Kent Sullivan represented by Michael Nored (TX); Scott A. White represented by Vicki Ayers and Eric Lowe (VA); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler represented by Molly Nollette and Lichiou Lee (WA); and Mark Afable represented by Nathan Houdek and Olivia Hwang (WI). Also participating was: Eric A. Cioppa (ME).

1. **Adopted its Oct. 18 Minutes**

   The Task Force met Oct. 18 and took the following action: 1) adopted the Artificial Intelligence (EX) Working Group’s Sept. 5 minutes; 2) adopted its 2020 proposed charges; and 3) adopted a Request for NAIC Model Law Development to develop model law language for the *Unfair Trade Practices Act* (#880).

   Mr. Taylor made a motion, seconded by Director Froment, to adopt the Task Force’s Oct. 18 minutes (Attachment Four). The motion passed unanimously.

2. **Adopted the Reports of its Working Groups**

   a. **Big Data (EX) Working Group**

   Commissioner Ommen said the Big Data (EX) Working Group met Dec. 7. He said after the Spring National Meeting and the referral to the Life Insurance and Annuities (A) Committee to study the use of external data and data analytics in accelerated life underwriting, the Working Group turned its attention to the use of data for fraud detection and claim settlements.

   Commissioner Ommen said the Working Group received presentations from the Insurance Services Office (ISO) and the National Insurance Crime Bureau (NICB) to help inform the Working Group about current market practices in the property/casualty (P/C) industry.

   Commissioner Ommen said the ISO provided an overview of three of its products the insurance industry uses for fraud detection and claim settlement: 1) ClaimSearch, which contains 1.4 billion records and is used by insurance companies to identify questionable relationships or networks within a claim record; 2) Verisk Weather, which provides historical weather data and loss exposure analysis for companies; and 3) ClaimXperience, a policyholder collaboration portal used for processing lower value property damage claims.

   Commissioner Ommen said the NICB presentation primarily focused on the NICB’s Geospatial Intelligence Center (GIC), which provides aerial imagery of pre- and post-catastrophe conditions of property to assess potential fraud and speed up the claim settlement process.

   Commissioner Ommen said the Working Group also received a brief update from the Casualty Actuarial and Statistical (C) Task Force regarding its white paper, *Regulatory Review of Predictive Models*. He said the Task Force will soon issue its third draft of the white paper, but it may need further input from the Big Data (EX) Working Group on the issues of causality versus statistical correlation and the confidentiality of predictive models.
Commissioner Ommen said the Working Group would like to delve deeper into the specific data elements used in fraud detection and claim settlement models beyond the traditional data collected during a claim investigation, and it will hold an interim conference call to explore these issues in more detail.

Commissioner Ommen made a motion, seconded by Commissioner Mais, to adopt the report of the Big Data (EX) Working Group (Attachment One). The motion passed unanimously.

b. Speed to Market (EX) Working Group

Superintendent Franchini said the Speed to Market (EX) Working Group met Dec. 3 and Sept. 12.

During its Sept. 12 meeting, the Working Group discussed and reviewed System for Electronic Rate and Form Filing (SERFF) enhancements and prioritization of several focus areas. He said NAIC staff members discussed suggested areas of improvement and goals for submission validations, review tools, workload management, performance and reliability, the search function, document management, reporting and data export, streamlined correspondence, and user experience. He said input was sought from Working Group members, interested state insurance regulators and interested parties as to which areas of improvement would provide the most benefit. He said a survey was distributed to seek feedback from all states.

During its Dec. 3 meeting, the Working Group took the following action: 1) adopted its Sept. 12 minutes; 2) heard an update on the SERFF capabilities survey; and 3) received a brief overview of the request for proposal (RFP) for a consultant to conduct a business and technical assessment of SERFF.

Superintendent Franchini said there was a great response to the SERFF survey sent in September, and all but 12 member jurisdictions provided feedback. He said some of the enhancement items reviewed are already being worked into the analysis and development process by NAIC staff, and others are going through the development pipeline. He said these matters will be reflected in an action plan for 2020 and beyond, so the SERFF application can provide more functionality for the states and insurance companies moving forward.

Superintendent Franchini made a motion, seconded by Director Farmer, to adopt the report of the Speed to Market (EX) Working Group (Attachment Two). The motion passed unanimously.

c. Artificial Intelligence (EX) Working Group

Commissioner Godfread said the Artificial Intelligence (EX) Working Group met Dec. 7 and discussed comments related to using the Organisation for Economic Co-operation and Development (OECD) Artificial Intelligence (AI) Principles as a basis for developing AI principles for the insurance industry.

Commissioner Godfread said the Working Group also reviewed a draft principles document from the North Dakota Insurance Department as a “strawman” for moving forward to complete the deliverable and decided to expose the draft for a public comment period ending Jan. 17, 2020. He said the Working Group agreed to meet at least once via conference call prior to the 2020 Spring National Meeting to discuss the comments and the draft.

Director Froment made a motion, seconded by Director Schraad, to adopt the report of the Artificial Intelligence (EX) Working Group (Attachment Three). The motion passed unanimously.

d. Innovation and Technology State Contacts

Denise Matthews (NAIC) said the Innovation and Technology State Contacts met Dec. 6. She said George Bradner (CT) chaired and reviewed the purpose of the meeting.

Ms. Matthews said the attendees discussed a proposed process to facilitate more frequent and regular webinars on various innovation and technology topics or presentations from innovators. She said the group agreed it would be appropriate and that it will proceed with that in 2020. She said the group also discussed defining “regulatory sandbox” because that term gets used frequently. She said there was a desire to ensure that when that term is used, there is a common understanding of what is means. She said NAIC Legal Division staff are also tracking sandbox and other types of state organized activity. She said Kentucky and Vermont are currently the only states to have implemented an insurance regulatory sandbox.
Ms. Matthews said the group also discussed innovation and technology education and information opportunities, including dates and locations taking place in 2020. She said updates on the Western Zone Silicon Valley Program, the InsureTech Connect event and the Insurtech on the Silicon Prairie event, all held in 2019, were provided by Ms. Nollette, Mr. Aufenthie and Matt Holman (NE), respectively.

Ms. Matthews said the group also received presentations on regulatory technology proof-of-concepts underway in a few states. She said the presentations focused on form filing review and analysis workflow tools that are using technology and some machine learning to make that process more efficient, including a discussion related to SERFF.

3. Discussed Anti-Rebating Draft Bulletin and Model Law Amendments

Commissioner Godfread said the Task Force adopted a motion to move forward with Request for NAIC Model Law Development to modify Model #880 during the Summer National Meeting. He said the Task Force reviewed and adopted the request during its Oct. 18 meeting, and the Executive (EX) Committee has since adopted it. Therefore, he said the Task Force may proceed with work on model law language.

Commissioner Godfread said, prior to deciding to work on the model law, the Task Force discussed a North Dakota draft bulletin on the rebating topic, and the Task Force has received comments related to that language. He said it was considered something that could be done in the nearer term or possibly as an alternative to the model law approach. He said that while the Task Force members agreed to accept comments and continue to work on the language for a bulletin, Task Force members did not make a decision as to if it wanted to pursue this work as an exercise to fine tune a North Dakota bulletin that other states may choose to use as a template for their state, or if it wanted to actually pursue using this to create an NAIC work product.

Commissioner Godfread asked if it is the will of the Task Force members to pursue an official NAIC anti-rebating bulletin, or to consider that work complete and move on with the work on the model law language.

Director Froment and Director Wing-Heier both said they thought it was time to move on to work on the model law language.

Ms. Nollette said the work on the North Dakota bulletin was valuable and will inform the model law work but agreed it was time to focus on the model law.

Commissioner Godfread said there was clear direction to proceed and discontinue work on the bulletin. He said there would be one more small tweak to the North Dakota bulletin before it is finalized, but he hopes to get it in place early next year and would be happy to work with any state interested in the bulletin.

Commissioner Godfread asked if anyone has any thoughts or suggestions regarding an approach to drafting the model law language discussed in the Request for NAIC Model Law Development. He said some draft language has been submitted by the American Property and Casualty Insurance Association (APCIA) during the Task Force meeting at the NAIC/NIPR Insurance Summit in June, and the Task Force has received a lot of thoughtful input via emails, comment letters and presentations.

Director Ramge recommended the Task Force assign this to another group to work via conference call with subject-matter experts (SMEs) and comments from interested parties, and Nebraska would volunteer to be on that group.

Commissioner Richardson agreed with Director Ramge that a smaller group would be good to begin this work.

Commissioner Ommen supported that, as well, to allow that drafting to take place but said there will obviously be a lot of opportunity for others to comment.

Commissioner Godfread suggested this be a drafting group as opposed to an NAIC working group.

Director Farmer agreed, as did other members of the Task Force.

Commissioner Godfread asked for volunteers to participate in the drafting group and to let NAIC staff know if interested. Hearing no other discussion, he said the drafting group will be formed and to move forward with the work on the model law.
4. Received an Update on Cybersecurity Initiatives, Including the Implementation of Model #668, and Data Privacy from the Privacy Protections (D) Working Group

   a. Update on Cybersecurity Initiatives

Commissioner Godfread said the Cybersecurity (EX) Working Group was disbanded in March 2018, and the Task Force now has the responsibility to monitor developments in this area. He said data, innovation and cyber continue to be a key regulatory priority including not only the ongoing work to implement the model law, but also monitoring data privacy activity and applicability to the insurance space. He said efforts in this area need to be well coordinated, and updates will continue to be provided to committees with a vested interest. He said he encourages everyone to look at the different committees overseeing these workstreams and pay attention to that activity.

Director Farmer provided an update on the Insurance Data Security Model Law (#668) and its implementation. He said adoption of the model law remains a high priority for the NAIC. He said state insurance regulators are dedicated to developing the necessary tools to ensure consumers are protected from data breaches and that Model #668 is the best way states can lead in this effort. He said eight states have adopted laws based on the NAIC model to date, and more are anticipated to follow next year. He said the U.S. Department of the Treasury (Treasury Department) endorsed the model law and recommended its prompt and uniform adoption by the states to avoid congressional action setting forth uniform requirements for insurer data security.

Director Farmer said a joint Kansas and Missouri ransomware cyber tabletop exercise was held Sept. 5 at the NAIC Central Office in Kansas City, MO. He said the event was well attended, with more than 40 participants comprised of staff from state insurance and information technology (IT) departments, 12 companies, financial examiners from several states, the Treasury Department and law enforcement. These events have prepared the NAIC with templated cyber scenarios, an event planning timeline and direction on facilitation of these events.

Director Farmer said Illinois will host a cyber tabletop exercise in Chicago in 2020, and the NAIC is currently working with Wisconsin to determine if this could be a joint event similar to the Kansas/Missouri tabletop and if it can be scheduled sometime between May and October 2020. He said a cyber tabletop exercise will also be held in Ohio on May 19, 2020, for Ohio domestic insurers only, as well as support entities like the FBI and local law enforcement. He said the NAIC is also talking with Connecticut about conducting a tabletop in October 2020. He said it will likely be a single-state event and would be the third cyber tabletop exercise in 2020, exceeding the NAIC’s original goal of two events for 2020.

   b. Update from Privacy Protections (D) Working Group

Ms. Amann provided an update on the work of the Privacy Protections (D) Working Group. She said it held its kick-off meeting Dec. 8. She said the Working Group was appointed Oct. 1, and it is in the process of finalizing its membership and distribution lists for interested state insurance regulators and parties.

Ms. Amann said the Working Group will work closely with the other working groups in this arena, including the Artificial Intelligence (EX) Working Group, the Accelerated Underwriting (A) Working Group and others, as each has its unique set of issues that will require coordination.

Ms. Amann said during the Dec. 8 meeting, the Working Group took the following action: 1) discussed its proposed workplan to meet monthly via conference call; 2) heard a presentation by Jennifer McAdam (NAIC) on the NAIC Insurance Information and Privacy Protection Model Act (#670), the Privacy of Consumer Financial and Health Information Regulation (#672), the General Data Protection Regulation (GDPR), the California Consumer Privacy Act (CCPA) and state data privacy legislation; 2) heard an update from Kendall Cotton (MT) on current legislative activities in Montana; and 3) discussed comments received from the Center for Economic Justice (CEJ), the National Association of Mutual Insurance Companies (NAMIC) and the APCIA.

Ms. Amann said the work will be to decide how effective amendments to these models may be versus drafting something new. She said there is a chart on the NAIC web page outlining state activity to date in this area. She said NAIC Legal Division staff are trying to keep it current, so contact NAIC staff if updates need to be made.
5. **Received an Update on Drafting a Document for Startups**

Commissioner Godfread said Birny Birnbaum (CEJ) submitted a request to the Task Force to draft a document targeted at educating startups regarding the difference between insurance products and other consumer products in the banking arena or otherwise. He said Mr. Birnbaum suggested that a document be developed for InsurTechs on why insurance is different from banking and other consumer products. Commissioner Godfread said most would likely agree Mr. Birnbaum’s points are well taken.

Commissioner Godfread said during events and opportunities that state insurance regulators have participated in over the past several years, it appears there has been fairly strong interest and awareness on the part of accelerators and others in terms of offering counsel and mentorship to startups in the InsurTech space, in regard to better understanding the insurance industry, its products and services, as well as how it is regulated. He said he is not sure that undertaking a charge to draft an official NAIC white paper on this topic would make sense or should be a priority for the Task Force, but maybe something could be drafted, informally, to address this area.

Commissioner Godfread also said the NAIC is working on opening up the Associate Professional in Insurance Regulation (APIR) designation program to tweak it for InsurTechs, and that could encapsulate a lot of the introduction to insurance regulation that InsurTechs may be missing. In addition, he said Shanique V. Hall (NAIC) is working on an InsurTech study and that she would be open to working with others to incorporate this work into the study, as well.

Commissioner Godfread said he would like to discuss the 10 points raised in Mr. Birnbaum’s letter. He said they were included in materials sent to the Task Force prior to this meeting. He said Task Force members were asked to read them over and give some thought as to if they think: 1) the 10 points represent a complete list of items that should be included in a document of this type; 2) if there is something important missing or something included that they think is inappropriate 3) if it is appropriate, is the language effective. He said the Task Force could work on the key points and then either publish just as that, as key points, or hand them off to be incorporated into something else—possibly the designation program materials.

Commissioner Ommen said Iowa has information available to startups and the responsibility to communicate to those coming into the insurance business. He said the suggestions made by the CEJ indicate some common themes that are mindful of concerns that many on the Task Force share, but he said risk discrimination is what we do in the business of insurance and is where companies compete to become faster and more efficient. He said this document might create an overemphasis on one particular aspect of the Task Force’s concerns, and it is difficult to boil all of this down to a short list. He said the Task Force should work on all of the issues contained in the list in Mr. Birnbaum’s letter, but it may be too heavily focused on one theme.

Commissioner Godfread said he likes the idea of working with the NAIC’s Center for Insurance Policy and Research (CIPR) and the NAIC Insurance Regulator Professional Designation Program, along with the consumer groups.

Director Froment agreed and said Ohio has a designated person who meets with the startups. She said they come in with different levels of knowledge, and it takes a person to navigate where they are and then work with them.

Mr. Slape said there is a list of state innovation and technology contacts on the NAIC website. He said it would be good to get that message out through social media and other methods, reminding startups of that list so they can contact the right person and get direct feedback.

Mr. Birnbaum said he would defer to the Task Force members’ best judgment on how to get this message out to InsurTechs. He said he would like to clarify that the intent of his letter was not to provide a list of things they need to do to comply with insurance regulation or a guide to becoming a producer or licensed company, but rather to explain the significant differences between insurance products and other consumer products. He said many InsurTechs come from other markets where there is no rate regulation or licensing and capital requirements. He said the goal was to help them navigate the regulatory system and to help them understand the key concepts and differences from other consumer product markets, using the unfair discrimination issue as an example.

Peter Kochenburger (University of Connecticut School of Law) said even skilled and knowledgeable individuals in other areas often do not know that these regulatory processes exist and that they should talk to a state insurance regulator.
Commissioner Godfread said he has seen a shift over the past few years and progress has been made, but that does not mean everybody is there yet. He said the CEJ letter includes a good list and points out those differences. He said state insurance regulators are committed to working with consumer groups to ensure this gets addressed. He said working through CIPR and the NAIC Designation Program, in his opinion, is the best approach.

6. Heard an Update on the NCOIL Insurance Modernization Activity

Indiana State Rep. Matt Lehman (R-Berne), who is also vice president of the National Conference of Insurance Legislators (NCOIL), provided an update on NCOIL’s insurance modernization activity.

Mr. Lehman said about a year ago, NCOIL began to receive comments about the market being ripe for clean-up legislation around technology and doing business the old way. He said a prime example is that some states do not have legislation to allow consumers to opt into electronic delivery of documents but mandate a requirement to do so via the U.S. mail, which is antiquated and needs to be updated. He said NCOIL made it a 2019 priority to develop insurance modernization legislation and at first was not sure if it would be some type of omnibus modernization deliverable or if it would get into more detailed issues. He said NCOIL looked at: 1) allowing consumers to opt into electronic delivery and posting of insurance notices; 2) modernizing the current paper process used to transfer ownership of a total loss vehicle; and 3) modernizing the anti-rebating laws.

Mr. Lehman said he heard the discussion on the anti-rebating topic earlier in the meeting and would be happy to work as partners with the NAIC on that effort and any topics the Task Force may wish to include. He expanded on the first topic, saying the industry took the federal e-signature law and customized it for the insurance industry. He said it requires an opt-in, so the consumer must consent, and it excludes cancellation and renewal notices. He said this type of insurance delivery method has been adopted in approximately 38 states, and approximately 25 states have enacted insurance posting legislation that is opt-out. This means that it only applies to the policy document itself and does not include any personally identifiable information (PII), and the consumer can request a paper copy, which most still do.

Mr. Lehman said in the case of an accident that results in a total loss where the insurance company takes ownership of the vehicle, the process is completely paper-based and requires paperwork that the consumer often does not have or cannot find. As a result, the consumer has to file for a duplicate from the state’s Department of Motor Vehicles (DMV), which takes time. He suggested if the process were digitized, the process could be sped up, money would be saved, and the consumer would get his or her money faster. He said the proposed NCOIL model would require the DMVs to develop and use electronic systems to process those transactions. He said Florida passed a law and that he hopes the NCOIL model can gain traction across the country.

Mr. Lehman said anti-rebating issues have been brought up a lot and are finally getting attention. He said the law covering this issue was drafted a long time ago when life insurance agents were paying rebates to clients to increase sales and then were demanding higher commissions, which led to solvency issues. He said he recognized the state insurance regulator’s charge is to not only protect consumers but also the solvency of companies, making this a big issue that also potentially has unfair discriminatory practice implications. He said he considers rebating to be an issue between brokers and carriers and not as much to the consumer as a loser. He said unfair trade practice issues are driven by the consumer. Therefore, rebating is tied more to the issue of an anti-trade violation as opposed to unfair trade practices, so they should be viewed as separate items.

Mr. Lehman said earlier conversations among the Task Force members regarding the desire to work on a model to avoid multiple bulletins and inconsistencies makes sense and that as a broker, he is aware of the challenges posed by state differences. Therefore, he said NCOIL is looking for a standard or benchmark for this area. He said the NCOIL model addresses those things and moves toward that direction. He said NCOIL is here to work with state insurance commissioners and to get those laws passed. He said he would be happy to work with the Task Force’s drafting group as a resource.

Commissioner Godfread said the Task Force would definitely keep NCOIL apprised on its work, as the two groups share a common goal to simplify this and make things easier and more understandable.

Mr. Lehman said he liked the three bullet points in the North Dakota draft bulletin on anti-rebating and, as the author of the NCOIL model, would be considering those as a filter to put the model through.
7. **Discussed Other Matters**

Commissioner Godfread said CIPR has posted a great summary of the *Journal of Insurance Regulators* (JIR) article titled, “Time to Dust the Anti-Rebating Laws,” and he encouraged those working on the anti-rebating model law language to read it.

Commissioner Godfread also said the Task Force has a charge to: “Monitor and discuss regulatory issues that arise with the development of autonomous vehicles. Study and, if necessary, develop recommendations for changes needed to the state-based insurance regulatory framework.” He said, in keeping with that, he wanted to let the Task Force members know about an upcoming webinar on the subject.

Ms. Hall provided a quick update on the webinar, noting it would build on the CIPR Autonomous Vehicle Symposium held in 2018 in Silicon Valley regarding this emerging technology.

Having no further business, the Innovation and Technology (EX) Task Force adjourned.
Big Data (EX) Working Group
Austin, Texas
December 7, 2019

The Big Data (EX) Working Group of the Innovation and Technology (EX) Task Force met in Austin, TX, Dec. 7, 2019. The following Working Group members participated: Doug Ommen, Chair (IA); Elizabeth Kelleher Dwyer, Vice Chair, represented by Matt Gendron (RI); George Bradner and Wanchin Chou (CT); Stephen C. Taylor and Sharon Shipp (DC); Frank Pyle (DE); Sandra Starnes (FL); Robert Muriel and Judy Mottar (IL); Rich Piazza (LA); Robert Baron (MD); Timothy Schott (ME); Karen Dennis (MI); Phil Vigliaturo (MN); Angela Nelson (MO); Christian Citarella (NH); Seong-min Eom (NJ); Jillian Froment (OH); Andrew Stolfi and TK Keen (OR); Michael McKenney and Shannen Logue (PA); Kendall Buchanan (SC); Rachel Cloyd and J’ne Byckovski (TX); Tomasz Serbinowski (UT); and Christina Rouleau (VT).

1. Adopted its Oct. 7 Minutes

The Working Group met Oct. 7 and took the following action: 1) adopted its Summer National Meeting minutes; and 2) discussed the use of big data in fraud detection and claim settlement.

Mr. Bradner made a motion, seconded by Ms. Nelson, to adopt the Working Group’s Oct. 7 minutes (Attachment One-A). The motion passed unanimously.

2. Discussed the Use of Big Data in Fraud Detection and Claim Settlement

Commissioner Ommen said the Working Group heard a presentation at the Summer National Meeting from Kevin Rawlins (Insurance Services Office—ISO) about ISO’s ClaimSearch and a presentation from Alan Haskins (National Insurance Crime Bureau—NICB) about NICB’s fraud detection services. Commissioner Ommen said the Working Group also heard a presentation during its Oct. 7 conference call from Carlos Martins (ISO) about ISO’s claims solutions.

Commissioner Ommen reviewed the three charges of the Working Group. He said the fraud detection and claims settlement practices discussed by the Working Group are subject to his regulatory jurisdiction under both Iowa’s unfair trade law and Iowa’s unfair claim settlement practices provisions, which are based on the NAIC Unfair Claims Settlement Practices Act (#900). He asked if the Working Group members have any observations about the adequacy of the current state insurance regulatory framework used to oversee the use of big data in fraud detection and claim settlement.

Ms. Nelson said she has concerns about the use of non-insurance data in fraud detection models because consumers may not know data about them is being used and how to correct inaccurate data. She said this concern is heightened with the use of third-party vendors because state insurance regulators may have challenges with access to information of third-party vendors.

Mr. McKenney said the presentations from ISO suggested there is not a lot of oversight by insurers.

Mr. Baron said the Maryland Insurance Administration would hold the licensee accountable, similar to how insurers are held accountable for the action of independent adjusters who have been hired.

Birny Birnbaum (Center for Economic Justice—CEJ) said there is a need for additional oversight of third-party vendors, which he believes are operating as advisory organizations. He said state insurance regulators should review whether an insurer’s practices result in disparate impact and should require insurers to disclose to consumers what third-party data and algorithms are being used.

Peter Kochenburger (University of Connecticut School of Law) said even if the states have regulatory authority under unfair trade laws, consumers need to know what data is being used because the accuracy of data can only be determined by the consumer. He said similar protections found in the federal Fair Credit Reporting Act should be applied to the use of data for fraud detection and claim settlement.
Commissioner Ommen said he would hold the insurer responsible for validating the accuracy of the data and model outputs.

Mr. Gendron said state insurance regulators need more detail on how insurers ensure the accuracy of data being used.

Mr. Bradner agreed and said insurers’ use of data from third-party vendors and how insurers validate the accuracy of this data warrants additional discussion.

3. Received a Report from the Casualty Actuarial and Statistical (C) Task Force

Mr. Piazza said the Casualty Actuarial and Statistical (C) Task Force has the following three charges to coordinate with the Big Data (EX) Working Group: 1) facilitate training and sharing of expertise on predictive analytics; 2) draft guidance for the review of state rate filings based on complex predictive models; and 3) draft changes to the Product Filing Review Handbook to include best practices for review of predictive models and analytics filed by insurers to justify rates.

Regarding the first charge, Mr. Piazza said the Task Force conducts monthly public education webinars on rate filings and regulator-to-regulator conference calls on specific rate filings of concern. He said the Task Force’s public calls since the Summer National Meeting addressed neural network, natural language processing, analytics and actual data-mining, and the open source model “R” and predictive analytics.

Regarding the two other charges, Mr. Piazza said the Task Force exposed the most recent draft of the regulatory review of predictive modeling white paper on Oct. 15 for a public comment period ending Nov. 22. The Task Force received comments from 11 interested parties and is beginning its review of the comments.

4. Received a Report from the Accelerated Underwriting (A) Working Group

Director Muriel said the Accelerated Underwriting (A) Working Group met Oct. 2 to review a work plan for accomplishing its charge, which is to “consider the use of external data and data analytics in accelerated life underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue and, if appropriate, drafting guidance for the states.” He said the work plan contemplates three general phases: 1) gather information; identify issues and the best ways to address them (white paper, model bulletin, model law or something else); and 3) develop a work product by the 2020 Fall National Meeting.

5. Received an Update on NAIC Technical and Non-Technical Rate Review Trainings

Kris DeFrain (NAIC) said the NAIC has been sponsoring predictive analytics training since 2017 through what is called the “Book Club” of the Casualty Actuarial and Statistical (C) Task Force. She said the topics presented at the “Book Club” are mostly focused on the review of predictive analytics in property/casualty (P/C) rate filings. She said the NAIC is developing non-technical and technical training. The non-technical training will be provided to rate filing reviewers and market conduct examiners and focus on how to ensure vital information is contained in a rate filing, how to evaluate rate classes for unfair discrimination and understanding when additional actuarial assistance may be needed.

Ms. DeFrain said this training will be conducted after the Task Force completes its white paper toward the end of this year or early in 2020. She said the technical training will be conducted by the NAIC’s consultant, Dorothy Andrews (Actuarial & Analytics Consortium LLC), and will focus on training actuaries and statisticians. Ms. DeFrain said the technical training will be presented through on-demand modules and will focus on data inputs, mathematical distributions and statistical techniques.

In response to Commissioner Ommen’s question about training addressing the use of models in fraud detection, Ms. DeFrain said the training will focus on rate models but could be expanded in the future to include the assessment of models used for fraud detection and claim settlement.

Mr. Vigliaturo said the technical training is very good, and each session takes approximately 12 hours to complete. He said the courses will increase the knowledge of participants but will not necessarily lead to a quicker review of rate filings. He suggested the training be added to the list of courses for the NAIC’s Insurance Regulator Professional Designation Program.
6. **Heard a Presentation from the CEJ on the Role of Advisory Organizations**

Mr. Birnbaum provided a presentation on the history of advisory organizations, current regulatory requirements for advisory organizations and third-party vendors that he believes are operating as unlicensed advisory organizations. He said the federal McCarran-Ferguson Act provides insurers with a limited exemption from federal antitrust laws to the extent that insurance is regulated by the states. Without this exemption from antitrust laws, he said insurers would not be able to use advisory organizations to collect and compile historical information for ratemaking purposes. He said the states have oversight of these activities through the licensing of advisory organizations.

In the late 1980s, Mr. Birnbaum said a number of state attorneys general brought legal action against the ISO, alleging its involvement in anticompetitive activities. He said the ISO settled this litigation by changing its corporate structure and going to loss costs in states for lines of insurance where it had not already done so.

By the early 1990s, Mr. Birnbaum said more states had enacted legislation to require organizations to file prospective loss costs instead of fully developed rates. He said rating organizations became more widely referred to as advisory organizations, with state insurance regulators having oversight of data collected and algorithms used for loss costs. He said the states conduct advisory organization examinations to determine that an advisory organization is performing its permitted regulated functions in a manner consistent with state rating laws and in a manner that results in accurate and compliant products or services for its subscribing companies.

Mr. Birnbaum said new third-party vendors engaged in collecting decision marking are not licensed as advisory organizations. He said the following activities raise antitrust concerns that require state supervision of organizations exempt from federal antitrust laws: 1) collecting data from insurers; 2) adding additional data to insurer data; and 3) analyzing the data to producer pricing recommendations in the form of prospective loss costs or risk classification.

Mr. Birnbaum questioned what the functional difference is between ISO, which is licensed as an advisory organization and produces personal auto risk classification relativities and third-party vendors, such as TransUnion, which provide credit scores, criminal history scores or vehicle scores. He said there is a need to create the accountability and regulatory oversight of vendors of big data algorithms as envisioned in antitrust laws and advisory organization statutes. He said this may mean not only bringing regulatory oversight to third-party algorithm vendors, but also updating advisory organization requirements and procedures for the era of big data.

Commissioner Ommen said this is an important issue to which the Working Group should give further consideration.

Having no further business, the Big Data (EX) Working Group adjourned.

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The Big Data (EX) Working Group of the Innovation and Technology (EX) Task Force met via conference call Oct. 7, 2019. The following Working Group members participated: Doug Ommen, Chair (IA); Elizabeth Kelleher Dwyer, Vice Chair (RI); Lori K. Wing-Heier, Shauna Nickel and Alex Romero (AK); Jerry Workman (AL); George Bradner and Wanchin Chou (CT); Stephen C. Taylor (DC); Frank Pyle (DE); Carly Jamarowicz, Rebecca Smid and Mike Yaworsky (FL); Susan Lamb (IL); Rich Piazza, Nathan Strebeck and Jeff Zewe (LA); Robert Baron (MD); Karen Dennis (MI); Phil Vigliaturo (MN); Carrie Couch, Angela Nelson, Julie Lederer and Cynthia Amann (MO); Christian Citarella (NH); Mark McGill (NJ); Mitchell Moore (NV); Jennifer Demory, Jillian Froment, Angela Dingus and Rodney Beech (OH); David Dahl, TK Keen, Ying Liu and Andrew Stolfi (OR); Michael McKenny (PA); Kendall Buchanan (SC); J’ne Byckovski and Rachel Cloyd (TX); Armand Glick, Reed Stringham and Tracy Klausmeier (UT). Also participating were: Lindsay Bates and Travis Grassel (IA).

1. Adopted its Summer National Meeting Minutes

Mr. Piazza made a motion, seconded by Ms. Nelson, to adopt the Working Group’s Aug. 3 minutes (see NAIC Proceedings – Summer 2019, Innovation and Technology (EX) Task Force, Attachment One). The motion passed unanimously.

2. Discussed the Use of Big Data in Fraud Detection and Claim Settlement

Commissioner Ommen said Carlos Martins (ISO Claims Solutions) will provide an update to the Working Group’s discussion with ISO at the Summer National Meeting. Commissioner Ommen asked for more detail on how ISO uses data in the ClaimSearch database. Mr. Martins said the ISO ClaimSearch database has been in existence since 1971. It is a contributory claims database, and subscribers must use all reasonable measures to ensure the quality of data being submitted. Mr. Martins said ISO also has data quality checks to verify data is what they would expect. For example, a company could not submit a date of birth as all nines or zeros. Mr. Martin said ISO uses commercially available address scrubbing solutions to ensure addresses are correct and adhere to U.S. postal code standards. Mr. Martins said ISO sends Social Security numbers (SSNs) to the federal Death Master File (DMF) to ensure the SSN is not associated with a deceased individual. If an SSN is associated with a deceased individual, ISO provides an alert to the subscriber. Mr. Martin said ISO will alert a subscriber if an address is associated with a prison or mail drop location.

Mr. Martins said ISO has had a voluntary program in existence for 15 years through which a person can contest information in the ClaimSearch database. If a citizen contests information, ISO communicates with the insurer that submitted the information and works with the insurer to address any inaccuracy. ISO also adds a notation in the database that the consumer has contested data submitted. Mr. Martins said ISO does not charge a fee for this service and had had only three inquiries in the last year. Mr. Martins said only the insurer that submitted the data can correct their information. Commissioner Ommen asked if all aspects of a claim are submitted at the consent of the consumer. Mr. Martins said consumer consent is not needed since the database operates under a fraud exemption of the federal Gramm-Leach-Bliley Act (GLBA).

Ms. Nelson said ISO’s website references a product called ClaimDirector, which advertises that subscribers are given access to financial, civil and criminal records. Ms. Nelson asked if insurers accessing and using this information is disclosed to consumers. Mr. Martins said ClaimDirector is a database created in 1971 and is used to deter and identify fraud and a consumer’s claim history. Mr. Martins said the database allows insurers to identify potentially duplicative claims being made with multiple insurers. Mr. Martin said the database helps process meritorious claims as quickly as possible. Mr. Martins said the database helps industry understand claims with suspicious indicators, but ISO does not make a judgment on whether a claim is fraudulent. Mr. Martins said ClaimDirector applies a set of business rules created by seasoned insurance claims professionals and presents back a score and report on rules that fail. Mr. Martin said suspicious indicators would include an individual submitting similar claims with multiple insurers or an individual filing a claim after two weeks of purchasing insurance without any evidence of prior insurance. Mr. Martin said ClaimDirector also pulls in data from third-party sources, which might include information on whether a person filing a claim has been convicted on an insurance related crime. Mr. Martins said ISO provides tips and leads to insurers for an insurer to investigate. Mr. Martins said ClaimSearch DNA is provided to all ClaimSearch subscribers. Mr. Martins said ClaimSearch DNA identifies relationships between claims and insurers across the industry. For
example, Mr. Martins said the database will identify cell phone numbers and addresses associated with insurance claims being processed by multiple insurers.

Mr. Chou asked how these databases are different from the Comprehensive Loss Underwriting Exchange (CLUE) database. Mr. Martins said CLUE is an underwriting database, and ClaimSearch data cannot be commingled with an underwriting database, which is subject to the federal Fair Credit Reporting Act (FCRA).

Ms. Nelson asked what disclosures are made to consumers and how a consumer would know an ISO database has been used in the claims process and how to contest data in a database. Mr. Martins said ISO contracts require confidentiality and privacy of information contributed to database and, by contract, subscribers are not allowed to share database reports with consumers or other third parties without ISO’s consent. Commissioner Ommen said it appears ISO uses business rules to identify potential fraud and provides an insurance fraud score that could potentially place a claim in a holding pattern for settlement. Commissioner Ommen asked how a consumer would evaluate data that might be delaying a claim settlement. Mr. Martin said a company claims adjuster should let the claimant know the claim investigation has identified information that might delay the claim settlement. At this point, the claims adjuster and claimant would discuss this information, and the claims adjuster would know if the claimant questions the accuracy of the information. At the same time, Mr. Martins said the claims adjuster would not be trained to tell a consumer about the existence of an ISO report because of the confidentiality of the report. If the claimant questions the accuracy of the data, the claims adjuster would then work with ISO to obtain more information on which insurer submitted the prior claims data. Ms. Nelson said she is most concerned with ISO accessing and using financial, civil and criminal records and a consumer not knowing this information is being used or having any recourse if there is an error in this information.

Mr. Martins said if ISO uses third-party, publicly available data, ISO would notify a subscriber of where information was obtained if the consumer contested this information. Mr. Martins said ISO would work with the third-party vendor to address data errors and said he believes vendors would have a process to correct data. Ms. Nelson said she is concerned with a claims adjuster being provided a high-level score but not the detail of how the score was calculated. Ms. Nelson said this requires the claim adjuster to ask about the detail of how a score was calculated and then to share this information with a claimant. Mr. Martins said ISO provides reasons for a score, and a claim adjuster would need to determine relevance to the claim. Ms. Nelson said insurers have different thresholds on reasons they would identify a claim to be potentially fraudulent. Mr. Martins said this process is used to process claims quickly, and only a small percentage have claims that have a fraud score that prompts further investigation.

Commissioner Ommen asked if data may identify a consumer’s propensity for litigation and whether state insurance regulators have reviewed the business rules being used. Mr. Martins said he is not aware of any data or product used to predict a consumer’s propensity for litigation. Mr. Martins said ISO works with subscribers on market conduct exams and that the rules used to identify a claim as potentially fraudulent come from the National Insurance Crime Bureau (NICB) and seasoned claims professionals. Mr. Martins said ISO has tried to automate these rules for more efficient claims processing.

Mr. Martins said data is not used for rating and underwriting, and this is a contractual requirement for companies submitting data. Mr. Martins said ISO does not have any systems or scores that identify gender, ethnicity or other prohibited factors. Mr. Martins said ISO also does not use this information in their databases. Mr. Martins said ISO is committed to safeguarding industry data. ISO applies the latest encryption techniques and is audited to Service Organization Control (SOC) 2 and SOC 3 level to make sure sensitive information is not misused. Mr. Martins said ISO audits data use by subscribers to make sure subscribers use data in accordance with contractual obligations.

Birny Birnbaum (Center for Economic Justice—CEJ) asked if ClaimSearch is FCRA-complaint. Mr. Martin said FCRA standards do not apply to ClaimSearch. Mr. Birnbaum asked if ISO has assessed rules to determine if they result in a disparate impact to low-income and minority consumers. Mr. Birnbaum asked if ISO has assessed algorithms to identify how many false positives occur when identifying a claim as potentially fraudulent. Mr. Martin said ISO has not conducted these types of assessments. Mr. Martins said ISO provides tips and leads to insurers and does not make a final judgement on claims. Mr. Martins said ISO works with subscribers on data quality to ensure that tips and leads are appropriate. In response to Mr. Birnbaum’s question about disparate impact, Mr. Martins said ISO does not know impact because ISO does not conduct this type of analysis.
Peter Kochenburger (University of Connecticut School of Law) said there appears to be no communication between ISO and the consumer to confirm accuracy of information in database. Mr. Kochenburger asked if ISO provides any guidelines to insurers on how to address data quality with consumers. Mr. Martins said ISO requires subscribers to use reasonable efforts to ensure data quality, and any data quality issues are brought to the attention of subscribers. Mr. Martins said data quality issues are rare because ISO receives data directly from subscribers’ claims systems. Mr. Martins confirmed there is no contact between ISO and the consumer.

Having no further business, the Big Data (EX) Working Group adjourned.
The Speed to Market (EX) Working Group of the Innovation and Technology (EX) Task Force met via conference call Dec. 3, 2019. The following Working Group members participated:

Maureen Motter, Vice Chair and Christine Wright (OH); Joanne Bennett (AK); Gina Hunt and Jerry Workman (AL); William Lacy (AR); Shirley Taylor (CO); Janet Brunory and Jocelyn Villanueva (DE); Tammy Lohmann (MN); Angela Nelson (MO); Tim Johnson (NC); Chrystal Bartuska (ND); Cuc Nguyen (OK); Tammy Vance (OR); Sharalyn Taylor and Mark Worman (TX); Bob Grissom (VA); Lichiou Lee (WA); and Lisa Brandt, Diane Dambach, Sue Ezalarab, Barry Haney and MaryKay Rodriguez (WI).

1. **Adopted its Sept. 12 minutes**

The Working Group met Sept. 12 and discussed and reviewed a presentation made by NAIC staff members Joy Morrison, Bridget Kieras and Brandy Woltkamp on enhancements and prioritization of capabilities in the System for Electronic Rate and Form Filing (SERFF). The following themes were discussed: Submission Validations, Review Tools, Workload Management, Performance and Reliability, Search, Document Management, Reporting and Data Export, Streamlined Correspondence and User Experience.

Ms. Nelson made a motion, seconded by Ms. Lee, to adopt the Working Group’s Sept. 12 minutes (Attachment Two-A). The motion passed unanimously.

2. **Received an Update on the RFP Related to SERFF**

Ms. Kieras advised that in mid-October, the NAIC issued a request for proposal (RFP) to engage a firm for assistance in conducting a business and technical assessment of SERFF to assess current regulatory needs and future areas of focus. The proposals, which were due in early November, are being reviewed by three state insurance commissioners and several senior NAIC staff members.

Once a firm is selected and begins its work, it will perform a number of functions, including stakeholder interviews. The interviews will include users of SERFF from various insurance companies, representing all lines of business. There will also be interviews of six to 12 insurance commissioners, representatives from State Based Exchanges, NAIC Consumer Representatives, some industry partners, Interstate Insurance Product Regulation Commission and SERFF staff members. The purpose of these interviews is to obtain an overview of the services and features of SERFF, the technology that SERFF is built upon, and the governance model under which SERFF operates, to determine if SERFF is meeting current regulatory needs and to assess how the SERFF application may need to be enhanced in the future.

Engagement with the firm ultimately selected is expected to start by the end of 2019 and is scheduled to conclude by May 31, 2020. Participants will be selected for the stakeholder interviews; some of these will occur at the 2020 Spring National Meeting, particularly at the commissioner level. The final deliverable for the request for proposal will include a written report and presentation to be made to the Executive (EX) Committee or other designated group.

The NAIC SERFF assessment RFP press release is posted to the NAIC website, and as there were no comments or questions from the Working Group, Ms. Kieras advised there is an email address in the RFP should anyone wish to submit questions at a later time.

3. **Received an Update on the SERFF Capabilities Survey**

On the Sept. 12 call, a list of capabilities relevant to the future of SERFF were presented to this Working Group for discussion. After the call, a survey was sent to all states and a presentation was also made at the Association of Insurance Compliance Professionals (AICP) Annual Educational Conference on this subject matter.
The survey questions asked respondents if they would use each of the capabilities and the answer choices provided were “yes,” “no,” and “not sure.” The survey also asked respondents to rank the capabilities in order of importance and for each area there was also a free form text field where additional ideas and/or comments could be provided. All but 12 jurisdictions responded to the survey and there was a good mix in the responses across various lines of business, as well as types of staff who responded to the survey.

Results of the ranking demonstrated that the categories “review tools” and “performance and reliability” scored the highest among the available capabilities, indicating that these two capabilities were the most important to survey respondents. The capabilities “user experience” and “streamlined correspondence” scored the lowest among the capabilities ranked.

The top features that survey respondents were interested in centered around the issue of attachments, to include the capabilities of “document comparison,” “improved versioning,” and “document search.” Survey comments and results continue to be reviewed by NAIC staff for other subject matter and issues. The capabilities survey will be assessed alongside the survey that was performed in 2018 to look at how things will work moving forward.

Some items from the capabilities survey are already being worked into the SERFF analysis and development process, such as search improvements, improvements to the quick text feature, and some preliminary proof of concept work for document comparison and document search. Some of these capabilities are already being moved through the development pipeline. Significant enhancements will follow a review process that may this Working Group, the Product Steering Committee or SERFF Advisory Board, while others are more straightforward and NAIC staff is working to implement them.

Final survey results will be reflected in an action plan for 2020 and beyond so the SERFF application can provide more functionality for states and insurance companies moving forward. The Working Group had no questions or concerns about the capabilities survey.

Having no further business, the Speed to Market (EX) Working Group adjourned.
The Speed to Market (EX) Working Group of the Innovation and Technology (EX) Task Force met via conference call Sept. 12, 2019. The following Working Group members participated: John G. Franchini, represented by Bryan Brock, Chair (NM); Maureen Motter, Vice Chair (OH); Austin Childs (AK); William Lacy (AR); Shirley Taylor (CO); Ann Lyon and Jennifer Stinson (DE); Heather Drogue (KS); Tammy Lohmann (MN); LeAnn Cox (MO); Timothy Johnson (NC); Mike Andring and Chris Aufenthie (ND); Chris Wright (OH); Nancy Clark, J’ne Byckovski, Marianne Baker, Rachel Bowden and David Muckerheide (TX); Bob Grissom and Trish Todd (VA); Lichiou Lee (WA); and Barry Haney (WI).

1. Discussed and Reviewed a Presentation on SERFF Enhancements and Prioritization of Focus Areas

The following themes were discussed and reviewed with the Working Group by NAIC staff members Joy E. Morrison, Bridget Kieras and Brandy Woltkamp:

a) Submission Validations: The goal of this theme is to increase up-front checks to improve compliance of filings at submission, reduce filing objections and rejections, and reduce manual verifications. The enhancements discussed include the creation of validation rules for state-specific fields, validations for correct state fees, field validations based on state business rules, and validation of prescribed language.

b) Review Tools: The goal is to provide tools that will provide a more comprehensive and consistent filing review and reduce time from filing to approval. Potential enhancements include automatically assigning filings in order to get to state filing reviewers faster; creating built in checklists; building out public access and System for Electronic Rate and Form Filing (SERFF) Filing Access (SFA) capabilities to help the states meet their requirements to consumers; and creating a holistic product review, which is the ability for state insurance regulators to review changes made to a product over a period of several years.

c) Workload Management: The goal is to provide analysts and filers tools to identify and organize workflows in a manner that maximizes time spent on the most critical filing process tasks. Enhancement suggestions include workload dashboards, email notifications that occur when a user is not logged into SERFF, and customized views.

d) Performance and Reliability: The goal is for the SERFF system to behave in a consistent and expected manner with little to no unplanned downtime. The enhancements suggested under this theme are cloud migration, the implementation of new technologies, and advanced monitoring.

e) Search: The goal is to allow users to perform quick and efficient searches to locate single filings or sets filings with similar characteristics. The enhancements suggested under this theme are a key word search, a document search, and a redesigned search screen.

f) Document Management: The goal is to implement a document management system to expedite filing reviews with improved document comparison, collaboration and tracking capabilities.

g) Reporting and Data Export: The goal is to provide analytical capabilities to help state insurance regulators with decision making and market oversight. Considerations for this area include Tableau implementation for graphical reporting, improving data export capabilities, and expanding and enhancing canned reports.

h) Streamlined Correspondence: The goal is to reduce complexity and improve communication and response time in resolving compliance issues. Considerations discussed include moving schedule item data updates to Post Submission Updates, simplifying the response and objection process, and expanding the use of Quick Text.

i) User Experience: The goal is to improve the look and feel of SERFF by introducing standard user patterns and easier to navigate workflows. Considerations discussed for this theme are a simpler and more intuitive interface, and an improved workflow.

After going over each of the areas of suggested improvement, input was sought from the conference call participants. Several states provided feedback but there was not a lot of discussion from working group members regarding which of these areas would provide the most benefit to them. The PowerPoint presentation used for this call will be provided to the Working Group to seek feedback and prioritization for the items discussed; that feedback may then be used to provide information and seek further feedback from the states that are not on the Working Group. No timeline for completion of the suggested enhancements has been confirmed, as this project is currently in the development phase.

Having no further business, the Speed to Market (EX) Working Group adjourned.
The Artificial Intelligence (EX) Working Group of the Innovation and Technology (EX) Task Force met in Austin, TX, Dec. 7, 2019. The following Working Group members participated: Jon Godfread, Chair (ND); Mark Afable, Vice Chair (WI); Anna Latham (AK); Keith Schraad (AZ); George Bradner and Josh Hershman (CT); Peg Brown (CO); Erin VanSickle (FL); Travis Grassel (IA); Robert H. Muriel and Judy Mottar (IL); Jerry Ehlers (IN); Rich Piazza (LA); Robert Baron (MD); Cynthia Amann (MO); Christian Citarella and Christie Rice (NH); Anna Krylova (NM); Jillian Froment (OH); Michael Humphreys and Michael McKenney (PA); Hodgen Mainda (TN); Eric Lowe (VA); and Christina Rouleau (VT). Also participating were: Phil Vigliaturo (MN); Brian Fordham (OR); Travis Jordan (SD); and James A. Dodrill (WV).

1. **Heard Introductory Remarks**

Commissioner Godfread provided a quick recap regarding the appointment of the Working Group and provided an overview of the its Sept. 5 conference call. He said this Working Group was appointed to: 1) study the development of artificial intelligence (AI), its use in the insurance sector, and its impact on consumer protection and privacy, marketplace dynamics and the state-based insurance regulatory framework; 2) develop regulatory guidance, beginning with guiding principles; and 3) make other recommendations to the Innovation and Technology (EX) Task Force, as appropriate, by the 2020 Summer National Meeting. He said the decision was made to focus first on the latter part of the charge, specifically to work on guiding principles.

Commissioner Godfread said he and Commissioner Afable decided a good approach would be to consider work already done in this area as a basis for this work. He said, on its Sept. 5 conference call, the Working Group heard an overview on AI from Scott Kosnoff (Faegre Baker Daniels LLP), who talked about: 1) AI principles generally; and 2) the Organisation for Economic Co-operation and Development’s (OECD) AI principles, which have been adopted by 42 countries, including the U.S. Commissioner Godfread said, ultimately, the decision was made to request comments regarding how the OECD principles might be “tweaked” or “tailored” for applicability to the insurance industry, with a comment deadline of Oct. 11.

Commissioner Afable said the goal is to get this work done by the 2020 Summer National Meeting, noting that it is important to hear from Working Group members and other stakeholders regarding the North Dakota draft of “NAIC Principles on Artificial Intelligence (AI).” He said he and Commissioner Godfread initially want to hear if there are concerns about using it as a working draft.

Commissioner Godfread said these principles are intended to be higher level, overarching principles, not a model law or model regulation. He said it is intended to be a guiding document, to be used by other NAIC committees, task forces and/or working groups as they look at issues related to AI in their respective areas.

2. **Discussed OECD Comment Letters and Development of AI Principles for Insurance**

Commissioner Godfread said he thought it would be helpful to have a “straw man” document to expedite progress, so he asked his staff to consider the submitted comments. He said this draft represents that work. He said the draft was then sent to the Working Group members for comment, noting they should feel free to offer alternative approaches to completing the deliverable. He asked the Working Group members for discussion regarding using the draft as a starting point and, if the answer is “yes,” then he would accept comments on the draft.

Mr. McKenney said he submitted substantial comments regarding the OECD AI principles, and this draft is entirely consistent with those comments. He said he would agree with moving forward with the North Dakota draft as the basis for completing the deliverable.

Mr. Grassel said his understanding is that the goal is to bring insurance-specific language and issues into the framework, and he believes the draft does a good job of that.
Mr. Citarella said the “Fair and Ethical” section of the draft in item (b) states that “AI systems must not be designed to harm or deceive people.” He said, ideally, AI systems would not harm people, but it would be difficult to regulate intentionality so that may need to be modified. He also said in the “Compliant” section, where it states that “data used by AI systems must be retained and able to be produced in accordance with each jurisdiction’s requirements,” is an excellent concept, but he is not sure how it would work in practice. He said it would likely generate quite a bit of pushback. He also said that because AI is an iterative process with data continuously being fed into the system, adjusting the results to be compliant with 50+ jurisdictions’ requirements could be difficult.

Commissioner Godfread said Mr. Citarella’s comments go a step or two beyond what the principles are designed to cover. He said there will be a whole host of things that will need to be figured out in terms of implementation. He said this is a new and evolving area and key principles requires consistent monitoring, and while he does not disagree with the point made, he said it is pretty detailed for this initial discussion.

Mr. Citarella also said transparency may mitigate the problems that arise from the amount of data involved in AI, but each actor will have a narrative about how they go about what they do and how they will address concerns and issues that develop. He said he does not have a recommendation on how the language might be revised to address that, but it should be given some thought.

Commissioner Godfread said the goal is not to explain the black box but be able to explain the purpose and—if the AI actor cannot articulate that—it might indicate transparency issues.

Mr. Fordham said compliance with state and federal laws is always required, so he questioned if the reference to it being required “whether intentional or unintentional” is necessary.

Birny Birnbaum (Center for Economic Justice—CEJ) thanked the Working Group for the draft and said it was well done and a good basis to start further work. He referenced the words under the “Fair and Equitable” section in item (b) regarding “beneficial outcomes,” stating there will be winners and losers in that and, while a majority may benefit, the cost to the minority may be unreasonable or unacceptable. He said he is not sure how to address that, but it is difficult to think about beneficial outcomes when most insurance involves segmenting the population one way or another. He said the “Accountable” section states that “AI actors should be accountable for the proper functioning of AI systems and compliance with all stated principles,” but he asked to whom the AI actors would be accountable. He said he has a similar question regarding transparency, noting that many might assume AI actors should be accountable and transparent to regulators, but he said they need to be accountable and transparent to the people impacted by the system.

Commissioner Godfread said he understood that point from the perspective of transparency, but the AI actors would be responsible to the regulators. He said the draft principles also refer to “relevant stakeholders” so that would, in his opinion, include consumers and discussion with consumers—including what the data is being used for—but said he is open to other clarifying language, as well.

Commissioner Afable agreed and said the explanatory piece would be there, as well.

3. **Discussed Next Steps**

 Commissioner Godfread said it appears the Working Group members are in favor of using the North Dakota draft as the basis for its work and, hearing no objection, said it will be posted for another exposure period. He encouraged everyone to contribute comments. He said, as a recap, the Working Group will:

1) Work off this draft.
4) Revise the draft and expose it again prior to the Spring National Meeting, March 21–24, 2020.

Ms. Amman said there are definitions and a glossary developed by the IT Examination (E) Working Group for the *Financial Condition Examiners Handbook* that may be helpful to this Working Group.

Having no further business, the Artificial Intelligence (EX) Working Group adjourned.

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© 2019 National Association of Insurance Commissioners 2
The Innovation and Technology (EX) Task Force met via conference call Oct. 18, 2019. The following Task Force members participated: Jon Godfread, Chair (ND); Keith Schraad, Vice Chair (AZ); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Jerry Workman (AL); Allen W. Kerr represented by Letty Hardee and Mel Anderson (AR); Ricardo Lara represented by Lucy Jaboluri (CA); Michael Conway represented by Peg Brown (CO); Andrew N. Mais and George Bradner (CT); Stephen C. Taylor (DC); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier represented by Rebecca Smid (FL); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Travis Grassel (IA); Robert H. Muriel represented by Judy Mottor (IL); Vicki Schmidt represented by LeAnn Crow (KS); Nancy G. Atkins represented by LeAnn Crow (KS); James J. Donelon represented by Rich Piazza and Tom Travis (LA); Al Redmer Jr. represented by Robert Baron (MD); Steve Kelley represented by Tammy Lohmann, Phil Vigliaturo and Grace Arnold (MN); Chlora Lindley-Myers represented by Angela Nelson and Cynthia Amann (MO); Bruce R. Ramge (NE); Marlene Caride represented by Carl Sornson (NJ); John G. Franchini (NM); Barbara D. Richardson (NV); Jillian Froment (OH); Glen Mulready represented by Cuc Nguyen (OK); Andrew Stolfi represented by Antonio Vargas (OR); Jessica Altman represented by Michael Humphreys (PA); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer represented by Daniel Morris (SC); Larry Deiter represented by Travis Jordan (SD); Hodgen Mainda represented by David Combs (TN); Kent Sullivan represented by Reagan Ellmar (TX); Todd E. Kiser represented by Tanji Northrup (UT); Scott A. White represented by Vicki Ayers (VA); Michael S. Pieciak represented by Emily Brown (VT); Mike Kreidler represented by Molly Nollette (WA); and Mark Afable represented by Nathan Houdek (WI). Also participating was: Chris Aufenthie (ND).

1. **Adopted its Summer National Meeting Minutes**

   Mr. Bradner made a motion, seconded by Director Froment, to adopt the Task Force’s Aug. 5 minutes (see NAIC Proceedings – Summer 2019, Innovation and Technology (EX) Task Force). The motion passed unanimously.

2. **Adopted the Minutes of the Artificial Intelligence (EX) Working Group**

   Commissioner Godfread said the Working Group met Sept. 5 to hear an overview on artificial intelligence (AI) from Scott Kosnoff (Faegre Baker Daniels LLP). Mr. Kosnoff talked about: 1) AI principles generally; and 2) the Organisation for Economic Co-operation and Development’s (OECD) AI principles, which have been adopted by 42 countries, including the U.S.

   Commissioner Godfread said that following Mr. Kosnoff’s presentation, there was discussion, reflected in the minutes, and the decision was made to request comments regarding how the OECD principles might be “tweaked” or “tailored” for applicability to the insurance industry. He said those comments were due Oct. 11, and the next steps for the Working Group will be to review the comments and meet again to discuss whether the OECD principles can be effectively “tweaked” and “tailored” to fit the insurance industry or if taking another approach would be better.

   Commissioner Godfread said the Working Group’s minutes were posted to its web page.

   Ms. Ayers made a motion, seconded by Mr. Bradner, to adopt the Working Group’s Sept. 5 minutes (Attachment Four-A). The motion passed unanimously.

3. **Adopted its 2020 Proposed Charges**

   Commissioner Godfread introduced the Task Force’s 2020 proposed charges. He said the charges include a few relatively minor changes from its 2019 charges: 1) working to amend the *Unfair Trade Practices Act* (#880) to clarify the anti-rebating issue; 2) adding clarification related to autonomous vehicles to reflect continuing to monitor this area closely, but removing language related to developing a white paper or model legislation; 3) adding an item to reflect closely monitoring the Market Regulation and Consumer Affairs (D) Committee’s work on data privacy, a charge referred by the Task Force; and 4) including the new Artificial Intelligence (EX) Working Group charge to the overall charges for 2020.
Mr. Bradner made a motion, seconded by Ms. Northrup, to adopt the Task Force’s 2020 proposed charges (Attachment Four-B). The motion passed unanimously.

4. Heard a Consumer Representative Request for an InsurTech Bulletin

Commissioner Godfread asked Mr. Aufenthie to present Birny Birnbaum’s (Center for Economic Justice—CEJ) request (Attachment Four-C) for the development of a bulletin directed to InsurTechs titled, “Why Insurance is Different from Other Consumer Products,” in Mr. Birnbaum’s absence.

Mr. Aufenthie said Mr. Birnbaum, after hearing a presentation from Plug and Play at the Task Force’s meeting during the Spring National Meeting, thought their survey was too generic to provide actionable insights and did not provide any way forward. He said Mr. Birnbaum’s letter indicated it would be more useful to spend resources educating startups on the business of insurance and suggested that the Task Force develop this bulletin. Mr. Aufenthie said Mr. Birnbaum’s letter suggested the bulletin include certain points such as: 1) insurance is regulated on a state-by-state basis; 2) insurance has a limited suggestion anti-trust exemption; and 3) there is a requirement for cost-based pricing to protect insurer financial condition and prevent intentional or unintentional unfair discrimination. He said the full list of items are in the request, which is posted on the NAIC’s website.

Commissioner Godfread said agrees that Mr. Birnbaum’s points are well taken. He said many have been discussed at length and presented during the many events and opportunities state insurance regulators have had over the past several years, and there is evidence that work has created fairly strong interest and awareness on the part of accelerators and others offering counsel and mentorship to startups in the InsurTech space. He said this has resulted in an understanding of the insurance industry, its products and services, and how it is regulated.

Commissioner Godfread said there are several documents geared toward this topic available on the internet, intended to better educate startups coming into insurance. He said his staff in North Dakota undertook a project to draft something along these lines and would be happy to share that with the consumer representative group for comment. He said his staff discovered during the development of the paper that there are clearly different opinions on how best to do this. He said it could probably be debated and wordsmithed for a long period of time, but the 10 basic items mentioned in Mr. Birnbaum’s letter represent an excellent start.

Commissioner Godfread said he is not sure undertaking a charge to draft an official NAIC bulletin is the best approach and opened it up for discussion. He suggested state insurance regulators could still work with consumer representatives to develop a paper on this topic, but he said he is reluctant to add it as a charge to the Task Force at this time.

Commissioner Godfread said he wants to make everyone aware of another undertaking related to development of an NAIC designation that will be discussed more during the Fall National Meeting. He said it involves working to find a way to open up the Associate Professional in Insurance Regulation (APIR) to tweak that for the InsurTech, basically opening up the designation that would encapsulate a lot of the introduction to insurance regulation that the InsurTech may be missing. He said this work is in progress and could be a good option as well for new entrants to this space, noting it could be a good introduction to what insurance regulation looks like. He then opened it up for discussion.

Mr. Grassel said the Global Insurance Accelerator (GIA) held its InsurTech event Oct. 14–18, and this topic was covered. Commissioner Godfread said those types of events are generally where this kind of education takes place. Mr. Bradner asked if Iowa could share that presentation with this group. Mr. Grassel said he would do that.

Peter Kochenburger (University of Connecticut School of Law) said this is a good idea and should not be a heavy lift, as there is already a lot of information on this topic available in the academic community. He said that it is written so it does not become dated and that he would be happy to provide some examples for the Task Force to review. He said having a consistent document would have a lot of value, and it could be shared online and elsewhere. He also said that if it is a charge, it is more likely to get done.

Commissioner Godfread said North Dakota is willing to offer what it has done so far. He said if the consumer representatives would be willing to offer up some of the work from the academic community, it may not take long to get something ready to share with the Task Force members.
Nikki Hall (NAIC) said she is working on an InsurTech study and would be open to working with others to incorporate this work into the study. She said she hopes to have a draft of the study ready to deliver to the Innovation and Technology State Contacts Roundtable at the Fall National Meeting.

Commissioner Godfread asked if what has been done to date could be shared with Ms. Hall, along with the presentation from the GIA, to get a full picture and then the study can be shared at the Roundtable. He said that a consistent document would be easier for those who work with InsurTechs and that coupled with the work on the designation side, it would be valuable. Mr. Bradner suggested it be put together as a video as opposed to a written document and could be made available online.

Superintendent Dwyer said the NAIC Communications Division staff have information on how to present materials for effectiveness and that might be good to consider.

Ms. Jabourian said she would like to see this material including information on the state insurance regulator’s obligation to enforce the law and that it is a legislative process to change those laws.

Angela Gleason (American Property Casualty Insurance Association—APCIA) said the APCIA would like to be involved in developing this guidance. She said it should be neutral and accurate in terms of what the state laws are and should not put forth any specific agenda.

Commissioner Godfread said that the Iowa presentation will be distributed and that Mr. Aufenthie will work with Mr. Kochenburger and Ms. Hall on the study, which will be revisited at the Task Force meeting during the Fall National Meeting. He asked if there was agreement with that approach. Hearing no disagreement or objection, he said that will be the approach.

5. **Adopted a Request for NAIC Model Law Development to Revise Model #880**

Commissioner Godfread said during the Summer National Meeting, the Task Force voted to move forward with work on an anti-rebating bulletin, as well as pursue development of language to revise Model #880 to further clarify what constitutes regulatory compliance in this area of anti-rebating. He said the first step to is to submit a Request for NAIC Model Law Development to the Executive (EX) Committee and the full membership asking for approval to work on Model #880. He said the Request for NAIC Model Law Development was posted on the Task Force’s web page.

David Kodama (APCIA) asked if the work would be limited to the section of Model #880 in the Request for NAIC Model Law Development, Section 4(H)(1). Commissioner Godfread said he thought the intention was to limit it to that. Mr. Kodama said the APCIA prefers it to be limited to that section.

John Fielding (The Council of Insurance Agenda and Brokers—CIAB) asked about item 4A in the Request for NAIC Model Law Development. He asked if the intent is to limit this to development of language specific to new technologies or if it is going to be generally applicable. He said the CIAB would urge that it not be limited just to technologies, but also other things that may not be specifically related to technology.

Commissioner Godfread said he does not read it that way. He said he reads it to say that is how this all came about; in other words, in light of new technologies, this needs to be addressed but does not restrict amendments to Model #880 to only be related to technology.

Mr. Baron made a motion, seconded by Ms. Brown, to adopt the Request for NAIC Model Law Development (Attachment Four-D). The motion passed unanimously.

6. **Discussed Comments Related to the North Dakota Anti-Rebating Bulletin**

Commissioner Godfread said the next agenda item is related to requested comments regarding the draft North Dakota anti-rebating bulletin. He said after discussions with NAIC Legal Division staff, the draft is more in line with a “bulletin” than a “guideline,” so it will be referred to as a “bulletin” going forward. He also said the Task Force members agreed to accept comments and continue to work on the language for a bulletin while it continues to pursue model law language development. He said the Task Force membership did not make a decision as to whether it would continue to work on “fine tuning” a North Dakota bulletin that other states may choose to use as a template for their state, or if the intent is to pursue developing...
an NAIC bulletin, meaning it would be developed and voted on, as a Task Force, and moved up through the NAIC committee process for a full vote of the membership.

Commissioner Godfread told the Task Force members that the comment letters have been posted to its web page. He said 13 letters/emails have been received, six from state insurance departments and the remainder from interested parties.

Commissioner Godfread asked the Task Force members if they want to pursue an official NAIC anti-rebating bulletin, to be voted on and sent up through the NAIC process as an NAIC work product, or if they want to discuss and consider the comment letters received and continue to work with the North Dakota draft bulletin to better understand the issues as it works toward the model language. He said based on the answer to that question, the Task Force will proceed with work to finish the discussion about the bulletin. He said once approval is received from the membership regarding the Request for NAIC Model Law Development, the Task Force will proceed with the work on the model law language. He said North Dakota is going to work on this bulletin anyway, so the thinking is to share that work with the Task Force to enable other states that want to move ahead with something in the short term.

Ms. Brown said Colorado appreciates having the North Dakota bulletin to identify some of the issues that Colorado would like to see addressed. She said all states have some rebating language, but the interpretation varies dramatically. She said that she is hoping this effort will lead to more uniformity in how states are looking at rebating and that this would apply to technology across the board.

Commissioner Godfread said the goal is to instill uniformity and reset some of the interpretation that exits across the country. He said the North Dakota bulletin is intended to address some of the issues identified and share that with other states, but the Task Force also voted to amend the Model #880, which is a good step, but both outcomes should help to make the states more consistent across the country. He said the bulletin is an option for a state to make that move sooner rather than later, and the model law process will hopefully also coincide somewhat with the bulletin language even though that is a different process.

Ms. Brown asked if the intention is to use the North Dakota bulletin as something of a launching pad for moving the model law discussion forward. Commissioner Godfread said that would be a fair assessment. Mr. Bradner said all states have the ability to be more consistent and deviate where they think they need to, but he said he would support continuing to work on the bulletin.

Superintendent Franchini agreed and said that in New Mexico, some companies that are using technology and AI to give credits or discounts want to include things to make the policyholder safer. He said he agrees with that premise, but he said state insurance regulators need to find a way to make sure technology does not get thrown in as a rebate. He said state insurance regulators need to find a way to separate the technology that mitigates risk from what used to be considered a rebate.

Commissioner Godfread agreed that the point is to look at technology that is being used for risk mitigation as something acceptable and by being able to be more efficient, the companies are able to save money and can pass that along to the consumer. He said he cannot see how that would be considered a rebate. He said if the focus is to offer something tied to risk mitigation, it is not a rebate. Superintendent Franchini said he agrees.

Commissioner Godfread said North Dakota has gone back and forth on whether it must be included in the policy. He said North Dakota has decided it does not necessarily need to be included, but he wants the ability to understand what is being offered in the marketplace so they can answer calls from consumers. He said he considers that to be information-sharing between the companies and the regulators.

Superintendent Franchini said not having it in the policy could lead to bad market behavior. He said if it is in the policy, it is harder to discriminate. Commissioner Godfread said that is why North Dakota initially wanted it specified in the policy. However, he said North Dakota also understands the counter argument to that, particularly in terms of having to revise the policy every time the value-added product may be upgraded. He said the level of specificity required is an issue if it is in the policy, and he and his staff have gotten more comfortable with information sharing as opposed to requiring it be in the policy. He said this will likely be debated as the Task Force works on the model law language.

Jeffrey Klein (McIntyre & Lemon PLLC), representing the Risk Insurance Management Society (RIMS), said he is pleased the Task Force is looking into this issue. He said from a procedural standpoint, the bulletin route may be important given the amount of time it might take to draft the model law language, but ultimately that will be necessary to ensure consistency and
uniformity across the states. He said the challenge will be to ensure the model law language is either consistent with or overrides the bulletin.

Commissioner Godfread said the bulletin was just the first crack at this and that the model law would trump the bulletin. He said if that happened, states could rescind the bulletin or pursue another option, as there is a host of ways to handle that.

Mr. Kodama said he suggests there be more discussion as to why these products and services can or should be specified in the policy. He said the APCIA is taking the position that this discussion is being taken up because the device is being offered outside of the policy. He said if it is something offered that is specified in the policy, it would be filed and approved, and those are already in the marketplace today. He said the monetary value is included in the insurance product and that what is being discussed is more along the lines of something separate that the insurance company or producer wants to offer to the consumer, like a supplement to the policy and provide information and risk awareness and mitigation. He said he wants to make sure that is clearly defined as this work moves forward.

Commissioner Godfread agreed and said there will be more discussion on this topic during the Task Force meeting at the Fall National Meeting. He asked Mr. Kodama to offer those comments there.

7. Discussed Other Matters

Commissioner Godfread said the annual report based on the Cybersecurity and Identity Theft Insurance Coverage Supplement filed by insurers with their annual statement was distributed to the Task Force members with the notice for this conference call. He said it has now been published on the Task Force’s web page and, hearing no objections to that, it is now available to the public. He said that it is the same format, basically presents the same data as the previous reports and is based on the 2018 data year.

Having no further business, the Innovation and Technology (EX) Task Force adjourned.

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The Artificial Intelligence (EX) Working Group of the Innovation and Technology (EX) Task Force met via conference call Sept. 5, 2019. The following Working Group members participated: Jon Godfread, Chair (ND); Mark Afable, Vice Chair (WI); Lucy Jabourian (CA); Andrew N. Mais (CT); Peg Brown (CO); David Altmayer (FL); Travis Grassel and Andria Seip (IA); Robert H. Muriel (IL); Amy Beard (IN); Tom Travis and Rich Piazza (LA); Ron Coleman (MD); Cynthia Amann, Angela Nelson and Teresa Kroll (MO); Keith Briggs (NC); Christian Citarella (NH); John G. Franchini (NM); Barbara D. Richardson (NV); Mark Hamlin (OH); Shannen Logue and Michael KeKenney (PA); Rachel Jade-Rice (TN); Eric Lowe (VA); and Christina Rouleau (VT). Also participating were: Timothy Schott (ME); Karen Dennis (MI); and Grace Arnold and Phil Vigliaturo (MN).

1. Heard Introductory Remarks

Commissioner Godfread said that at the Spring National Meeting, the Innovation and Technology (EX) Task Force adopted a motion to establish this Working Group to study the development of artificial intelligence (AI), its use in the insurance sector, and its impact on consumer protection and privacy, marketplace dynamics, and the state-based insurance regulatory framework. He said the charge also stated that the Working Group will develop regulatory guidance, beginning with guiding principles, and make other recommendations to the Innovation and Technology (EX) Task Force as appropriate by the 2020 Summer National Meeting.

Commissioner Godfread said the plan is to focus on that latter part of the charge, specifically to work on guiding principles. He said that other groups outside of the NAIC are working on principles for AI, and some have even adopted them, such as the Organisation for Economic Cooperation and Development’s (OECD) principles, as well as those being considered by the Australian government’s Department of Industry, Innovation and Science. He said these principles were sent out as materials for this call.

Commissioner Godfread said he and Commissioner Afable discussed how to approach developing these principles for the insurance industry. He said they think it is important to discuss and establish the scope of the Working Group’s work and to keep it at a high level in order to get these principles drafted. He said both he and Commissioner Afable realize it is going to be hard to keep from getting into details in terms of definitions and exactly what is meant by some regarding these terms. However, he said they would like the Working Group to stay out of the weeds and get some high, overarching principles drafted that can be used across the NAIC workstreams. He said the timeline is tight and somewhat aggressive, so he would ask the Working Group members, other state insurance regulators and interested parties to keep the timeline in mind as they prioritize this work. Commissioner Afable reiterated the importance of staying focused on high-level guiding principles and that other committees and Task Forces will determine where the specific issues are best developed once the principles have been drafted. He said he and Commissioner Godfread realize there is work going on in the space without guiding principles in place, making it important to get this work done quickly.

Commissioner Godfread said there are other organizations putting out principles and that it is important for the NAIC to get out some insurance guidelines as well with principles that are tailored to the insurance industry.

2. Heard a Presentation on AI from Faegre Baker Daniels LLP

Scott Kosnoff (Faegre Baker Daniels LLP) provided an AI overview. He began with offering common definitions for AI and its genesis. He said its growth can be attributed to the explosive amounts of data now available for use and the availability of storage that allows this data to be stored and made available, widely, as well as the amazing strengthening of processing power. He talked about the difference between “general” AI, which can think like a human in all respects, and “narrow” AI, which is focused on very specific tasks. He said while “general” AI is still a long way off, “narrow” AI is here and alive and well. Mr. Kosnoff reviewed why AI is so important and some important applications for AI, including medical research, hiring decisions, lending, insurance and more. He said insurers are interested in AI to improve marketing and customer engagement, underwriting, rating, claims decisions and fraud detection, and he talked about what is in it for consumers. Mr. Kosnoff also reviewed the concerns related to AI. He said the most frequently cited concern deals with fairness, bias/discrimination and the lack of transparency/explainability. He said these are not unique to the insurance industry related to AI but are concerns that...
are agnostic to the use of AI. He also reviewed other AI challenges, including incomplete, inaccurate and outdated data, as well as having embedded bias in the data. He said there are also algorithm challenges, including unreliable accuracy and algorithms that are too complex or rely on unlawful factors such as race, gender or religion. He said this can have a widespread impact with AI. Mr. Kosnoff provided some examples where these issues became a problem. Mr. Kosnoff said there is strong consensus regarding AI’s ability to offer extraordinary benefits but that reasonable and measured guardrails are needed. He said there is an important role for state insurance regulators and that it is important to get engaged as the federal government already is, as well as international standard-setters such as the OECD and the International Association of Insurance Supervisors (IAIS). He said the principles should not be overly restrictive or prescriptive, but there should be a balance between the need for consumer protections and the desire to encourage innovation.

Commissioner Godfread reiterated that while data issues and algorithmic challenges exist, it is not the charge of this Working Group to solve those issues or develop details of what that means as that will likely be the purview of another group. However, he said setting up the guardrails needs to be done and that time is of the essence. He said with the availability of 5G networks, data issues will only continue to grow and will create more privacy issues. However, he said the details will be handled elsewhere and that this Working Group will address areas of focus for the broader industry.

Ms. Jabourian said there need to be guidelines that emphasize the importance of transparency and explainability of the algorithms versus being told it is the AI and that it cannot necessarily be explained. She said as state insurance regulators, we need to be able to understand how the AI came to its conclusions. Commissioner Godfread agreed. He said the principles need to lay out what is required, but not necessarily provide all the details of how that will be done just now.

3. Discussed the Adopted OECD AI Principles and Australia’s Ethics Framework Discussion Paper

Mr. Kosnoff provided an overview of the OECD principles. He said several workstreams to develop AI principles are in progress or have been completed, most limited to a specific country. He said the OECD AI principles, however, are the first and only set of inter-government policy guidelines adopted by multiple countries. He said 42 countries, including the U.S., have adopted the OECD AI principles. He said they are for general application and are not targeted at the insurance sector. Mr. Kosnoff pointed out portions of the principles that might have application for the insurance industry, including:

1. Inclusive growth, sustainable development and well-being
   - Advancing inclusion of underrepresented populations.
   - Reducing economic, social, gender and other inequalities.
2. Human-centered values and fairness
   - Respect of the rule of law, human rights and democratic values throughout the AI system lifecycle.
   - Privacy and data protection.
   - Non-discrimination and equality.
   - Fairness.
   - Mechanisms and safeguards, such as human determination.
3. Transparency and explainability
   - Provide meaningful information to stakeholders so that they know when they are interacting with AI.
   - Stakeholders affected by an AI system should be able to understand the outcome.
   - Stakeholders adversely affected by an AI system should be provided information so that they can challenge the outcome and the logic that served as the basis for the decision.
4. Robustness, security and safety
   - Should be robust, secure and safe throughout their entire lifecycle.
   - Should ensure traceability to enable analysis of outcomes.
   - Systematic risk management approach to each phase of the AI system lifecycle on a continuous basis.
5. Accountability
   - All organizations that deploy or operate an AI system should be accountable for the proper functioning of the system and for the respect of the above principles.

Mr. Kosnoff said the OECD principles appear to be a good place to start for the Working Group. He said the Australian draft principles are also very interesting and may be more reader-friendly than the OECD principles, but they are just a proposal out for comment and have not been adopted anywhere.
4. **Discussed the Process for Development of AI Principles for Insurance and Next Steps**

Commissioner Godfread asked the Working Group members how they would like to move forward in drafting AI principles for the insurance industry. He asked if the Working Group would like to use the OECD principles or some other entity’s principles as a starting point and accept comments on how to tailor it to the individual insurance industry as a whole. Commissioner Richardson said it would be good to start with something already based in reality. Commissioner Mais agreed and said there is no reason to reinvent the wheel. He said the OECD principles provide a good basis for creating a set of principles uniquely tailored to the insurance industry. Commissioner Afable said NAIC staff had been asked to look at other standards out there and that research came back to the ones being discussed. He asked Mr. Kosnoff if he sees any significant difference between the OECD AI principles and the Australian draft. Mr. Kosnoff said he does not think there is any meaningful difference and if an exhaustive study of all workstreams were done, it would likely reveal far more commonality among the different versions than differences. He said there may be differences in emphasis and the way they are expressed but still more commonality than differences. Mr. Logue said there should be a constant reminder to creators of AI systems that unfair trade practice laws must always be kept in mind.

Commissioner Godfread asked if interested parties had any comments. Hearing none, he said there is a clear direction to work with the OECD AI principles as a starting point. He said NAIC staff will publish a pared down version of the OECD AI principles and expose them for a public comment period.

Having no further business, the Artificial Intelligence (EX) Working Group adjourned.
2020 PROPOSED CHARGES

INNOVATION AND TECHNOLOGY (EX) TASK FORCE

The mission of the Innovation and Technology (EX) Task Force is to provide a forum for regulator education and discussion of innovation and technology in the insurance sector, to monitor technology developments that affect the state insurance regulatory framework, and to develop regulatory guidance, as appropriate.

Ongoing Support of NAIC Programs, Products or Services

1. The Innovation and Technology (EX) Task Force will:
   A. Provide forums, resources and materials for the discussion of innovation and technology developments in the insurance sector, including the collection and use of data by insurers and state insurance regulators—as well as new products, services and distribution platforms—in order to educate state insurance regulators on how these developments affect consumer protection, privacy, insurer and producer oversight, marketplace dynamics and the state-based insurance regulatory framework.
   B. Develop regulatory guidance, model laws or model law revisions, and white papers or make other recommendations to the Executive (EX) Committee, as appropriate.
   C. Monitor and discuss regulatory issues that arise with the development of autonomous vehicles. Study and, if necessary, develop recommendations for changes needed to the state-based insurance regulatory framework.
   D. Discuss emerging issues related to companies or licensees leveraging new technologies to develop products for on-demand insurance purposes—in addition to potential implications on the state-based insurance regulatory structure—including, but not limited to, reviewing new products and technologies affecting the insurance space and the associated regulatory implications.
   E. Monitor developments in the area of cybersecurity, including the implementation of the Insurance Data Security Model Law (§668) and representing the NAIC and communicating with other entities/groups, including sharing information as may be appropriate.
   F. Coordinate with other NAIC committees and task forces, as appropriate, on technology, innovation, cybersecurity issues and data privacy.

2. The Big Data (EX) Working Group will:
   A. Review current regulatory frameworks used to oversee insurers’ use of consumer and non-insurance data. If appropriate, recommend modifications to model laws and/or regulations regarding marketing, rating, underwriting and claims, regulation of data vendors and brokers, regulatory reporting requirements, and consumer disclosure requirements.
   B. Propose a mechanism to provide resources and allow the states to share resources to facilitate their ability to conduct technical analysis of, and data collection related to, the review of complex models used by insurers for underwriting, rating and claims. Such a mechanism shall respect and in no way limit the states’ regulatory authority.
   C. Assess data needs and required tools for state insurance regulators to appropriately monitor the marketplace and evaluate underwriting, rating, claims and marketing practices. This assessment shall include gaining a better understanding of currently available data and tools, as well as recommendations for additional data and tools, as appropriate. Based on this assessment, propose a means to collect, house and analyze needed data.
INNOVATION AND TECHNOLOGY (EX) TASK FORCE (continued)

3. The Speed to Market (EX) Working Group will:
   A. Consider proposed System for Electronic Rate and Form Filing (SERFF) features or functionality presented to the Working Group by the SERFF Advisory Board, likely originating from the SERFF Product Steering Committee. Upon approval and acquisition of any needed funding, direct the SERFF Advisory Board to implement the project. Receive periodic reports from the SERFF Advisory Board, as needed.
   B. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed to market operational efficiencies related to product filing needs, efficiencies and effective consumer protection. This includes the following activities:
      1. Provide a forum to gather information from the states and the industry regarding tools, policies and resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency issues for state insurance regulators and the industry, particularly with regard to uniformity. In 2020, evaluate the state survey results compiled in 2019 regarding the usefulness of existing tools and potential new tools and propose a plan to make improvements.
      2. Use SERFF data to develop, refine, implement, collect and distribute common filing metrics that provide a tool to measure the success of the speed to market modernization efforts as measured by nationwide and individual state speed to market compliance, with an emphasis on monitoring state regulatory and insurer responsibilities for speed to market for insurance products.
      3. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal document (UTD) on an annual basis, including the review, approval and notification of changes. Monitor, assist with and report on state implementation of any PCM changes.
      4. Facilitate the review and revision of the Product Filing Review Handbook, which contains an overview of all of the operational efficiency tools and describes best practices for industry filers and state reviewers with regard to the rate and form filing and review process. In 2020, develop and implement a communication plan to inform states about the Product Filing Review Handbook.
   C. Provide direction to NAIC staff regarding SERFF functionality, implementation, development and enhancements. Direct NAIC staff to provide individual state speed to market reports to each commissioner at each national meeting. Receive periodic reports from NAIC staff, as needed.
   D. Conduct the following activities as desired by the Interstate Insurance Product Regulation Commission:
      1. Provide support to the Compact as the speed to market vehicle for asset-based insurance products, encouraging the states’ participation in, and the industry’s usage of the Compact.
      2. Receive periodic reports from the Compact, as needed.

4. The Artificial Intelligence (EX) Working Group will:
   A. Study the development of artificial intelligence (AI), its use in the insurance sector, and its impact on consumer protection and privacy, marketplace dynamics, and the state-based insurance regulatory framework. The Working Group will develop regulatory guidance, beginning with guiding principles, and make other recommendations to the Innovation and Technology (EX) Task Force as appropriate by the 2020 Summer National Meeting.

NAIC Support Staff: Scott Morris/Denise Matthews

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Comments of the Center for Economic Justice

To the NAIC Innovation and Technology Task Force

Suggested Bulletin Directed at Insurtechs:
Why Insurance is Different from Other Consumer Products

April 19, 2019

During the Innovation and Technology Task Force’s meeting earlier this year, we listened with interest to the presentation by Plug and Play and to the questions and discussion that followed the presentation. We felt that the survey results presented by Plug and Play were too generic to provide actionable insights. Rather, information on what type of regulation presented what type of barrier would have been far more useful.

Some of the perceived barriers may be a result of Insurtech’s thinking that insurance is like any other consumer product, in spite of the fact that regulation of insurance is predicated on the fact that insurance is not like other consumer products. To educate Insurtechs to basic issues of insurance regulation, we suggest the ITTF develop a bulletin for Insurtechs entitled “Why insurance is different from other consumer products—a primer for Insurtechs.” Such bulletin might include discussion of the following topics to provide a context for Insurtechs to understand the purposes of insurance regulation and to help guide their efforts in support of the goals of insurance regulation. In no particular order:

1. Insurance is generally regulated on a state-by-state basis

2. Insurance has a limited exemption from federal anti-trust laws. Activities that might otherwise violate anti-trust laws are permissible if regulated by the state.

3. The nature of insurance products have resulted in particular statutory requirements and regulatory practices

4. Cost-based pricing is required by actuarial standards of practice and financial solvency. The requirement for cost-based pricing is to protect insurer financial condition and prevent intentional or unintentional unfair discrimination
5. States generally prohibit discrimination on the basis of specific consumer characteristics – such as race, religion or national origin – as well as require discrimination on the basis of other consumer characteristics be justified by differences in expected losses or expenses. Pricing practices – such as dynamic pricing or price optimization – are not permitted in personal lines insurance.

6. Some insurance is required either by law or by lenders requiring protection of home or vehicle collateralizing the loan.

7. An insurance contract is a promise for future benefits if an undesirable event occurs. If the product “fails” – the consumer learns the insurance policy won’t cover the loss – she is stuck and can’t purchase another policy that would protect her against a known loss.

8. Consumers have little or no information about the insurers’ performance.

9. There is profound public interest in broad coverage – failure or inability of consumers and businesses to access insurance has implications not just for individual families and businesses, but for taxpayers, communities and the nation.

10. State insurance regulators have resources to assist you to understand, navigate and develop products in compliance with the consumer protection goals of the state-based insurance regulatory system

   We suggest that the proposed bulletin would provide a useful introduction to insurance regulation and provide a roadmap for innovation.
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:
   Innovation and Technology (EX) Task Force

2. NAIC staff support contact information:
   Denise Matthews
dmatthews@naic.org
   816-783-8007

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.
   
   NAIC Unfair Trade Practices Act (Model #880)
   Section 4(H)(1)

   The Innovation and Technology (EX) Task Force will draft amendments to the NAIC Unfair Trade Practices Act (Model #880), focusing on Section 4H, to clarify what is considered a “rebate” or “inducement”.

4. Does the model law meet the Model Law Criteria? X Yes   or   □ No   (Check one)
   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).
   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? X Yes   or   □ No   (Check one)
      If yes, please explain why: Inconsistency in the interpretation of the Model language necessitates revisions to clarify the intent and ensure necessary consumer protections remain in place in light of technologies being deployed to add value to existing insurance products and services.
   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?
      X Yes   or   □ No   (Check one)
5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

☐ 1  ☑ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood    Low Likelihood

Explanation, if necessary: A significant amount of time and discussion has already been devoted to this topic including presentations from all stakeholders and discussion around draft guideline language. That should help in accelerating the development process related to this model language.

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

☐ 1  ☑ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood    Low Likelihood

Explanation, if necessary:

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

☐ 1  ☑ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood    Low Likelihood

Explanation, if necessary:

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

No

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

No.
LONG-TERM CARE INSURANCE (EX) TASK FORCE

Long-Term Care Insurance (EX) Task Force Dec. 9, 2019, Minutes.................................................................4-110
Long-Term Care Insurance (EX) Task Force Oct. 31, 2019, Minutes (Attachment One).................................4-113
Long-Term Care Insurance (EX) Task Force 2020 Proposed Charges (Attachment One-A) .........................4-114
The Long-Term Care Insurance (EX) Task Force met in Austin, TX, Dec. 9, 2019. The following Task Force members participated: Scott A. White, Chair, and Doug Stolte (VA); Michael Conway, Vice Chair, represented by Eric Unger (CO); Lori K. Wing-Heier (AK); Allen W. Kerr represented by William Lacy (AR); Stephen C. Taylor (DC); Trinidad Navarro (DE); David Altmaier (FL); Colin M. Hayashida (HI); Doug Ommen (IA); Dean L. Cameron (ID); Robert H. Muriel (IL); Stephen W. Robertson represented by Amy Beard and Karl Knable (IN); Nancy G. Atkins (KY); James J. Donelon represented by Rich Piazza (LA); Gary Anderson (MA); Eric A. Cioppa (ME); Anita G. Fox represented by Karen Dennis (MI); Steve Kelley, Grace Arnold and Fred Anderson (MN); Bruce R. Ramge and Rhonda Ahrens (NE); Marlene Caride (NJ); John G. Franchini represented by Anna Krylova (NM); Barbara D. Richardson represented by Stephanie McGee (NV); Glen Mulready represented by Ron Kreiter (OK); Andrew Stolfi (OR); Jessica Altman (PA); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer (SC); Larry Deiter (SD); Hodgen Mainda (TN); Kent Sullivan and Doug Slape (TX); Todd E. Kiser represented by Tanji Northrop (UT); Michael S. Pieciak represented by Anna Van Fleet (VT); Mike Kreidler (WA); Mark Afable (WI); and James A. Dodrill (WV).

1. **Adopted its Oct. 31 and Summer National Meeting Minutes**

The Task Force conducted an e-vote that concluded Oct. 31 to adopt its 2020 proposed charges.

Commissioner Kreidler made a motion, seconded by Commissioner Altman, to adopt the Task Force’s Oct. 31 (Attachment One) and Aug. 4 (see NAIC Proceedings – Summer 2019, Long-Term Care Insurance (EX) Task Force) minutes. The motion passed unanimously.

Commissioner White said the Task Force also met Oct 16, in regulator-to-regulator session pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss workstream planning.

2. **Received a Progress Report on Activities of the Task Force**

Commissioner White said the goals of the Task Force were divided into six workstreams, each of which has work underway or planned. Commissioner White said a public summary report on each of the workstreams was posted to the Task Force’s web page and was distributed to all interested state insurance regulators and interested parties on Oct. 25.

   a. **Multistate Rate Review Practice**

Ms. Ahrens said the workstream met Nov. 13 to discuss base questions and criteria for selecting a recommended long-term care insurance (LTCI) rate increase review methodology to use in a multistate review. Next, several actuaries were asked to refine the base questions and criteria, which will be discussed during a conference call in December.

   b. **Restructuring Techniques**

Mr. Slape said the workstream was organized to consider if any restructuring techniques could be used to protect policyholders as opposed to receivership. The group has met to develop a set of guiding principles and a scope of work. He said a conference call is scheduled for next week to review the scope of work and consider next steps for analysis.

   c. **Reduced Benefit Options and Consumer Notices**

Commissioner Altman said the workstream has met several times and is focused on information gathering from state insurance regulators on states’ practices for the review of reduced benefit options and consumer notices sent by companies, sample of notices and decisions states have made related to reduced benefit options. The group plans to continue information gathering by hearing from states that have robust review processes, discuss specific types of reduced benefit options and then shift to consumer disclosures.

Bonnie Burns (California Health Advocates—CHA) asked how reduced benefit options are regulated by the states because they are not included in NAIC models and there is inconsistency between states.
Commissioner Altman said the workstream has found that states have different review processes. One of the goals of the workstream is to reach a high level of consistency, keeping in mind the concerns affecting policyholders.

Ms. Burns asked when the workstream meetings would be open to interested parties. Commissioner White said the Task Force wants to be transparent and get input from stakeholders. Therefore, at the appropriate time, more information will be made available and more feedback will be requested from interested stakeholders. Commissioner Altman said with respect to this workstream, the input from consumer representatives and industry is necessary; it is just a matter of reaching the right point in the process to involve interested parties.

d. Valuation of LTCI Reserves

Mr. Andersen said the workstream’s primary charge regarding coordination and communication of LTCI reserving issues is being accomplished under the Valuation Analysis (E) Working Group and its review of companies’ Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) filings and meeting with companies. In 2019, the Working Group’s focus was on morbidity improvement, rate increase and investment return assumptions. In 2020, the focus has been on morbidity, including cost of care projections, effect of underwriting and what happens with older age policies. The workstream is also looking at ways to assist states in understanding the commonality between drivers of rate increases and reserving. The workstream conducted a survey on states’ interdepartmental coordination and communication between rate review actuaries and valuation actuaries and found that with few exceptions, states’ actuaries do communicate with each other.

Ms. Burns asked what happens to policyholder reserves when benefits are reduced. Mr. Andersen said companies are required to project out all cash flows, including premium, claims and investment income. When there are rate increases, the premium cash-flow projection for premium is changed for the new premium rate. When there are benefit changes, the cash-flow projections for benefits would be changed. That is something the workstream will focus on but does not have any data yet.

Birny Birnbaum (Center for Economic Justice—CEJ) asked which workstream will be looking at if the reduced benefit options offered to consumers are fair and equitable. Commissioner Altman, Mr. Andersen and Ms. Ahrens confirmed that the prospective review of reduced benefit options is within the scope of the reduced benefit option and consumer notice workstream and the multistate rate review practice workstream, while the historical review falls within the scope of the valuation of LTCI reserves workstream.

e. Non-Actuarial Variations

Commissioner Kreidler said the workstream is focused on evaluating the variances between states’ use of non-actuarial factors and review considerations in reviewing rate increase requests and develop best practices.

The workstream began with a limited scope survey of 14 workstream members about their departments’ policies, practices and authority to modify rate increase determinations of LTC rate filings based on non-actuarial factors. Nearly all states responding indicated they have authority to consider non-actuarial factors in the rate approval process. The top three factors were phase-in periods, caps (or limits) on the amount of allowed rate increases, and waiting periods between rate increase approvals and subsequent requests. The workstream also found that the length of phase-in and waiting periods and the threshold for caps varied from state to state. The workstream noted other factors included such things as the size of the block of policyholders, prior rate increase approvals, the size of the rate increase and its impact on consumers.

The workstream thinks the results of the survey are a representative sample of states’ practices, and it intends to use the results to develop recommendations for possible best practices. Over the next few weeks, the workstream will first be working on gathering additional information to better understand how the states determined these factors and established thresholds. Following that, the workstream will begin to develop possible best practices for the use of non-actuarial practices in the rate determination process that the Task Force can consider at a future date.

f. Data Call Design and Oversight

Mr. Stolte said the workstream was organized to perform two functions: 1) define a scope of work data call for certain long-term care (LTC) insurers in order to accumulate and analyze the current level of potential LTCI rate inequity among states’ policyholders; and 2) review the work of a consultant performing such a data call for communication to the Task Force.
Mr. Stolte said the workstream held preliminary discussions in July to brainstorm the type of data that may be needed to achieve the objective, and then in August, the actuaries began designing the data call. In September, testing and proposed improvements were made mostly from an instructional perspective. Ultimately, the workstream drafted a proposed scope of work for a consultant to complete such work. On Nov. 11, the NAIC released a Request for Proposal (RFP), which is posted to the NAIC website. Some key dates in the RFP are as follows:

- On Nov. 19, notification of intent to bid and submission of questions from bidders was due. Ten firms responded with their intent to bid, and on Nov. 22, responses to questions were provided.
- Bids are due Dec. 11.
- Firm selection is expected to be made in mid-February 2020.

Commissioner Stolfi said one data point that he is interested in receiving is how carriers have distributed dividends, whether currently available in annual financial reporting or through the data call.

3. Received Comments from Consumer and Industry Representatives

Patrick Cantilo (Cantilo & Bennett LLP) said the problem with LTCI rates is that pricing was originally based on modeling like life and annuities. The assumptions for lapse rates, termination rates, morbidity and mortality were misjudged. Investment yield assumptions have changed due to economic changes. For policies sold in the 1970s and 1980s, the premium was found to be grossly underpriced. It is not uncommon today for a company to have policies for a single product with rates that vary as much as sevenfold to tenfold between states. State insurance regulators have had a variety of valid concerns regarding companies’ rate increase requests. He said he has two observations:

- Policyholders had little input in the setting of premium rates and were often led to believe the rates would not change over time.
- Policyholders were inadvertently receiving a bargain, which was not a sustainable model.

Mr. Cantilo said there are three options for legacy blocks of LTCI:

- Market solutions are like the work being evaluated by the restructuring workstream group. Some in industry are developing creative solutions that have not been tested. Criteria should be observed with those solutions, including that the solutions be nondiscriminatory and treat policyholders fairly, and that the solutions must be effective and workable.
- Rehabilitation gives the domiciliary regulator broad authority to restructure the company and an opportunity to provide a better outcome for policyholders than market solutions or liquidation.
- Liquidation adds the value of guaranty association safety net but comes with benefit limitations.

Charles Piacentini (American Council of Life Insurers—ACLI) said the first message to convey is that the ACLI is committed to providing resources to answer questions and provide information. He said that all the workstreams are important and that the multistate rate review workstream is the cornerstone of all the workstreams. Industry has coalesced around the prospective present value (PPV) methodology, also known as the “Texas Approach,” as it achieves the objectives identified by state insurance regulators and concerns expressed by consumers. Stabilization and addressing legacy blocks are important to having coverage in the future and providing solutions to protect the financial security for consumers. He said coming up with a standard methodology addresses the concerns across jurisdictions to treat similarly situated policyholders equitably.

Jan Graeber (ACLI) said she encourages the Task Force to leverage the work completed by the Long-Term Care Pricing (B) Subgroup. She said the ACLI is committed to devoting resources to demonstrate how the PPV address state insurance regulators’ concerns. The PPV requires carriers to share in the cost by absorbing the losses that have occurred in the past. The PPV addresses the inequity between states that have approved different rate increases. Internally, the ACLI is developing a high-level demonstration to show how the PPV addresses these concerns. Carriers need a level of predictability to price and manage their business.

Mr. Knable said that while Indiana is fine with a consistent approach to reviewing rates, he emphasized the need to maintain a state-based approach to applying rate increases to policyholders that considers actuarial factors and policyholder expectations.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned.
The Long-Term Care Insurance (EX) Task Force conducted an e-vote that concluded Oct. 31, 2019. The following Task Force members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair (CO); Lori K. Wing-Heier (AK); Allen W. Kerr represented by William Lacy (AR); Ricardo Lara represented by Camilo Pizarro (CA); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier (FL); Colin M. Hayashida represented by Martha Im (HI); Robert H. Muriel represented by Mike Chrysler (IL); Stephen W. Robertson represented by Karl Knable (IN); James J. Donelon represented by Rich Piazza (LA); Eric A. Cioppa represented by Marti Hooper (ME); Anita G. Fox represented by Karen Dennis (MI); Bruce R. Ramge (NE); John G. Franchini represented by Anna Krylova (NM); Andrew Stolfi (OR); Jessica Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry Deiter (SD); Kent Sullivan represented by Doug Slape (TX); Mike Kreidler represented by Michael Bryant (WA); Mark Afable (WI); and James A. Dodrill represented by Tonya Gillespie (WV).

1. **Adopted its 2020 Proposed Charges**

The Task Force conducted an e-vote to consider adoption of its 2020 proposed charges. A majority of the members voted in favor of adopting the 2020 proposed charges (Attachment One-A). The motion passed, with Indiana dissenting.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned.
2020 Proposed Charges

LONG-TERM CARE INSURANCE (EX) TASK FORCE

The Long-Term Care Insurance (EX) Task Force will:

A. Recognizing the gravity of the threat posed by the current long-term care insurance (LTCI) environment both to consumers and our state-based system of insurance regulation, this Task Force is charged to:

1. Developing a consistent national approach for reviewing long-term care insurance (LTCI) rates that results in actuarially appropriate increases being granted by the states in a timely manner, and eliminates cross-state rate subsidization.

2. Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.

3. Deliver such a proposal to the Executive (EX) Committee by the 2020 Fall National Meeting.

A.B. Provide periodic reporting to the Long-Term Care Insurance (E/B) Task Force to help ensure coordination between the two task forces on LTCI issues.

Unless otherwise affirmatively extended or modified by the Executive (EX) Committee, the Task Force and its charges will expire Jan. 31, 2021.

NAIC Support Staff: Jeffrey C. Johnston
INFORMATION SYSTEMS (EX1) TASK FORCE

Information Systems (EX1) Task Force Dec. 6, 2019, Minutes

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The Information Systems (EX1) Task Force met in Austin, TX, Dec. 6, 2019. The following Task Force members participated: Al Redmer Jr., Chair, represented by Paula Keen (MD); Lori K. Wing-Heier (AK); Allen W. Kerr represented by Letty Hardee (AR); Keith Schraad represented by Tom Zuppan (AZ); Michael Conway represented by Damion Hughes (CO); Trinidad Navarro represented by Frank Pyle (DE); Robert H. Muriel represented by Judy Mottar (IL); Vicki Schmidt (KS); Nancy G. Atkins represented by John Melvin (KY); Chlora Lindley-Myers represented by Cynthia Amann (MO); Barbara D. Richardson (NV); Jillian Froment represented by Angela Dingus (OH); Glen Mulready represented by Cuc Nguyen (OK); Kent Sullivan represented by Kenisha Schuster, Regan Ellmer, Nancy Clark, Marianne Baker and David Muckerheide (TX); and Scott A. White represented by Vicki Ayers (VA). Also participating were: Robin David (DE); Elizabeth Nunes (GA); Jerry Ehlers (IN); Robert Baron (MD); Matt Vatter (MN); Jennifer Demory (OH); Kirsten Anderson and Brian Fordham (OR); Matt Gendron (RI); Jessica Sherpa (VT); and John Haworth (WA).

1. **Adopted its Summer National Meeting Minutes**

Ms. Dingus made a motion, seconded by Mr. Pyle, to adopt the Task Force’s Aug. 2 minutes (*see NAIC Proceedings – Summer 2019, Information Systems (EX1) Task Force*). The motion passed unanimously.

2. **Received an Update on Draft 2020 Fiscals with a Technology Component**

Ms. Keen reported that the Task Force met Sept. 26, in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings, to review and discuss the technical approach described by the three proposed 2020 fiscal impact statements: 1) Cloud Transition Phase IV: Cloud Migration; 2) Enhanced Regulatory Data Collection; and 3) Uniform Certificate of Authority Application (UCAA) Redesign and Biographical Affidavit Database.

3. **Received the IT Operational Report**

Scott Morris (NAIC) highlighted four sections included in the Information Technology (IT) Operational Report received by the Task Force members. The report outlines work that the NAIC Information Technology Group (ITG) performs, new offerings from the NAIC, and general updates on the activities of the NAIC technology team.

a. **Product Highlights**

Missouri and West Virginia transitioned from Legacy State Based Systems (SBS) to the new platform. Five states remain to transition to the new platform as follows: Alaska (December), New Hampshire (February), Iowa (April), North Carolina (June) and Tennessee (August). Connecticut is currently licensed and in queue for its new implementation planned for early 2021. An SBS collaboration space was recently implemented to provide state insurance regulators with opportunities to connect with other state insurance regulators using the system.

The Market Analysis Procedures (D) Working Group’s short-term limited duration (STLD) data call is a collaborative data call of 40 participating NAIC jurisdictions. This call used new features released in October for the Regulatory Data Collection (RDC) system. The enhancements allow business users to more easily set up a data call without assistance by the technology team. The administrative tool allows the user to define the data call format, data definitions, validations, and error tolerances. The tool and its database were moved to the cloud to take full advantage of the elasticity, resilience and flexibility of the cloud.

NAIC membership approved the System for Electronic Rate and Form Filing (SERFF) Data Hosting fiscal on Aug. 3 at the Summer National Meeting, allowing the NAIC to proceed with de-commissioning the current data hosting model and replacing it with NAIC hosting for industry customers. NAIC hosting services became available on Nov. 1, and replication of data to the current hosting vendors will cease on Dec. 31. NAIC hosting will eliminate the need for customers to log in to two different places to see submitted and hosted filings.
The NAIC created a functioning proof of concept (POC) collaboration tool for the Big Data (EX) Working Group. NAIC technical and actuarial staff worked closely together to identify the processes and procedures to develop the POC to meet member requirements. The tool provides the ability to collaborate on big data topics. We expect to receive feedback and adjust before releasing to a wider group early next year.

On Oct. 18, the NAIC released a Request for Proposal (RFP) for analysis of SERFF. The NAIC will hire an agency to do detailed analysis of the capabilities of SERFF in conjunction with the business needs of the association and its members. SERFF was built in 1997, with the first production filings submitted in early 1998, and it is widely used and has many stakeholders. Responses to the RFP were evaluated by a team of three state insurance regulators to select the firm. The assessment is expected to take four to six months, and it will include interviews with key stakeholders, including state insurance regulators who use the system, commissioners, and industry users.

b. Innovation and Technology

Three strategic decisions were made to help optimize the cost footprint in the cloud, increase operational capacity, and add to internal technical leadership: 1) the NAIC engaged with Cloudreach to help identify cost saving opportunities and provide expert feedback and industry best practices to minimize cloud costs; 2) the NAIC decided to partner with a cloud managed service provider (MSP) to help manage cloud infrastructure. The MSP will perform activities like installing patches, performing backups, and monitoring the performance of infrastructure; and 3) the Chief Architect position was filled, and this role’s top priority is the cloud technical strategy.

Work continues to implement capabilities for the Service Organization Control (SOC) 2 for the cloud. The team has submitted 23 of the 30 controls for review by outside auditors. The auditors provided feedback on additional items needed for the controls to be complete, and the team is working to complete these tasks, as well as the remaining controls.

Protecting data that the NAIC collects and stores continues to be a top priority. In October, the Data De-identification project completed the implementation of software and processes to protect Personally Identifiable Information (PII) data in NAIC and National Insurance Producer Registry (NIPR) test environments.

c. Service and Support

The NAIC’s service request volume remains steady around 11,500–13,000 inquiries per month. The NAIC anticipates overall volume remaining steady throughout the remainder of the year. Key call drivers included: SBS transitions for Missouri and West Virginia; as well as industry filing deadlines for Internet Filing, Online Premium Tax for Insurance (OPTins), SERFF, risk-based capital (RBC), and Market Conduct Annual Statement (MCAS).

d. Team

The ITG team completed an engagement survey for the fourth consecutive year that measures the level of connection, motivation and commitment that staff feel for their place of work. This year, the survey was expanded to all NAIC employees. Also, the ITG Culture Committee was formed a year ago, and it meets bi-weekly in an effort to fulfill its mission, which is to embody, reinforce and promote the core values to all employees. The committee has recently morphed into an all NAIC culture committee.

4. Received a Portfolio Update and Project Status Reports

Cheryl McGee (NAIC) reported on the project portfolio. As of November, the NAIC’s technical project portfolio includes 20 active technical projects, 17 of which are projects of the State Head strategic plan. Three projects have been completed since the last report.

5. Received an Update on the NAIC Catalog

Jennifer Boren (NAIC), the NAIC’s SBS and Service Management Assistant Director, provided an overview of the new NAIC Technology Products and Services Catalog.
6. **Discussed Other Matters**

Ms. Keen encouraged state insurance regulators—both current and new members—to reach out to their commissioner to serve on the Task Force next year if interested.

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The Life Insurance and Annuities (A) Committee met in Austin, TX, Dec. 8, 2019. The following Committee members participated: Doug Ommen, Chair, and Mike Yanacheak (IA); Stephen C. Taylor, Vice Chair (DC); Jim L. Ridling represented by Steve Ostlund and Reyn Norman (AL); Keith Schraad (AZ); Trinidad Navarro represented by Fleur McKendell and Frank Pyle (DE); Dean L. Cameron (ID); James J. Donelon represented by Frank Opelka (LA); Jon Godfread (ND); Bruce R. Ramge Matt Holman and Rhonda Alhrens (NE); Barbara D. Richardson (NV); Linda A. Lacewell represented by Victor Agbu (NY); Jillian Froment (OH); Hodgen Mainda (TN); and Mark Afable and Richard Wicka (WI). Also participating were: Nour Benchaaboun (MD); Michael Humphreys (PA); Elizabeth Kelleheer Dwyer, Matt Gendron and Sarah Neil (RI); Travis Jordan (SD); Mike Boerner (TX).

1. **Adopted its Nov. 4 Minutes**

Director Froment made a motion, seconded by Commissioner Taylor, to adopt the Committee’s Nov. 4 minutes (Attachment One). The motion passed unanimously.

2. **Adopted the Report of the Annuity Suitability (A) Working Group**

Director Froment said the Annuity Suitability (A) Working Group met Dec. 7 and took the following action: 1) adopted its 2020 proposed charges; 2) adopted the Life Actuarial (A) Task Force’s 2020 proposed charges; 3) adopted Actuarial Guideline LII—Variable Annuity Early Adoption (AG 52); 4) adopted the 2020 Generally Recognized Expense Table (GRET); and 5) adopted its Summer National Meeting minutes.

Commissioner Ommen explained the history of Model #275 that resulted in the Nov. 5 draft revisions to Model #275. He said Model #275 is a professional conduct standard that by most measures is an important part of each state’s and territory’s consumer protection toolkit. He said it was not, is not and never will be the silver bullet to cure all concerns in the annuity market. He said well-informed sellers and well-informed buyers who understand and can therefore balance the risks and potential rewards of any given annuity contract may be the most important ingredients to a healthy, functioning competitive market. He said the professional care and competence standards for insurers and producers is also very important.

During each of the conference calls, there was robust discussion among all stakeholders on those provisions in the draft related to the proposed best interest obligations and supervision system. The Working Group also discussed and made revisions to the model’s safe harbor provisions as part of its effort to harmonize as much as possible its revisions with the U.S. Security and Exchange Commission’s (SEC) final Regulation Best Interest for the benefit of consumers and the industry. At the end of its last conference call on Nov. 5, the Working Group agreed that it had completed its work as directed by the Life Insurance and Annuities (A) Committee and forwarded the Nov. 5 draft to the Committee for its consideration. Commissioner Ommen, Life Insurance and Annuities (A) Committee chair, exposed the draft for a public comment period ending Nov. 26.

3. **Discussed Comments Received on the Nov. 5 Revisions to Model #275**

Commissioner Ommen explained the history of Model #275 that resulted in the Nov. 5 draft revisions to Model #275. He said Model #275 is a professional conduct standard that by most measures is an important part of each state’s and territory’s consumer protection toolkit. He said it was not, is not and never will be the silver bullet to cure all concerns in the annuity market. He said well-informed sellers and well-informed buyers who understand and can therefore balance the risks and potential rewards of any given annuity contract may be the most important ingredients to a healthy, functioning competitive market. He said the professional care and competence standards for insurers and producers is also very important.

Commissioner Ommen said the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) was a long, complicated and at times, not well-understood law that was signed into law in 2010. He said it contained two important
provisions that have shaped the work of the Annuity Suitability (A) Working Group over the last several years: Section 989J and Section 913(g)(2). He said Section 913(g)(2) authorized the SEC to promulgate a standard of conduct across both the securities brokerage business and the investment adviser business that required all securities professionals to “act in the best interest of the customer.” He said that while legal opinions vary as to what the U.S. Congress meant, it is clear that it did not intend to require a fiduciary relationship. He said Congress wrote in Section 913 that “material conflicts of interest shall be disclosed and may be consented to by the customer.” Congress also wrote in the text of Section 913 that “the receipt of compensation based upon commission or fee shall not, in and of itself, be considered a violation.” Commissioner Ommen said if Congress intended to impose a fiduciary standard, it would have used the word “fiduciary,” and it did not.

Commissioner Ommen explained that the states are not required by law to use exactly the same language that Congress chose to use in the Dodd-Frank Act, but there are consumer protection reasons to harmonize our standards. He said one reason is that most insurance producers already act in the best interest of their customers, so a best interest standard makes sense. He said, however, regulators must keep in mind that all regulations carry costs and other burdens on businesses establishing and maintaining procedures. He said compliance costs include preparation for and cooperation with regulatory examinations, and dual or redundant standards would burden many annuity issuers and dually licensed financial professionals requiring them to try to implement and maintain two parallel systems. He said it is obvious that these costs would raise costs for consumers, with no measurable benefit to consumers. He said that, as Director Froment explained, the Working Group has defined thorough its care, disclosure, conflict of interest and documentation obligations a best interest standard in Model #275 that is more than suitability and draws on the provisions in Section 913 of the Dodd-Frank Act and SEC Regulation Best Interest, but is not a fiduciary mandate.

Commissioner Ommen explained that Section 989J was also enacted in the Dodd-Frank Act. He said it confirmed the state insurance regulators’ role in establishing the appropriate standards of conduct for annuity sales and confirmed the state safe harbor for fixed indexed annuities from federal securities law and the SEC. He said he reads Section 989J as providing congressional direction to state insurance regulators to do what is best in light of the SEC’s recent change. He said that the Annuity Suitability (A) Working Group, under the leadership of Director Froment, has developed a draft that reflects that best balance of preserving for consumers the choice between commission-based and fee-based retirement advice. The Working Group’s Nov. 5 draft aligns the state standard of conduct with the SEC’s final Regulation Best Interest, which also struck that balance of more than suitability, but not a fiduciary mandate.

Commissioner Ommen said he would like to review the comments received on the Nov. 5 draft revisions to Model #275. He said he considers most of the comments received as recommendations for clarification.

a. Comments on Section 1. Purpose

Birny Birnbaum (Center for Economic Justice—CEJ) suggested inserting clarifying language in Section 1A. The Committee agreed to add the following clarifying language:

A. The purpose of this regulation is to require producers, as defined in this regulation, to act in the best interest of the consumer when making a recommendation of an annuity and to require insurers to establish and maintain a system to supervise recommendations so that the insurance needs and financial objectives of consumers at the time of the transaction are effectively addressed.

The Independent Insurance Agents and Brokers of America (IIABA) suggested adding language to Section 1B to clarify that the revisions are not intended to civil liability or a private right of action. Director Ramge said he supports the additional clarification. Director Froment said, and Mr. Ostlund agreed, that the suggested language is in line with the intent of the provision. The Committee agreed to make the following change:

B. Nothing herein shall be construed to create or imply a private cause of action for a violation of this regulation or to subject a producer to civil liability under the best interest standard of care outlined in Section 6 of this regulation or under standards governing the conduct of a fiduciary.

b. Comments on Section 5. Definitions

Mr. Birnbaum suggested revisions to Section 5I “material conflict of interest.” He suggested deleting 5I(2) “Material conflict of interest does not include cash compensation or noncash compensation.” Commissioner Taylor said he does not think this revision is necessary. The Committee agreed not to make this change.
Mr. Birnbaum suggested the following revisions to Section 5M “Recommendation”:

(2) “Recommendation” does not include general communication to the public, generalized consumer services assistance or administrative support, general educational information and tools, or prospectuses, or other product and sales material.

The Committee agreed not to make this change.

c. Comments on Section 6. Duties of Insurers and Producers

The Committee discussed comments on Section 6A:

A. Best Interest Obligations. A producer, when making a recommendation of an annuity, shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the producer’s or the insurer’s financial interest ahead of the consumer’s interest. A producer has acted in the best interest of the consumer if they have satisfied the following obligations regarding care, disclosure, conflict of interest and documentation:

The IIABA suggested deleting section 6A. Best Interest Obligations or, alternatively, deleting just the term “best interest.” The Committee did not agree with either suggested change. Mr. Birnbaum suggested that this section should be revised to make clear that the best interest of the consumer requires a producer to disregard his or her own interests completely. Mr. Birnbaum said the current language says a producer should not put his or her financial interests ahead of a consumer’s, which sets up an unenforceable situation where the producer is weighing his own financial interest against a consumer’s. Mr. Birnbaum also suggested that this language could be vulnerable to the creation of a ploy where a producer could sell several products, one of which is a very high commission but is never sold, just so that he can always point to that product as evidence of not putting his financial interests first.

Director Cameron said that he appreciates Mr. Birnbaum’s perspective but disagrees that the language in the Nov. 5 draft is unenforceable. He said it is not realistic to set a standard where someone is expected to disregard information once they have it. He said the Nov. 5 draft language takes the honest approach in a system where producers know how they are going to be compensated. He said that there are always competing factors and that a producer’s decision will always involve some measure of judgment. He said the concern about a scheme would be exposed in a market conduct review, and it is expensive to develop and market products that are never sold, so he doesn’t envision this scheme being very likely. Director Ramge said the language in the Nov. 5 draft is consistent with consumer’s expectations and the way producers operate. Commissioner Taylor said the standard in the Nov. 5 draft strikes the right balance. The producer has to put his or her needs behind the consumer’s, and there are also the obligations of care, disclosure, conflict of interest and documentation. Mr. Gendron said from an enforcement perspective, it is impossible to know what a producer is thinking, and he said he does not see any reason to change the language in the Nov. 5 draft. The Committee agreed not to make any changes to the language.

The IIABA suggested adding the following language to Section 6A(1)(d):

(d) The requirements under this subsection do not create a duty of loyalty or a fiduciary obligation or relationship and only create a regulatory obligation as established in this regulation.

Commissioner Taylor said that adding this language is not necessary and may create confusion. The Committee agreed not to make this change.

The Fixed Annuity Consumer Choice Campaign (FACCC) suggested the following revision to 6A(1)(c) and the creation of a new 6A(1)(k):

(c) The requirements under subparagraph (a) of this paragraph require a producer to consider the types of products the producer is authorized and licensed to recommend or sell that address the consumer’s financial situation, insurance needs and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation.

Producers shall be held to standards applicable to producers with similar authority and licensure.
(k) Nothing in this regulation should be construed to require a producer to obtain any license other than a producer license with the appropriate line of authority to sell, solicit or negotiate insurance in this state, including but not limited to any securities license, in order to fulfill the duties and obligations contained in this regulation; provided the producer does not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring other professional licenses.

Director Range said the suggested language is reasonable and that it is important to acknowledge that this standard does not mean producers need to get a new license. Commissioner Ommen agreed that the proposed language is consistent with the intent of the revised Model #275. Commissioner Richardson agreed that the new language clarifies things. The Committee agreed to add the revision 6A(1)(c) and the new 6A(1)(k).

Mr. Birnbaum suggested revisions to Section 6A(2)(a) Disclosure Obligation. He suggested the following revisions:

(a) Prior to or at the time of the recommendation or sale of an annuity, the consumer providing to the producer the consumer’s consumer profile information, the producer shall prominently disclose to the consumer on a form substantially similar to the “Producer Relationship Disclosure Form” in Appendix A:

Mr. Birnbaum explained a consumer needs information to be able to decide whether to work with a particular producer, and at the time of the recommendation or sale is too late to be meaningful. Commissioner Taylor agreed with changing the timing to “prior to” and deleting “or at the time of” in order for the consumer to be able to get the information. The Committee agreed to the following language as suggested by Commissioner Taylor:

(a) Prior to or at the time of the recommendation or sale of an annuity, the producer shall prominently disclose to the consumer on a form substantially similar to the “Producer Relationship Disclosure Form” in Appendix A:

The IIABA suggested adding a new Section 6A(2)(a)(vi) and deleting the 6A(3) Conflict of interest obligation.

(vi) A description of any material ownership interests the producer has in the insurer that would issue the recommended annuity or any parent, subsidiary or affiliate of that insurer.

(3) Conflict of interest obligation. A producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts of interest related to an ownership interest.

The Committee discussed whether “material conflicts of interest” need to be defined. The Committee concluded that materiality is a facts and circumstances question, and a list would be limiting in an enforcement context. The Committee agreed not to make either change suggested by the IIABA and to keep the language in Section 6A(3) unchanged.

The Committee discussed and agreed to make the following change suggested by the CEJ to Section 6A(5) Application of the best interest obligation.

(5) Application of the best interest obligation. Any requirement applicable to a producer under this subsection shall apply to every producer who has exercised material control or influence in the making of an individualized recommendation and has directly received compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.

The Committee discussed and agreed to make the following revision suggested by the CEJ to Section 6C(2)(g) Supervision system:

(g) The insurer shall establish and maintain reasonable procedures to identify and address potentially suspicious consumer refusals to provide consumer profile information.
The Committee discussed the CEJ suggestion to delete Section 6C(4)(b) from what an insurer is not required to include in its system of supervision:

(b) Include consideration of or comparison to options available to the producer or compensation relating to those options other than annuities or other products offered by the insurer.

Director Froment explained that this exception was included because producers cannot be expected to understand products that they are not authorized to sell. Mr. Ostlund and Mr. Gendron also agreed with keeping this exception. The Committee agreed not to make this change.

The Committee discussed and agreed to make the following revisions to Section 6C(2)(e) jointly suggested by the American Council of Life Insurers (ACLI), Committee of Annuity Insurers (CAI), Financial Services Institute (FSI), Indexed Annuity Leadership Council (IALC), Insured Retirement Institute (IRI), National Association for Fixed Annuities (NAFA), National Association of Insurance and Financial Advisors (NAIFA) and Association for Advanced Life Underwriting (AALU)

(e) The insurer shall establish and maintain reasonable procedures to detect recommendations that are not suitable in compliance with subsections A, B, D and E. This may include, but is not limited to, confirmation of the consumer’s suitability consumer profile information, systematic customer surveys, producer and consumer interviews, confirmation letters, producer statements or attestations and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures, or by confirming the suitability consumer profile information or other required information under this section after issuance or delivery of the annuity;

The Committee discussed and agreed not to follow the suggestion by the IIABA to delete Section 6C(2)(h):

(h) The insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities within a limited period of time. The requirements of this subparagraph are not intended to prohibit the receipt of health insurance, office rent, office support, retirement benefits or other employee benefits by employees as long as those benefits are not based upon the volume of sales of a specific annuity within a limited period of time;

The Committee discussed and agreed to make the following revision to the title of Section 8 and to add a new 8C:

Section 8. Compliance Mitigation; Penalties; Enforcement

C. The authority to enforce compliance with the regulation is vested exclusively with the commissioner.

The Committee approved the Nov. 5 draft, as revised during this meeting, with the exception of the draft templates, which were referred back to the Annuity Suitability (A) Working Group for discussion during a conference call to be scheduled before the end of the year. The Committee planned to meet via conference call before the end of the year to consider adoption of the model with the revised template/appendices language and any other technical revisions.

4. Adopted the Reports of its Working Groups and Task Force

Director Cameron made a motion, seconded by Mr. Ostlund, to adopt the following reports: the Annuity Disclosure (A) Working Group, including its Sept. 19 minutes (Attachment Three) and an extension of the Request for NAIC Model Law Development; the Accelerated Underwriting (A) Working Group (Attachment Four), including its Oct. 2 minutes (Attachment Four-A); the Life Insurance Illustration Issues (A) Working Group, including its Oct. 21 (Attachment Five), Sept. 17 (Attachment Six), Sept. 3 (Attachment Seven) and July 30 (Attachment Eight) minutes and an extension of the Request for NAIC Model Law Development; the Life Actuarial (A) Task Force, including the creation of a new Guaranteed Issue Life Valuation (A) Subgroup; and the Retirement Security (A) Working Group, including its Nov. 13 (Attachment Nine) and Oct. 23 (Attachment Ten) minutes.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.
The Life Insurance and Annuities (A) Committee met via conference call Nov. 4, 2019. The following Committee members participated: Doug Ommen, Chair, Lindsay Bates, Russ Gibson and Mike Yanacheak (IA); Stephen C. Taylor, Vice Chair, represented by Philip Barlow (DC); Jim L. Ridling represented by Steve Ostlund (AL); Keith Schraad represented by Matt Holman (NE); Linda A. Lacey represented by James Regalbuto and Mark McLeod (NY); Jillian Froment and Peter Weber (OH); Hodgen Mainda represented by Brian Hoffmeister and Rachel Jade-Rice (TN); and Mark Afaile represented by Jerry DeArmond and Richard Wicka (WI). Also participating were: Perry Kupferman (CA); Jason Lapham (CO); Fleur McKendell (DE); David Altmaier represented by Chris Struk (FL); Teresa Winer (GA); Mike Chrysler (IL); Barbara Torkelson, Tate Flott and Julie Holmes (KS); Mary Mealer (MO); Regan Hess (MT); Denise Lamy (NH); Ron Kreiter (OK); Thomas Kilcoyne (PA); Sarah Neil (RI); Mike Boerner and Deanna Osmonson (TX); and Tanji Northrup and Tomasz Serbinowski (UT).

1. **Adopted its 2020 Proposed Charges**

   Commissioner Ommen explained that the Committee’s charges reflect the addition of two new working groups—the Accelerated Underwriting (A) Working Group and the Retirement Security (A) Working Group—adopted by the Committee at the Summer National Meeting. Birny Birnbaum (Center for Economic Justice—CEJ) submitted revisions to the Committee’s charges. He explained that these changes are necessary because the Working Groups are not coordinating with each other, and his proposed revisions will better reflect the current work being undertaken, as well as allow for much needed coordination on life and annuity disclosures being undertaken currently.

   Mr. Ostlund said Alabama is supportive of Mr Birnbaum’s suggestions and would like to discuss them at the upcoming Fall National Meeting.

   Mr. Ostlund made a motion, seconded by Mr. Wicka, to adopt the Committee’s 2020 proposed charges (see NAIC Proceedings – Fall 2019, Executive (EX) Committee and Plenary, Attachment Two). The motion passed unanimously.

2. **Adopted the Life Actuarial (A) Task Force’s 2020 Proposed Charges**

   Mr. Boerner explained that most of the changes to the Task Force’s charges were updates necessitated by the completion of the variable annuity (VA) framework.

   Mr. Wicka made a motion, seconded by Commissioner Mainda, to adopt the Task Force’s 2020 proposed charges (see NAIC Proceedings – Fall 2019, Executive (EX) Committee and Plenary, Attachment Two). The motion passed unanimously.

3. **Adopted AG 52**

   Mr. Boerner said *Actuarial Guideline LII—Variable Annuity Early Adoption* (AG 52) is informational only and explains the availability of early adoption of the VA framework at a company’s election. Brian Bayerle (American Council of Life Insurance—ACLI) said the ACLI is supportive of AG 52.

   Director Schraad made a motion, seconded by Mr. Wicka, to adopt AG 52 (see NAIC Proceedings – Fall 2019, Executive (EX) Committee and Plenary, Attachment Four). The motion passed unanimously.

4. **Adopted the 2020 GRET**

   Mr. Boerner said the Generally Recognized Expense Table (GRET) is updated by the Society of Actuaries (SOA) every year, and it is adopted by the Committee and NAIC membership. He said the GRET is referenced in the *Life Insurance Illustrations Model Regulation* (#582) to be used as assumed experience in illustrations, and it is used by 25%–28% of companies.
Mr. Ostlund made a motion, seconded by Mr. Wicka, to adopt the 2020 GRET (see *NAIC Proceedings – Fall 2019, Executive (EX) Committee and Plenary, Attachment Three*). The motion passed unanimously.

5. **Adopted its Summer National Meeting Minutes**

Commissioner Donelon made a motion, seconded by Mr. Ostlund, to adopt the Committee’s Aug. 4 minutes (see *NAIC Proceedings – Summer 2019, Life Insurance and Annuities (A) Committee*). The motion passed unanimously.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.
The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met in Austin, TX, Dec. 7, 2019. The following Working Group members participated: Jillian Froment, Chair (OH); Doug Ommen, Vice Chair (IA); Steve Ostlund (AL); Fleur McKendell (DE); Dean L. Cameron (ID); Vicki Schmidt (KS); Nour Benchaaboun (MD); Renee Campbell (MI); Matt Holman (NE); Victor Agbu (NY); Andrew Schallhorn (OK); Matt Gendron and Sarah Neil (RI); Rachel Jade-Rice (TN); and Mark Afable and Richard Wicka (WI). Also participating were: Stephen C. Taylor (DC); Karl Knable (IN); Tricia Goldsmith (OR); and Michael Humphreys (PA).


The Working Group met Nov. 5, Oct. 29, Oct. 15, Oct. 8, Sept. 17, Aug. 3, July 29 and July 23. During these meetings, the Working Group took the following action: 1) reviewed and discussed a draft of proposed revisions to the *Suitability in Annuity Transactions Model Regulation* (#275) developed by a technical drafting group. The technical drafting group’s draft reflected the framework developed by the Working Group during its discussions at the Summer National Meeting, its July 29 and July 23 conference calls, and its June 20 meeting in Columbus, OH to include a best interest standard of conduct in Model #275; 2) exposed a Working Group draft of proposed revisions to Model #275 for a public comment period ending Sept. 30; 3) discussed the comments received by the Sept. 30 public comment period deadline; and 4) adopted a motion to forward the revised draft of revisions to Model #275 to the Life Insurance and Annuities (A) Committee for its consideration. As part of that motion, it was noted that in sending the draft to the Committee, it does not mean that each Working Group member supports every provision in the draft, but that the Working Group has completed its work as directed by the Committee at the Spring National Meeting. The Committee chair exposed the revised draft for a public comment period ending Nov. 26.

Commissioner Schmidt acknowledged and applauded the hard work done by the Working Group chair and the Working Group to develop the Model #275 revisions.

Mr. Ostlund made a motion, seconded by Mr. Gendron, to adopt the Working Group’s Nov. 5 (Attachment Two-A), Oct. 29 (Attachment Two-B), Oct. 15 (Attachment Two-C), Oct. 8 (Attachment Two-D), Sept. 17 (Attachment Two-E), July 29 (Attachment Two-F), July 23 (Attachment Two-G) and Aug. 3 minutes (*see NAIC Proceedings – Summer 2019, Life Insurance and Annuities (A) Committee, Attachment Four*). The motion passed unanimously.

Having no further business, the Annuity Suitability (A) Working Group adjourned.

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Annuity Suitability (A) Working Group
Conference Call
November 5, 2019

The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call Nov. 5, 2019. The following Working Group members participated: Jillian Froment, Chair (OH); Doug Ommen, Vice Chair (IA); Jerry Workman and Steve Ostlund (AL); Jodi Lerner (CA); Fleur McKendell (DE); Weston Trexler (ID); Vicki Schmidt, Tate Flott and Shannon Lloyd (KS); Nour Benchaaboun (MD); Renee Campbell (MI); Matt Holman (NE); Keith Nyhan (NH); Andrew Schallhorn (OK); Elizabeth Kelleher Dwyer, Matt Gendron and Sarah Neil (RI); Rachel Jrade-Rice (TN); and Richard Wicka (WI).

1. Continued its Discussion of the Comments Received on Proposed Revisions to Model #275

Director Froment reminded the Working Group of its goals for its June 20 meeting and its subsequent meetings, which is to develop a framework for revising the Suitability in Annuity Transactions Model Regulation (#275) to include a best interest standard of conduct that is more than the model’s current suitability standard, but not a fiduciary standard.

She said that based on the developed framework and as discussed at the Working Group’s meeting at the Summer National Meeting, the Working Group’s technical drafting group met in September and developed a draft of proposed revisions to Model #275 (see NAIC Proceedings – Fall 2019, Life Insurance and Annuities (A) Committee, Attachment Two-E1).

She said that during the Working Group’s Sept. 17 conference call, the Working Group developed a Working Group draft of proposed revisions to Model #275 (see NAIC Proceedings – Fall 2019, Life Insurance and Annuities (A) Committee, Attachment Two-D1) based on the technical drafting group’s draft and exposed it for a public comment period ending Sept. 30.

She said the purpose of this conference call is for the Working Group to continue its section-by-section discussion of the comments received by the public comment deadline. She explained that the Working Group would begin its discussion with Section C—Disclosure Obligation, deferring discussion of the additional suggested revisions in Section 5 because those definitions involved the safe harbor provision in Section 6E. The Working Group would discuss those definitions as part of its discussion of that provision.

Director Froment also explained that the Working Group received additional suggested revisions on specific issues in response to the Working Group’s request for additional comment. She said those suggested revisions would be discussed at the appropriate time and would include discussion of outstanding issues, such as the proposed drafting note in Section 1B concerning the successor draft issue.

Director Froment reminded the Working Group members and interested parties that only those suggested revisions having the support of a Working Group member and broad consensus from the Working Group would be considered for inclusion in the revised model.

a. Section 6C—Supervision System

Director Froment said the Joint Trades—in a joint comment submission from the American Council of Life Insurers (ACLI), the Committee of Annuity Insurers (CAI), the Financial Services Institute (FSI), the Indexed Annuity Leadership Council (IALC), the Insured Retirement Institute (IRI), the National Association for Fixed Annuities (NAFA), the National Association of Insurance and Financial Advisers (NAIFA) and the Association for Advanced Life Underwriting (AALU)—the Fixed Annuity Consumer Choice Campaign (FACC) and the Independent Insurance Agents & Brokers of America (IIABA) submitted comments on Section 6C—Supervision System.

Jason Berkowitz (IRI) said the Joint Trades suggest deleting Section 6C(1) because the substance of this paragraph is covered in other provisions in Section 6C.

Birny Birnbaum (Center for Economic Justice—CEJ) disagreed with the Joint Trades’ reasoning for deleting Section 6C(1). There was no Working Group support for deleting Section 6C(1).
Robbie Meyer (ACLI) said the Joint Trades suggest technical revisions to Section 6C(2)’s lead-in paragraph to make it clear that an insurer’s supervision system only applies to the insurer’s annuity products. She said that in addition, the Joint Trades suggest adding language to Section 6C(2)(e) to make it clear an insurer is not required to warrant the producer is acting in the consumer’s best interest. Specifically, the Joint Trades suggest revising Section 6C(2)(e) as follows: “The insurer shall establish and maintain reasonable procedures to detect recommendations that where there is not a reasonable basis to determine the recommendation would effectively address the particular consumer’s financial situation, insurance needs and financial objectives are not in compliance with subsections A, B, D and E. This may include, but is not limited to, confirmation of the consumer’s consumer profile information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures, or by confirming the consumer profile information after issuance or delivery of the annuity. An insurer is not required to warrant the producer is acting in the consumer’s best interest.”

Commissioner Ommen asked how this revised language would apply when no recommendation is made.

Ms. Meyer said the Joint Trades also suggest deleting Section 6C(2)(f) in its entirety because when a producer is engaged in activities relating to the sale of other insurers’ products, an insurer does not have the requisite knowledge or control over the producer to gauge compliance with the disclosure requirements of Section 6A(2). There was no support from the Working Group for the Joint Trades’ suggested revisions to Section 6C(2)’s lead-in paragraph or Section 6C(2)(e) or deleting Section 6C(2)(f).

Wes Bissett (IIABA) discussed the IIABA’s suggestion to delete Section 6C(2)(h). He said Section 6C(2)(h) is not needed given the provisions of Section 6A. He also questioned if states could implement Section 6C(2)(h) by regulation. There was no support for the IIABA’s suggestion to delete Section 6C(2)(h).

Ms. Meyer discussed the Joint Trades’ suggested revisions to Section 6C(2)(h). She said the purpose of the suggested revisions is to make the provisions of Section 6C(2)(h) applicable to sales contests and other types of non-cash compensation based on the sales of specific annuities of the insurer. She said the Joint Trades suggest deleting the reference to “specific types of annuities” because of concerns that the language may be overly broad as applied in the context of annuities. She said the Joint Trades also have clarified that Section 6C(2)(h) only applies to the insurer because the insurer does not have control over the business of third-party entities. She said the Joint Trades’ additional suggested revisions clarify, consistent with the U.S. Securities and Exchange Commission’s (SEC) best interest regulation (Reg BI), that the requirements of Section 6C(2)(h): 1) do not apply to compensation practices based on total annuity products sold; 2) would not prevent the offering of proprietary products, placing material limitations on the menu of products or incentivizing the sale of such products through its compensation practices, as long as the incentive is not based on the sale of a specific annuity product of the insurer within a limited period of time; and 3) are not intended to prohibit the receipt of employee benefits by employees.

The Working Group discussed the Joint Trades’ suggested revisions to Section 6C(2)(h). Some Working Group members expressed support for some of the suggested revisions. After discussion, the Working Group agreed on the following language for Section 6C(2)(h), which accepts some of the Joint Trades’ suggested revisions: “The insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses and non-cash compensation that are based on the sales of specific annuities within a limited period of time. The requirements of this subparagraph are not intended to prohibit the receipt of health insurance, office rent, office support, retirement benefits or other employee benefits by employees as long as those benefits are not based upon the volume of sales of a specific annuity within a limited period of time.”

Kim O’Brien (FACC) discussed the FACC’s suggested revisions for Section 6C(4). She said the FACC suggests revising Section 6C(4) to clarify an insurer’s scope of supervision for its producers by adding the following language: “nor is it required to include consideration of or comparison to options available to the producer or compensation related to those options other than annuities offered by the insurer.”

The Working Group discussed the suggested language. After discussion, the Working Group agreed to add the suggested language with some modifications.

No comments were received on Section 6D—Prohibited Practices.
b. **Section 6E—Safe Harbor**

The Working Group next discussed Section 6E—Safe Harbor. Director Froment said the IRI, Nationwide and Jackson National Life Insurance Company (Jackson) submitted comments. She explained that the IRI had submitted revised comments on Section 6E expanding the provision’s safe harbor language to apply to all financial professionals, including broker-dealers, investment advisers and fiduciaries.

Mr. Berkowitz said the IRI supports its initial suggested revisions to Section 6E, but the IRI believes the Working Group should consider expanding the safe harbor provisions to apply to all financial professionals.

Drew Bowden (Jackson) expressed support for the IRI’s suggested revisions. He also said that if the Working Group accepts the revisions, it would address Jackson’s comments.

Mr. Birnbaum, Mr. Bissett and Ms. O’Brien expressed concern with the safe harbor provisions.

Ms. Campbell said she believes the Working Group should consider the IRI’s proposal. Commissioner Ommen agreed.

Mr. Gendron expressed caution with the proposal and whether it could require state insurance regulators to become experts on securities.

The Working Group discussed the proposal. After discussion, the Working Group decided to include the language in the revised draft and receive comments on it.

Director Froment said the Working Group does not need to discuss the additional suggested definitions in Section 5 related to the safe harbor provision because those additional suggested definitions are included in the IRI’s revised comments, which the Working Group agreed to include in the revised draft in order to receive comments on it.

c. **Section 7—Producer Training**

Director Froment said the Joint Trades submitted comments on Section 7B—Producer Training.

Mr. Berkowitz said the Joint Trades suggest adding a new paragraph to Section 7B to account for producers who have had required training before the effective date of the revised model.

Mr. Gendron asked if Mr. Berkowitz had had discussions with any continuing education (CE) providers on whether they could develop a course for producer training within the proposed six-month time frame provided in the Joint Trades’ proposed language.

Mr. Berkowitz said he spoke with one CE provider, which said it could meet the proposed six-month time frame.

Mr. Bissett said he believes CE providers would be challenged to develop a course and receive approval from state insurance departments within the proposed time frame. After discussion, the Working Group decided to add the language to the revised draft.

No comments were received on Section 9—Recordkeeping or Section 10—Effective Date.

d. **Appendix A—Producer Relationship Disclosure Form and Appendix B—Consumer Refusal to Disclose All or Partial Consumer Profile Information Form**

Director Froment said the Joint Trades had submitted comments on Appendix A—Producer Relationship Disclosure Form. The Working Group decided to defer discussion of the comments and have the Life Insurance and Annuities (A) Committee finalize the form language because the language in Section 6 related to the form has not been finalized. The Working Group agreed to take the same approach for Appendix B—Consumer Refusal to Disclose All or Partial Consumer Profile Information Form.
2. Discussed the Working Group Chair’s Requested Supplemental Comments

   a. Section 5C—Definition of “Consumer Profile Information”

Mr. Berkowitz said the Joint Trades submitted supplemental comments on Section 5C—Definition of “Consumer Profile Information” in response to the Working Group’s discussion of the Joint Trades’ initial comments during its Oct. 8 conference call. He said that during that call, the Joint Trades had expressed concern about the uncertainty inherent in the addition of “including debts and other obligations” in Section 5C(3). He said that to address this concern, in its supplemental comments, the Joint Trades suggest adding “to the extent relevant to the recommendation” to the lead-in paragraph, and deleting “including debts and other obligations” in Section 5C(3) and adding that language to Section 5C(7).

Some Working Group members questioned the value of adding the suggested language to the lead-in paragraph. After additional discussion, there was no Working Group support expressed for the Joint Trades’ suggested language.

   b. Section 6A—Best Interest Obligations

Mr. Berkowitz said the Joint Trades submitted supplemental comments related to its initial comments discussed during the Working Group’s Oct. 15 conference call on the Joint Trades’ suggested language for Section 6A—Best Interest Obligations to prevent a producer’s or insurer’s recommendation being evaluated in hindsight based on things that may happen that are out of the producer’s or insurer’s control.

Mr. Berkowitz said the Working Group expressed concern with the Joint Trades’ initial suggested language to address the situation. He said to address the Working Group’s concern, the Joint Trades suggest adding the following language as a new paragraph in Section 6A: “Compliance with the obligation to act in the best interest of the consumer in this Section 6A and the obligations regarding care, disclosure, conflicts of interest and documentation in paragraphs (1) through (4) above shall be determined on the basis of the conduct of the producer at the time of the recommendation, and not on the basis of the actual financial performance of the recommended annuity (whether positive or negative) so long as the relevant facts and factors, including the reasonable range of possible outcomes in the performance of non-guaranteed elements of the annuity, were appropriately considered in light of the consumer’s financial situation, insurance needs and financial objectives. Nothing contained herein will be deemed to impair or otherwise impact contractual guarantees included in a recommended annuity.”

There was no Working Group support for the Joint Trades’ suggested language.

   c. Section 6A(2)—Disclosure Obligation

Director Froment said that during the Working Group’s Oct. 29 conference call, the Working Group discussed suggested revisions to Section 6A(2)(a). This section describes what information a producer must disclose to a consumer about the producer’s relationship with the consumer on a form substantially similar to the Producer Relationship Disclosure Form in Appendix A. She said the Working Group asked Mr. Gendron to develop language for the Working Group’s review.

Mr. Gendron said his suggested revisions to Section 6A(2)(a) are derived in part from requirements for financial professionals selling securities.

Ms. Meyer expressed concern generally with including a list and with the list including non-insurance products. Ms. O’Brien agreed with Ms. Meyer.

After discussion, the Working Group agreed to add Mr. Gendron’s suggested language to Section 6A(2)(a) with some wordsmithing, nonsubstantive changes.

   d. Section 6A—Additional Paragraph

Director Froment said that during the Working Group’s Oct. 29 conference call, the Working Group discussed placeholder language based on New York language, which would apply the model’s provisions to any producer who “materially participated” in the transaction. She said the Working Group requested Mr. Gendron develop language on this issue for the Working Group’s review.
Mr. Gendron said the goal of his suggested language is to notify producers not directly involved in a recommendation of their potential liability if a producer has exercised material control or influence in the making of an individualized recommendation and has directly received compensation as a result regardless of whether the producer has had any direct contact with the consumer.

The Working Group discussed Mr. Gendron’s suggested language.

Mr. Birnbaum expressed opposition to the language. He said New York’s language is a lot clearer and more straightforward.

Gary Sanders (NAIFA) said Mr. Gendron’s suggested language is better than New York’s language, but he said he still is unclear on how the language provides additional protections to consumers. He said it could have a chilling effect.

There was no opposition from Working Group members to adding the language. However, some Working Group members suggested the language is unnecessary given other provisions in the revised model.

3. Agreed to Refer the Revised Model to the Life Insurance and Annuities (A) Committee and Exposed it for Public Comment

Director Froment said that during the Working Group’s Oct. 8 conference call, the Working Group discussed comments from the IIABA concerning the drafting note for Section 1—Purpose. The proposed drafting note states that for purposes of Section 989J of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (Dodd-Frank Act), the revised Model #275 is a successor to the 2010 revisions, which added a suitability standard of conduct.

Director Froment said the Working Group deferred discussion on the drafting note and asked the NAIC Legal Division to research whether the revised model would be considered a successor model to the 2010 revisions for purposes of Section 989J. She said the Legal Division most likely would consider the revised model to be a successor to the 2010 revisions. She said given this, she believes this is a policy issue for the Life Insurance and Annuities (A) Committee, the Executive (EX) Committee and Plenary to decide.

Mr. Gendron made a motion, seconded by Commissioner Ommen, to refer the draft to the Life Insurance and Annuities (A) Committee for its consideration. As part of the motion, it was noted that in sending the draft to the Life Insurance and Annuities (A) Committee, it does not mean that each Working Group member supports every provision in the draft, but that the Working Group has completed its work as directed by the Life Insurance and Annuities (A) Committee at the Spring National Meeting. The motion passed.

Commissioner Ommen said that as chair of the Life Insurance and Annuities (A) Committee, he is exposing the draft for a 21-day public comment period ending Nov. 26. He said the Life Insurance and Annuities (A) Committee will consider any comments received during its meeting at the Fall National Meeting.

Having no further business, the Annuity Suitability (A) Working Group adjourned.
Annuity Suitability (A) Working Group
Conference Call
October 29, 2019

The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call Oct. 29, 2019. The following Working Group members participated: Jillian Froment, Chair (OH); Doug Ommen, Vice Chair (IA); Steve Ostlund (AL); Jodi Lerner (CA); Fleur McKendell (DE); Tate Flott (KS); Nour Benchaboun (MD); Renee Campbell (MI); Matt Holman (NE); Keith Nyhan (NH); James Regalbuto (NY); Andrew Schallhorn (OK); Elizabeth Kelleher Dwyer, Matt Gendron and Sarah Neil (RI); Rachel Trade-Rice (TN); and Richard Wicka (WI).

1. Continued its Discussion of the Comments Received on Proposed Revisions to Model #275

Director Froment reminded the Working Group of its goal from its June 20 meeting and its subsequent meetings, which was to develop a framework for revising the *Suitability in Annuity Transactions Model Regulation (#275)* to include a best interest standard of conduct that is more than the model’s current suitability standard, but not a fiduciary standard.

She said that based on the developed framework and as discussed at the Working Group’s meeting at the Summer National Meeting, the Working Group’s technical drafting group met in September and developed a draft of proposed revisions to Model #275 (see NAIC Proceedings – Fall 2019, Life Insurance and Annuities (A) Committee, Attachment Two-E1).

She said that during the Working Group’s Sept. 17 conference call, the Working Group developed a Working Group draft of proposed revisions to Model #275 (see NAIC Proceedings – Fall 2019, Life Insurance and Annuities (A) Committee, Attachment Two-D1) based on the technical drafting group’s draft and exposed it for a public comment period ending Sept. 30.

Director Froment said the purpose of this conference call is for the Working Group to continue its section-by-section discussion of the comments received by the public comment deadline. She explained that the Working Group would begin its discussion with Section 6A(2)—Disclosure Obligation, deferring discussion of the additional suggested revisions in Section 5 because those definitions involved the safe harbor provision in Section 6E. She said the Working Group would discuss those definitions as part of its discussion of that provision.

a. Section 6A(2)—Disclosure Obligation

Director Froment said the Joint Trades—in a joint comment submission from the American Council of Life Insurers (ACLI), the Committee of Annuity Insurers (CAI), the Financial Services Institute (FSI), the Indexed Annuity Leadership Council (IALC), the Insured Retirement Institute (IRI), the National Association for Fixed Annuities (NAFA), the National Association of Insurance and Financial Advisers (NAIFA) and the Association for Advanced Life Underwriting (AALU)—and the Independent Insurance Agents & Brokers of America (IIABA) submitted comments on Section 6A(2)—Disclosure Obligation.

Before discussing the Joint Trades’ suggested revisions, Robbie Meyer (ACLI) pointed out that Section 6A(2)(a) references the defined term “non-cash compensation.” She reiterated the Joint Trades’ concern raised during the Working Group’s Oct. 8 conference call about the definition of “material conflict of interest” in Section 5I and the definition of “non-cash compensation” in Section 5J and its suggested revisions to exclude certain benefits from being considered non-cash compensation for purposes Section 6C(2)(h), which could prohibit producers from receiving these benefits if considered non-cash compensation.

The Working Group discussed the suggested revisions, with some Working Group members noting the importance of Section 6C(2)(h) to discourage any of the types of benefits listed in the definition of “non-cash compensation” being tied to the sale of a particular annuity within a specified period of time. The Working Group decided to defer discussion of the issue until it discusses Section 6C(2)(h).

Jason Berkowitz (IRI) discussed the Joint Trades’ suggested revisions to Section 6A(2)(a) and Section 6A(2)(b), explaining that except for the suggestion to add a new item (v) to Section 6A(2)(a), the suggested revisions were technical and clarifying.
Ms. Meyer said the Joint Trades suggest adding the new item (v) to Section 6A(2)(a) to require a producer or insurer to disclose any material of conflicts of interest to better align with the requirements under the U.S. Securities and Exchange Commission’s (SEC) best interest final regulation (Reg BI). She said the Joint Trades suggest a conforming change to Appendix A, Producer Disclosure Form.

Wes Bissett (IIABA) asked if the suggested revision to add a new (v) to Section 6A(2)(a) to require a producer to disclose material conflicts of interest would affect Section 6A(3)—Conflict of Interest Obligation.

Jim Szostek (ACLI) explained that this provision concerns disclosure and that the ACLI believes this suggested revision would not affect Section 6A(3)’s provisions.

The Working Group discussed the Joint Traders’ suggested revisions. There was no support for the Joint Traders’ suggested revisions to Section 6A(2)(a)(iii) to restructure the language. The Working Group deferred making a decision on whether to add the new item (v) until it discusses Section 6A(3)—Conflict of Interest Obligation.

Mr. Berkowitz explained that the Joint Traders’ suggested revisions to Section 6A(2)(b) are intended to be technical and clarifying, such as specifying that the consumer would make the request to the producer to disclose additional information about the producer’s cash compensation, not a member of the general public. He said the other revisions are meant to address salaried employees who are not directly compensated for the sale of a particular annuity. The revisions would require such employees only to provide a description of general compensation practices relevant to the producer.

Birny Birnbaum (Center for Economic Justice—CEJ) expressed concern with the revisions. He suggested that if the Working Group accepted the suggested revision concerning the consumer requesting the information that the language also include the consumer’s authorized representative.

The Working Group discussed the suggested revisions. After discussion, the Working Group decided to accept the Joint Traders’ suggested revisions concerning the consumer making the request, but there was no support to accept the Joint Traders’ suggested revisions concerning salaried employees.

Mr. Bissett discussed the IIABA’s suggestion to restructure item (ii) in Section 6A(2)(a) for clarity and remove the word “limitations.”

The Working Group discussed the suggested revisions. Some Working Group members expressed concern that the IIABA’s restructured language was too vague with respect to what the producer would need to disclose concerning the products the producer is authorized and licensed to recommend or sell.

Mr. Birnbaum expressed concern that the IIABA’s restructured language is too limiting because it references only annuity and securities products.

Some Working Group members expressed support for the IIABA’s efforts to provide more clarity, but they could not support the IIABA’s suggested revisions. After additional discussion, the Working Group asked Mr. Gendron to develop language to address the issue for the Working Group to discuss during its Nov. 5 conference call. The Working Group deferred discussion of the IIABA’s suggestion to add a new provision to Section 6A(2)(a) to require a producer to disclose a description of any material ownership interest the producer has in the insurer that would issue the recommended annuity until it discusses Section 6C(2)(h) and the definition of “material conflict of interest.”

b. Section 6A(3)—Conflict of Interest Obligation

Director Froment said the Joint Traders, the Fixed Annuity Consumer Choice Campaign (FACC) and the IIABA submitted comments on Section 6A(3)—Conflict of Interest Obligation.

Mr. Berkowitz said the Joint Traders’ suggested revisions are intended to be clarifying.

The Working Group discussed the suggested revisions. After discussion, no Working Group member expressed support for accepting the suggested revisions.
Kim O’Brien (FACC) said the FACC suggests striking “avoid or otherwise reasonably manage” and replacing it with a disclosure requirement because to “reasonably manage” is to disclose.

Mr. Bissett explained the IIABA’s suggestion to delete Section 6A(3). He said the language “material conflict” is ambiguous and asked what a producer is supposed to do if a “material conflict” exists. He said the FACC’s suggested revision addresses this issue. He expressed support for a disclosure-based approach.

Mr. Szostek expressed support for the FACC’s suggested revision.

The Working Group discussed Section 6A(3)’s language, the definition of “material conflict of interest” in Section 5I and whether material conflicts of interest should be “managed and disclosed” or “managed or disclosed.”

Commissioner Ommen suggested revising Section 6A(3) to require a producer to “identify and avoid or reasonably manage and disclose material conflicts of interest.” After discussion, the Working Group agreed to accept Commissioner Ommen’s suggested revision.

c. Section 6A(4)—Documentation Obligation

Director Froment said the Joint Trades and the FACC submitted comments on Section 6A(4)—Documentation Obligation.

Mr. Berkowitz said the Joint Trades’ suggested revisions are intended to be clarifying.

The Working Group discussed the suggested revisions. After discussion, no Working Group member expressed support for accepting the suggested revisions.

Ms. O’Brien said the FACC suggests adding language to Section 6A(4)(a) requiring a producer to make a written “reasonable summary” record of any recommendation and the basis for the recommendation. She said the FACC’s suggested revision is based on a provision in New York’s best interest regulation.

After discussion, no Working Group member expressed support for accepting the suggested revision.

The Working Group next discussed the comments received on a proposed provision in the revised model suggested by New York. The Working Group had requested specific comments on whether such a provision should be included in the revised model.

Mr. Berkowitz said the Joint Trades suggest not including this provision, which would apply the model’s provisions to any producer who “materially participated” in the transaction. He said such language is too vague and as such would create too much uncertainty in the marketplace as to when a producer is considered to have “materially participated” in a transaction and, therefore, subject to the model’s provisions. He said the model includes supervision requirements that would address any issues this proposed provision is intended to address, such as ensuring that more senior producers were not shielding themselves from responsibility by using junior producers to technically make a recommendation. He said the Joint Trades believe this provision is not needed and urged the Working Group not to include it in the revised model.

The Working Group discussed the Joint Trades’ comments and the proposed revisions.

Mr. Gendron said he views the proposed language as fair warning to producers as to how state insurance regulators will interpret the model’s provisions and its application.

Mr. Regalbuto said New York has a host of examples it could provide where this has been an issue, which is why its best interest regulation includes such a provision.

Mr. Berkowitz acknowledged Mr. Gendron’s comments. He said he believes these issues are already addressed in the model. He said his concern is that the language could be interpreted and applied to any person who had any involvement in the transaction.
Director Froment reminded the Working Group that this provision is not in the revised model. As such, a Working Group member would have to express support for adding it.

The Working Group discussed what “materially participated” means. After additional discussion, the Working Group requested that Mr. Gendron work on language for the Working Group to discuss during its Nov. 5 conference call.

d. Section 6B—Transactions Not Based on a Recommendation

Director Froment said the Joint Trades submitted comments on Section 6B—Transactions Not Based on a Recommendation.

Mr. Berkowitz said the revised draft defines “producer” to include an insurer where no producer is involved in Section 5K. He said the revised definition works throughout the model except for Section 6B. He said in Section 6B, the insurer is the supervising entity. He said the Joint Trades’ suggested revision addresses this issue.

Mr. Birnbaum said the Joint Trades are conflating two issues. He said Section 6B is intended to limit a producer’s obligation, not the insurer’s obligation as a supervising entity.

There was no Working Group support for accepting the Joint Trades’ suggested revision.

e. Section 8—Compliance Mitigation; Penalties

Director Froment said the Joint Trades submitted comments on Section 8—Compliance Mitigation; Penalties.

Mr. Berkowitz said the Joint Trades suggest revising Section 8 for consistency with the model’s insurer supervision responsibilities, which require an insurer to supervise transactions related to the insurer’s own annuity products.

There was no Working Group support for accepting the Joint Trades’ suggested revision.

Having no further business, the Annuity Suitability (A) Working Group adjourned.
Annuity Suitability (A) Working Group
Conference Call
October 15, 2019

The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call Oct. 15, 2019. The following Working Group members participated: Jillian Froment, Chair (OH); Doug Ommen, Vice Chair (IA); Steve Ostlund (AL); Jodi Lerner (CA); Fleur McKendell (DE); Karl Fromm (ID); Tate Flott and Shannon Lloyd (KS); Nour Benchaaboun (MD); Renee Campbell (MI); Matt Holman (NE); Keith Nyhan (NH); Andrew Schallhorn (OK); Elizabeth Kelleher Dwyer, Matt Gendron and Sarah Neil (RI); Rachel Jrade-Rice (TN); and Richard Wicka (WI).

1. Continued its Discussion of the Comments Received on Proposed Revisions to Model #275

Director Froment reminded the Working Group of its goal for its June 20 meeting and its subsequent meetings, which was to develop a framework for revising the Suitability in Annuity Transactions Model Regulation (#275) to include a best interest standard of conduct that is more than the model’s current suitability standard, but not a fiduciary standard.

She said that based on the developed framework and as discussed during the Working Group’s meeting at the Summer National Meeting, the Working Group’s technical drafting group met in September and developed a draft of proposed revisions to Model #275 (see NAIC Proceedings – Fall 2019, Life Insurance and Annuities (A) Committee, Attachment Two-E1).

She said that during the Working Group’s Sept. 17 conference call, the Working Group developed a Working Group draft of proposed revisions to Model #275 (see NAIC Proceedings – Fall 2019, Life Insurance and Annuities (A) Committee, Attachment Two-D1) based on the technical drafting group’s draft and exposed it for a public comment period ending Sept. 30.

She said the purpose of this conference call is for the Working Group to continue its section-by-section discussion of the comments received by the public comment deadline. She explained that the Working Group would begin its discussion with Section 6—Duties of Insurers and Producers, deferring discussion of the additional suggested revisions in Section 5 because those definitions involved the safe harbor provision in Section 6. The Working Group would discuss those definitions as part of its discussion of that provision.

a. Section 6A—Best Interest Obligations

Director Froment said the Joint Trades—in a joint comment submission from the American Council of Life Insurers (ACLI), the Committee of Annuity Insurers (CAI), the Financial Services Institute (FSI), the Indexed Annuity Leadership Council (IALC), the Insured Retirement Institute (IRI), the National Association for Fixed Annuities (NAFA), the National Association of Insurance and Financial Advisers (NAIFA), and the Association for Advanced Life Underwriting (AALU)—the Fixed Annuity Consumer Choice Campaign (FACC) and the Independent Insurance Agents & Brokers of America (IIABA) submitted comments on the lead-in paragraph for Section 6A—Best Interest Obligations.

Robbie Meyer (ACLI) said the Joint Trades suggest adding the following language at the end of Section 6A’s lead-in paragraph: “independent of the performance of the recommended annuity.” She said the Joint Trades suggest this language to avoid a producer’s or insurer’s recommendation being evaluated in hindsight based on things that may happen that are out of the producer’s or insurer’s control.

The Working Group discussed the suggested language and after discussion decided that if this issue needs to be addresses, the Section 6A lead-in paragraph is not the appropriate place to address it. Director Froment suggested the Joint Trades submit revised language for the Working Group to consider at the appropriate time during its later discussions.

Kim O’Brien (FACC) said the FACC suggests deleting the references to the best interest standard of conduct because the FACC thinks the best interest standards is undefined, ambiguous and subjective and, as such, will lead to litigation. She said the FACC has suggested language for Section 6A(1)—Care Obligation it believes is a better approach.

Mr. Bissett noted that the IIABA has concerns with the best interest standard of conduct similar to the FACC’s concerns.
The Working Group discussed the FACC’s suggested revision. During the discussion, Working Group members reiterated their support for the best interest standard of conduct reflected in the revisions and noted provisions in the proposed revisions that address the FACC’s and the IIABA’s concerns, particularly the second sentence in Section 6A’s lead-in paragraph. The Working Group also discussed revising Section 6A to clarify what a producer or an insurer needs to do to satisfy the best interest standard of conduct.

Director Froment suggested revising the second sentence in Section 6A as follows: “A producer has acted in the best interest of the consumer if they have satisfied the following obligations regarding care, disclosure, conflict of interest and documentation.” After discussion, the Working Group agreed to include the suggested language in the revised draft.

b. Section 6A(1)—Care Obligation

Director Froment said the Joint Trades, the FACC and the IIABA submitted comments on Section 6A(1). Ms. Meyer said the Joint Trades suggest several revisions to Section 6A(1) to clarify its language. She said the Joint Trades suggest deleting “over the life of the contract” in Section 6A(1)(a)(iii) to address a concern that the language could be interpreted as requiring an ongoing duty to the consumer.

The Joint Trades also suggest adding “provided to the producer” to Section 6A(1)(a)(iii) to make it clear that producers can only evaluate the information they actually receive from a consumer. She said the Joint Trades suggest deleting the word “substantially” for consistency with other provisions in the revised model and changing “60” months to “36” months to bring the time frame closer in line to the current replacement requirements in most states.

The Working Group discussed the Joint Trades’ suggested revisions. Some Working Group members expressed concern with adding “provided by the consumer” because producers have an obligation to be aware of a consumer’s actual circumstances, not just what is included in the consumer profile information form, particularly in situations that could involve a vulnerable adult. With respect to the “over the life the contract” suggested revision, some Working Group members noted that the language was meant to address those consumers with long-term concerns and seeking to purchase an annuity for retirement purposes.

Ms. Meyer said she believes the language requiring a producer or insurer to recommend a product that “effectively addresses the consumer’s financial situation, insurance needs and financial objectives” applies to both a consumer’s short-term and long-term concerns.

Ms. O’Brien said the FACC has the same concerns with the language “over the life of the product.”

Birny Birnbaum (Center for Economic Justice—CEJ) expressed concerns with the Joint Trades’ comments.

Gary Sanders (NAIFA) suggested the Working Group consider adding the language “available to the producer” to Section 6A(1)(a)(iii) if the Working Group is uncomfortable with the Joint Trades’ suggested language.

Jason Berkowitz (IRI) expressed support for Mr. Sanders’ suggested language.

There was no Working Group support for the Joint Trades’ suggested revisions or Mr. Sanders’ suggested alternative language.

Ms. O’Brien discussed the FACC’s suggested revision to add a new provision to Section 6A(1) to require that a producer’s recommendation can be compared only to other producers as opposed to being compared to investment advisers or possibly higher-level fiduciaries, such as trust officers or plan sponsors under the federal Employee Retirement Income Security Act of 1974 (ERISA) for compliance and enforcement purposes. She said that if this language is not included in the revised model, it makes the proposed best interest standard of conduct even more subjective and approaches a kind of strict liability depending on how state insurance regulators or the courts decide to enforce a best interest standard of conduct with ill-defined requirements. She also suggested revising Section 6A(1)(a)(iv) to require a producer to communicate “a reasonable summary of” the basis or bases of the recommendation.

The Working Group discussed the FACC’s comments. There was no support for making the suggested revisions.
Mr. Bissett discussed the IIIABA’s suggested revisions to Section 6A(1)(c) and (d). He said the IIABA suggests adding the word “annuity” to Section 6A(1)(c) to limit its scope to annuity products. The IIABA suggests adding the language “or relationship and only” to Section 6A(1)(d) for clarity.

The Working Group discussed the IIABA’s suggested revision to Section 6A(1)(c). Some Working Group members expressed concern with adding the limiting language, particularly as to how it could affect replacement products. There was no support for making the suggested revision.

The Working Group discussed the IIABA’s suggested revision to Section 6A(1)(d). After discussion, the Working Group agreed to accept the suggested revision. The Working Group also discussed whether Section 6A(1)(d) is the appropriate place to add language to address an issue raised in the Joint Trades’ comments, which it previously discussed, concerning the possibility of consumers tying a recommendation to a particular outcome or performance. After discussion, the Working Group again deferred making a decision until the Joint Trades presented revised language.

Director Froment said the Working Group would begin its next conference call on Oct. 29 with discussing the comments received on Section 6A(2)—Disclosure Obligation.

Having no further business, the Annuity Suitability (A) Working Group adjourned.

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The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call Oct. 8, 2019. The following Working Group members participated: Jillian Froment, Chair (OH); Doug Ommen, Vice Chair (IA); Jodi Lerner (CA); Susan Jennette (DE); Dean L. Cameron (ID); Tate Flott (KS); Nour Benchaaboun (MD); Renee Campbell (MI); Matt Holman (NE); Andrew Schallhorn (OK); Elizabeth Kelleher Dwyer, Matt Gendron and Sarah Neil (RI); Rachel Jrade-Rice (TN); and Richard Wicka (WI).

1. Discussed Comments Received on Proposed Revisions to Model #275

Director Froment reminded the Working Group of its goals for its June 20 meeting and its subsequent meetings, which was to develop a framework for revising the Suitability in Annuity Transactions Model Regulation (#275) to include a best interest standard of conduct that is more than the model’s current suitability standard, but not a fiduciary standard.

She said that based on the developed framework and as discussed at the Working Group’s meeting at the Summer National Meeting, the Working Group’s technical drafting group met in September and developed a draft of proposed revisions to Model #275 (see NAIC Proceedings – Fall 2019, Life Insurance and Annuities (A) Committee, Attachment Two-E1).

She said that during the Working Group’s Sept. 17 conference call, the Working Group developed a Working Group draft of proposed revisions to Model #275 (Attachment Two-D1) based on the technical drafting group’s draft and exposed it for a public comment period ending Sept. 30.

She said the purpose of this conference call is to begin a section-by-section discussion of the comments received by the public comment deadline.

a. Title

Director Froment said the Independent Insurance Agents & Brokers of America (IIABA) submitted comments on the title of Model #275, suggesting revising it from “Suitability in Annuity Transactions Model Regulation” to “Suitability in Annuity Transactions Model Law.”

Wes Bissett (IIABA) said the IIABA believes Model #275 should be a model law because the proposed revisions will require statutory authority for a state to adopt.

Mr. Holman said it is a state-by-state decision whether to adopt the proposed revisions by regulation or by statute.

After discussion, the Working Group decided not to accept the IIABA’s suggested revision.

b. Section 1—Purpose

Director Froment said the Joint Trades—in a joint comment submission from the American Council of Life Insurers (ACLI), the Committee of Annuity Insurers (CAI), the Financial Services Institute (FSI), the Indexed Annuity Leadership Council (IALC), the Insured Retirement Institute (IRI), the National Association for Fixed Annuities (NAFA), the National Association of Insurance and Financial Advisers (NAIFA) and the Association for Advanced Life Underwriting (AALU)—the Fixed Annuity Consumer Choice Campaign (FACC) and the IIABA submitted comments on Section 1A—Purpose.

Pat Reeder (ACLI) said the Joint Trades suggest revising Section 1A to clarify that the required standard of conduct does not guarantee an outcome. He said similar language is included in New York’s Regulation 187, which establishes a best interest standard of conduct.

After discussion of the suggested revisions, the Working Group decided not to accept it because of concerns about its appropriateness for this section.
Kim O’Brien (FACC) said the FACC suggests revising Section 1A to delete the reference to “best interest” because of its concerns with using an undefined and ambiguous term.

Mr. Bissett asked the Working Group to defer the IIABA’s suggested revisions to Section 1A until the Working Group discusses Section 6—Duties of Insurers and Producers.

Director Cameron said any discussions related to whether to include a best interest standard of conduct in the Model #275 revisions should be deferred until the Working Group discusses Section 6—Duties of Insurers and Producers.

Director Froment noted that all of the draft provisions are open until the Working Group completes its work and forwards the draft revisions to the Life Insurance and Annuities (A) Committee for its consideration. She reminded the Working Group that as it moves through the discussion of the comments, the Working Group’s goal is to see if it can reach general support and consensus to make any requested changes to the draft based on the comments received.

The Working Group discussed the IIABA’s suggestion to delete the proposed drafting note for Section 1B. The proposed drafting note states that for purposes of Section 989J of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (Dodd-Frank Act), the revised Model #275 is a successor to the 2010 revisions, which added a suitability standard of conduct.

Mr. Bissett explained that the purpose of Section 989J was to permit states to continue to regulate equity-indexed annuities if they adopted the NAIC’s 2010 amendments to Model #275. He said the current draft of proposed revisions to Model #275 will replace the suitability standard of conduct with a best interest standard of conduct. He said that for those states that do not want to adopt such a standard, there would be a question about their ability to continue to regulate equity-indexed annuities.

The Working Group discussed the IIABA’s suggested revision. After additional discussion, the Working Group decided to defer making any decision on the suggested revision and asked NAIC staff to contact the NAIC Legal Division to research this issue.

c. Section 2—Scope and Section 3—Authority

Director Froment said the IIABA submitted comments on Section 2—Scope and Section 3—Authority consistent with its suggested revision to the title and Section 1 to change Model #275 to a model law. She said that based on the Working Group’s discussion of those suggested revisions, the Working Group will not accept the IIABA’s suggested revisions for those sections. The Working Group agreed. No other comments were received on Section 2 or Section 3.

d. Section 4—Exemptions

Director Froment said the Joint Trades submitted comments on Section 4A—Exemptions.

Gary Sanders (NAIFA) said the Joint Trades suggest deleting language providing a specific exemption for certain direct response solicitations. He said that based on the on the proposed revisions to Model #275, the Joint Trades believe the revised model is intended to apply only to solicitations where there is a recommendation.

Commissioner Ommen said Section 4A is an existing model provision. He said the proposed revision broadens the existing exemption.

After discussion, the Working Group decided not to accept the suggested revision. The Working Group next discussed the FACC’s suggested revisions to Section 4B.

Ms. O’Brien said the FACC suggests adding the following language to the lead-in to Section 4B: “Contracts that are not individually solicited and are used to fund.” She said this proposed revision is intended to address a situation in the marketplace where consumers are being individually solicited to purchase an annuity for a plan described in Section 4B.

Jason Berkowitz (IRI) said the Section 4 exemption language has been in Model #275 since its inception. He said federal law preempts the states from regulating the types of plans described in Section 4B. He also said another reason for the exemption is that federal law imposes a fiduciary duty on plan sponsors with respect to these types of plans.
Ms. O’Brien said the FACC’s proposed revision was included in a previous draft of proposed revisions to Model #275.

Mr. Berkowitz said the California Department of Insurance offered that suggested revision to address specific concerns in their marketplace. He suggested that California’s concerns could be addressed in another way.

After discussion, the Working Group decided not to accept the FACC’s suggested revision.

e. Section 5—Definitions

The Working Group discussed Section 5—Definitions. No comments were received on the definition of “annuity” in Section 5A or the definition of “cash compensation” in Section 5B.

Pam Heinrich (NAFA) said the Joint Trades suggest deleting Section 5C(3) and Section 5C(5) in the definition of “consumer profile information” because these provisions are duplicative of other language used in the definition. She said the Joint Trades also suggest deleting the language “including variability in premium, death benefit or fees” in paragraph (11) and substituting the proposed newly defined term “non-guaranteed elements.” She said the proposed definition of “non-guaranteed elements” encompasses the language the Joint Trades suggests deleting. She said the definition for “non-guaranteed elements” is taken from the Annuity Disclosure Model Regulation (#245).

Commissioner Ommen asked if Section 5C(3) and Section 5C(5) are deleted, then what would require a producer or an insurer to specifically review the consumer’s financial situation and needs or financial objectives.

Ms. Heinrich said the requirement to review these specific elements is part of the producer’s or insurer’s general requirement under the proposed revisions to make recommendations that effectively address the consumer’s financial situation, insurance needs and financial objectives.

The Working Group discussed the suggested revisions. Director Cameron expressed support for retaining Section 5C(3) and Section 5C(5) because it is critical that the producer have this information as part of the consumer’s profile information when making a recommendation. After additional discussion, the Working Group decided to retain Section 5C(3) and Section 5C(5).

Mr. Berkowitz requested the Working Group consider language that would clarify what is meant by the language “debts and obligations” in Section 5C(3). The Working Group agreed and asked Mr. Berkowitz to submit language for its review during its next conference call.

Birny Birnbaum (Center for Economic Justice—CEJ) asked the Working Group to consider adding “insurance needs” to the list of information required to be considered as part of the consumer’s consumer profile information.

Superintendent Dwyer said she assumed “insurance needs” was incorporated in the list of information already in the definition of “consumer profile information,” but said she has no objection to specifically adding it to the list.

After discussion, the Working Group agreed to add “insurance needs.”

The Working Group discussed whether to delete the language “including variability in premium, death benefit or fees” in Section 5C(11) and substitute the proposed new definition for the term “non-guaranteed elements.”

Mr. Birnbaum suggested that the definition could be added without deleting the suggested language.

After discussion, the Working Group agreed to accept the suggested revisions and to add the language “including, but not limited to,” as Commissioner Ommen suggested.

No comments were received on the following definitions: 1) “continuing education credit” in Section 5D; 2) “continuing education provider” in Section 5E; 3) “FINRA” in Section 5F; 4) “insurer” in Section 5G; or 5) “intermediary” in Section 5H.

The Working Group discussed the Joint Trades’ suggested revisions to the definitions of “material conflict of interest” in Section 5I and “non-cash compensation” in Section 5J.
Robbie Meyer (ACLI) said the Joint Trades are suggesting these revisions for clarity and to expressly exclude benefits from being considered “non-cash compensation.” She said the concern is that if these benefits are not expressly excluded, they would be considered non-cash compensation and producers would be prohibited from receiving these benefits in accordance with Section 6C(2)(h).

The Working Group discussed the suggested revisions and decided to defer making a decision on the suggested revisions until it discusses Section 6—Duties of Insurers and Producers.

No comments were received on the definition of “producer” in Section 5K.

The Working Group discussed the Joint Trades’ suggested revision to the definition of “recommendation” in Section 5L. Mr. Berkowitz said the Joint Trades’ suggested revision is intended to make clear that a recommendation is advice given to the consumer regardless of whether the transaction is completed.

The Working Group discussed the suggested revision and decided not to accept it because of concerns that the suggested revision narrowed the language.

The Working Group discussed the Joint Trades’ suggested revision to the definition of “replacement” in Section 5M. Mr. Berkowitz said the Joint Trades suggests these revisions for consistency with the definition of “annuity” in Section 5A.

After discussion, the Working Group agreed to accept the suggested revisions.

No comments were received on the definition of “SEC” in Section 5N.

Director Froment said the Working Group would defer discussion of the remaining additional suggested definitions because those definitions involved the safe harbor provision in Section 6. She said the Working Group would discuss them as part of its discussion of that provision.

Having no further business, the Annuity Suitability (A) Working Group adjourned.
SUITABILITY IN ANNUITY TRANSACTIONS
MODEL REGULATION

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Section 1. Purpose

A. The purpose of this regulation is to require producers to act in the best interest of the consumer when making a recommendation of an annuity and to require insurers to establish and maintain a system to supervise recommendations and to set forth standards and procedures for recommendations to consumers that result in transactions involving annuity products so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately effectively addressed.

B. Nothing herein shall be construed to create or imply a private cause of action for a violation of this regulation.

Drafting Note: The language of subsection B comes from the NAIC Unfair Trade Practices Act. If a State has adopted different language, it should be substituted for subsection B.

Drafting Note: Section 989J of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 ("Dodd-Frank Act") specifically refers to this model regulation as the "Suitability in Annuity Transactions Model Regulation." Section 989J of the Dodd-Frank Act confirmed this exemption of certain annuities from the Securities Act of 1933 and confirmed state regulatory authority. This regulation is a successor regulation that exceeds the requirements of the 2010 model regulation.

Section 2. Scope

This regulation shall apply to any sale or recommendation to purchase, exchange or replace of an annuity made to a consumer by an insurance producer, or an insurer where no producer is involved, that results in the purchase, exchange or replacement recommended.

Section 3. Authority

This regulation is issued under the authority of [insert reference to enabling legislation].

Drafting Note: States may wish to use the Unfair Trade Practices Act as enabling legislation or may pass a law with specific authority to adopt this regulation.

Section 4. Exemptions

Drafting Note: States may wish to use the Unfair Trade Practices Act as enabling legislation or may pass a law with specific authority to adopt this regulation.
Unless otherwise specifically included, this regulation shall not apply to transactions involving:

A. Direct response solicitations where there is no recommendation based on information collected from the consumer pursuant to this regulation;

B. Contracts used to fund:
   (1) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);
   (2) A plan described by sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the Internal Revenue Code (IRC), as amended, if established or maintained by an employer;
   (3) A government or church plan defined in section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax-exempt organization under section 457 of the IRC; or
   (4) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

C. Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

D. Formal prepaid funeral contracts.

Section 5. Definitions

A. “Annuity” means an annuity that is an insurance product under State law that is individually solicited, whether the product is classified as an individual or group annuity.

B. “Cash compensation” means any discount, concession, fee, service fee, commission, sales charge, loan, override, or cash benefit received by a producer in connection with the recommendation or sale of an annuity from an insurer, intermediary, or directly from the consumer.

C. “Consumer profile information” means information that is reasonably appropriate to determine whether a recommendation addresses the consumer’s financial situation, insurance needs and financial objectives, including, at a minimum, the following:
   (1) Age;
   (2) Annual income;
   (3) Financial situation and needs, including debts and other obligations;
   (4) Financial experience;
   (5) Financial objectives;
   (6) Intended use of the annuity;
   (7) Financial time horizon;
   (8) Existing assets or financial products, including investment, annuity and insurance holdings;
   (9) Liquidity needs;
(10) Liquid net worth;

(11) Risk tolerance, including willingness to accept non-guaranteed elements in the annuity, including variability in premium, death benefit or fees;

(12) Financial resources used to fund the annuity; and

(13) Tax status.

BD. “Continuing education credit” or “CE credit” means one continuing education credit as defined in [insert reference in State law or regulations governing producer continuing education course approval].

CE. “Continuing education provider” or “CE provider” means an individual or entity that is approved to offer continuing education courses pursuant to [insert reference in State law or regulations governing producer continuing education course approval].

DF. “FINRA” means the Financial Industry Regulatory Authority or a succeeding agency.

EG. “Insurer” means a company required to be licensed under the laws of this state to provide insurance products, including annuities.

F. “Insurance producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities.

H. “Intermediary” means an entity contracted directly with an insurer or with another entity contracted with an insurer to facilitate the sale of the insurer’s annuities by producers.

I. (1) “Material conflict of interest” means a financial interest of the producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation.

(2) “Material conflict of interest” does not include cash compensation or non-cash compensation.

J. “Non-cash compensation” means any form of compensation that is not cash compensation, including, but not limited to, health insurance, office rent, office support and retirement benefits.

K. “Producer” means a person or entity required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities. For purposes of this regulation, “producer” includes an insurer where no producer is involved.

GL. (1) “Recommendation” means advice provided by an insurance producer, or an insurer where no producer is involved, to an individual consumer that was intended to result or does result in a purchase, an exchange or a replacement of an annuity in accordance with that advice.

(2) Recommendation does not include general communication to the public, generalized customer services assistance or administrative support, general educational information and tools, prospectuses, or other product and sales material.

NOTE: THE WORKING GROUP IS REQUESTING COMMENTS ON REVISING THE DEFINITION OF “RECOMMENDATION” TO ADDRESS IN-FORCE SALES BY ADDING LANGUAGE EXPANDING THE DEFINITION TO INCLUDE WHEN A MODIFICATION IS MADE OR THE CONSUMER ELECTS A CONTRACTUAL OPTION, WHICH GENERATES CASH OR NON-CASH COMPENSATION FOR THE PRODUCER PROVIDING THE ADVICE. THE WORKING GROUP ALSO REQUESTS COMMENTS ON WHETHER TO INCLUDE A TIME FRAME FOR A PRODUCER TO REVIEW A CONSUMER’S CONSUMER PROFILE INFORMATION. CURRENTLY FINRA REQUIRES A REVIEW OF SUCH INFORMATION AT LEAST EVERY 3 YEARS. THE WORKING GROUP IS ALSO REQUESTING COMMENTS ON WHETHER THE DRAFT SHOULD ADDRESS IN-FORCE SALES.
“Replacement” means a transaction in which a new policy or contract annuity is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no whether or not a producer is involved, that by reason of the transaction, an existing insurance policy or contract has been or is to be any of the following:

1. Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;
2. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
3. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
4. Reissued with any reduction in cash value; or
5. Used in a financed purchase.

Drafting Note: The definition of “replacement” above is derived from the NAIC Life Insurance and Annuities Replacement Model Regulation. If a State has a different definition for “replacement,” the State should either insert the text of that definition in place of the definition above or modify the definition above to provide a cross-reference to the definition of “replacement” that is in State law or regulation.

I. “Suitability information” means information that is reasonably appropriate to determine the suitability of a recommendation, including the following:

1. Age;
2. Annual income;
3. Financial situation and needs, including the financial resources used for the funding of the annuity;
4. Financial experience;
5. Financial objectives;
6. Intended use of the annuity;
7. Financial time horizon;
8. Existing assets, including investment and life insurance holdings;
9. Liquidity needs;
10. Liquid net worth;
11. Risk tolerance; and
12. Tax status.

N. “SEC” means the United States Securities and Exchange Commission.

Section 6. Duties of Insurers and Insurance Producers

A. Best Interest Obligations. A producer, when making a recommendation of an annuity, shall act in the best
interest of the consumer under the circumstances known at the time the recommendation is made, without placing the producer’s or the insurer’s financial interest ahead of the consumer’s interest. A producer is deemed to comply with this subsection by satisfying the following obligations regarding care, disclosure, conflict of interest and documentation:

A. In recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer’s suitability information, and that there is a reasonable basis to believe all of the following:

1. (a) Care Obligation. The producer, in making a recommendation shall exercise reasonable diligence, care and skill to:

   i. Know the consumer’s financial situation, insurance needs and financial objectives;

   ii. Understand the available recommendation options after making a reasonable inquiry into options available to the producer;

   iii. Have a reasonable basis to believe the recommended option effectively addresses the consumer’s financial situation, insurance needs and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and

   iv. Communicate the basis or bases of the recommendation.

   b. The requirements under subparagraph (a) of this paragraph include making reasonable efforts to obtain consumer profile information from the consumer prior to the recommendation of an annuity.

   c. The requirements under subparagraph (a) of this paragraph require a producer to consider the types of products the producer is authorized and licensed to recommend or sell that address the consumer’s financial situation, insurance needs and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation.

   d. The requirements under this subsection do not create a fiduciary obligation but create a regulatory obligation as established in this regulation.

   e. The consumer profile information, characteristics of the insurer, and product costs, rates, benefits and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer’s financial situation, insurance needs and financial objectives, but the level of importance of each factor under the care obligation of this paragraph may vary depending on the facts and circumstances of a particular case. However, each factor may not be considered in isolation.

   f. The requirements under subparagraph (a) of this paragraph include having a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit or other insurance-related features.

   g. The requirements under subparagraph (a) of this paragraph apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar producer enhancements, if any.
(h) The requirements under subparagraph (a) of this paragraph do not mean the annuity with the lowest one-time or multiple occurrence compensation structure shall necessarily be recommended.

(i) The requirements under subparagraph (a) of this paragraph do not mean the producer has ongoing monitoring obligations under the care obligation under this paragraph, although such an obligation may be separately owed under the terms of a fiduciary, consulting, investment advising or financial planning agreement between the consumer and the producer.

(j) In the case of an exchange or replacement of an annuity, the producer shall consider the whole transaction, which includes taking into consideration whether:

   (i) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, such as death, living or other contractual benefits, or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;

   (ii) The replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and

   (iii) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 60 months.

(2) Disclosure obligation.

(a) Prior to or at the time of the recommendation or sale of an annuity, the producer shall prominently disclose to the consumer on a form substantially similar to the “Producer Relationship Disclosure Form” in Appendix A:

   (i) A description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction;

   (ii) Any limitations the producer or the insurer has concerning the following:

      (I) The type of products that the producer is authorized and licensed to recommend or sell; and

      (II) Whether only products issued by a specific insurer or an otherwise limited range of annuity products may be offered;

   (iii) A description of the sources and types of cash compensation and non-cash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission as part of premium or other remuneration received from the insurer, intermediary or other producer or by fee as a result of a contract for advice or consulting services; and

   (iv) A notice of the consumer’s right to request additional information regarding cash compensation described in subparagraph (b) of this paragraph;

Drafting Note: If a state approves forms, a state should add language to subparagraph (a) reflecting such approvals.

(b) Upon request, the producer shall disclose:
(i) A reasonable estimate of the amount of cash compensation, which may be stated as a range of amounts or percentages; and

(ii) Whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts or percentages; and

Drafting Note: If a State has adopted the NAIC Annuity Disclosure Model Regulation, the State should insert an additional phrase in paragraph (1) subparagraph (c) above to explain that the requirements of this section are intended to supplement and not replace the disclosure requirements of the NAIC Annuity Disclosure Model Regulation.

(2) The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;

(3) The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and

(4) In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:

(a) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;

(b) The consumer would benefit from product enhancements and improvements; and

(c) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

(3) Conflict of interest obligation. A producer shall identify and avoid or otherwise reasonably manage material conflicts of interest, including material conflicts of interest related to an ownership interest.

(4) Documentation obligation. A producer shall at the time of recommendation or sale:
(a) Make a written record of any recommendation and the basis for the recommendation subject to this regulation;

(b) Obtain a customer signed statement on a form substantially similar to the “Consumer Refusal to Disclose All or Partial Consumer Profile Information” form in Appendix B documenting:

(i) A customer’s refusal to provide the consumer profile information, if any; and

(ii) A customer’s understanding of the ramifications of not providing his or her consumer profile information or providing insufficient consumer profile information; and

(c) Obtain a customer signed statement acknowledging the annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the producer’s recommendation.

Drafting Note: If a state approves forms, a state should add language to subparagraph (b) of this paragraph reflecting such approvals.

B. Prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain the consumer’s suitability information.

C. Except as permitted under subsection D, an insurer shall not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity is suitable based on the consumer’s suitability information.

NOTE: THE PROVISION BELOW IS STILL UNDER CONSIDERATION. THE WORKING GROUP IS REQUESTING COMMENT ON IT.

[7. Any requirement applicable to a producer under this section shall apply to every producer who has materially participated in the making of a recommendation and received compensation as a result of the sales transaction, regardless of whether the producer has had any direct contact with the consumer, provided that product wholesaling or product support based on generic client information, or the provision of education or marketing material, does not constitute participating in the making of a recommendation.]

DB. Transactions not based on a recommendation.

(1) Except as provided under paragraph (2) of this subsection, neither an insurance producer, nor an insurer, shall have any obligation to a consumer under subsection A(1) or C related to any annuity transaction if:

(a) No recommendation is made;

(b) A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer;

(c) A consumer refuses to provide relevant suitability consumer profile information and the annuity transaction is not recommended; or

(d) A consumer decides to enter into an annuity transaction that is not based on a recommendation of the insurer or the insurance producer.
(2) An insurer’s issuance of an annuity subject to paragraph (1) shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

C. Supervision system.

(1) Except as permitted under subsection B, an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would effectively address the particular consumer’s financial situation, insurance needs and financial objectives based on the consumer’s consumer profile information.

E. An insurance producer or, where no insurance producer is involved, the responsible insurer representative, shall at the time of sale:

(1) Make a record of any recommendation subject to section 6A of this regulation;

(2) Obtain a customer signed statement documenting a customer’s refusal to provide suitability information, if any; and

(3) Obtain a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer’s or insurer’s recommendation.

F. An insurer shall establish and maintain a supervision system that is reasonably designed to achieve the insurer’s and its insurance producers’ compliance with this regulation, including, but not limited to, the following:

(a) The insurer shall establish and maintain reasonable procedures to inform its insurance producers of the requirements of this regulation and shall incorporate the requirements of this regulation into relevant insurance producer training manuals;

(b) The insurer shall establish and maintain standards for insurance producer product training and shall establish and maintain reasonable procedures to require its insurance producers to comply with the requirements of section 7 of this regulation;

(c) The insurer shall provide product-specific training and training materials which explain all material features of its annuity products to its insurance producers;

(d) The insurer shall establish and maintain procedures for review of each recommendation prior to issuance of an annuity that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable, the recommended annuity would effectively address the particular consumer’s financial situation, insurance needs and financial objectives. Such review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

(e) The insurer shall establish and maintain reasonable procedures to detect recommendations that are not in compliance with subsections A, B, D and E. This may include, but is not limited to, confirmation of the consumer’s consumer profile information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures, or by confirming the consumer profile information after issuance or delivery of the annuity; and
(f) The insurer shall establish and maintain reasonable procedures to assess, prior to or upon issuance or delivery of an annuity, whether a producer has provided to the consumer the information required to be provided under this section;

(g) The insurer shall establish and maintain reasonable procedures to identify and address potentially suspicious consumer refusals to provide consumer profile information;

(h) The insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities or specific types of annuities within a limited period of time; and

(i) The insurer shall annually provide a written report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

(2) An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to section 8 of this regulation regardless of whether the insurer contracts for performance of a function and regardless of the insurer’s compliance with subparagraph (b) of this paragraph.

(a) Nothing in this subsection restricts an insurer from contracting for performance of a function (including maintenance of procedures) required under paragraph (1) this subsection. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to section 8 of this regulation regardless of whether the insurer contracts for performance of a function and regardless of the insurer’s compliance with subparagraph (b) of this paragraph.

(b) An insurer’s supervision system under paragraph (1) this subsection shall include supervision of contractual performance under this subsection. This includes, but is not limited to, the following:

(i) Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and

(ii) Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

(4) An insurer is not required to include in its system of supervision an insurance producer’s recommendations to consumers of products other than the annuities offered by the insurer.

GD. Prohibited Practices. Neither a producer nor an insurer shall dissuade, or attempt to dissuade, a consumer from:

(1) Truthfully responding to an insurer’s request for confirmation of the suitability consumer profile information;

(2) Filing a complaint; or

(3) Cooperating with the investigation of a complaint.

HE. Safe harbor.

(1) Sales made in compliance with SEC regulations and applicable FINRA requirements pertaining to suitability best interest obligations and supervision of annuity transactions shall satisfy the requirements under this regulation. This subsection applies to FINRA broker-dealer sales of annuities if, in connection with the sale of an annuity, the broker-dealer and the producer, who also is appropriately registered as a representative with FINRA, have complied with the business rules, controls and procedures for securities transactions, the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the insurance
commissioner’s ability to investigate and enforce (including investigate) the provisions of this regulation.

**Drafting Note:** Non-compliance with SEC and FINRA requirements means that the broker-dealer transaction is subject to compliance with the suitability requirements of this regulation.

(2) For paragraph (1) to apply, an insurer shall:

(a) Monitor the FINRA member broker-dealer using information collected in the normal course of an insurer’s business; and

(b) Provide to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

### Section 7. Insurance Producer Training

**A.** An insurance producer shall not solicit the sale of an annuity product unless the insurance producer has adequate knowledge of the product to recommend the annuity and the insurance producer is in compliance with the insurer’s standards for product training. An insurance producer may rely on insurer-provided product-specific training standards and materials to comply with this subsection.

**B.**

(1) An insurance producer who engages in the sale of annuity products shall complete a one-time four (4) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider.

(2) The minimum length of the training required under this subsection shall be sufficient to qualify for at least four (4) CE credits, but may be longer.

(3) The training required under this subsection shall include information on the following topics:

(a) The types of annuities and various classifications of annuities;

(b) Identification of the parties to an annuity;

(c) How product specific annuity contract features affect consumers;

(d) The application of income taxation of qualified and non-qualified annuities;

(e) The primary uses of annuities; and

(f) Appropriate standard of conduct, sales practices, replacement and disclosure requirements.

(4) Providers of courses intended to comply with this subsection shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer’s products. Additional topics may be offered in conjunction with and in addition to the required outline.

(5) A provider of an annuity training course intended to comply with this subsection shall register as a CE provider in this State and comply with the rules and guidelines applicable to insurance producer
continuing education courses as set forth in [insert reference to State law or regulations governing producer continuing education course approval].

(6) Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with [insert reference to State law or regulations governing producer continuing education course approval].

(7) Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with [insert reference to State law or regulations governing to producer continuing education course approval].

(8) The satisfaction of the training requirements of another State that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this State.

(9) The satisfaction of the components of the training requirements of any course or courses with components substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this state.

(9)(10) An insurer shall verify that an insurance producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

Section 8. Compliance Mitigation; Penalties

A. An insurer is responsible for compliance with this regulation. If a violation occurs, either because of the action or inaction of the insurer or its insurance-producer, the commissioner may order:

(1) An insurer to take reasonably appropriate corrective action for any consumer harmed by a failure to comply with this regulation by the insurer’s supervisory duties or by its insurance-producer’s violation of this regulation.

(2) A general agency, independent agency or the insurance-producer to take reasonably appropriate corrective action for any consumer harmed by the insurance-producer’s violation of this regulation; and

(3) Appropriate penalties and sanctions.

B. Any applicable penalty under [insert statutory citation] for a violation of this regulation may be reduced or eliminated [ according to a schedule adopted by the commissioner.] if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice.

Drafting Note: Subsection B above is intended to be consistent with the commissioner’s discretionary authority to determine the appropriate penalty for a violation of this regulation. The language of subsection B is not intended to require that a commissioner impose a penalty on an insurer for a single violation of this regulation if the commissioner has determined that such a penalty is not appropriate.

Drafting Note: A State that has authority to adopt a schedule of penalties may wish to include the words in brackets. In that case, “shall” should be substituted for “may” in the same sentence. States should consider inserting a reference to the NAIC Unfair Trade Practices Act or the State’s statute that authorizes the commissioner to impose penalties and fines.

Section 9. [Optional]. Recordkeeping
A. Insurers, general agents, independent agencies and insurance producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer, disclosures made to the consumer, including summaries of oral disclosures, and other information used in making the recommendations that were the basis for insurance transactions for [insert number] years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

**Drafting Note:** States should review their current record retention laws and specify a time period that is consistent with those laws. For some States this time period may be five (5) years.

B. Records required to be maintained by this regulation may be maintained in paper, photographic, micro-process, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

**Drafting Note:** This section may be unnecessary in States that have a comprehensive recordkeeping law or regulation.

**Section 10. Effective Date**

The amendments to this regulation shall take effect [six (6)X] months after the date the regulation is adopted or on [insert date], whichever is later.
APPENDIX A

PRODUCER RELATIONSHIP DISCLOSURE FORM

Date: ________________________

INSURANCE AGENT/PRODUCER INFORMATION (“Me”, “I”, “My”)

First Name: ______________________________ Last Name: __________________________

Firm Name: ______________________________ Website: _____________________________

Business Mailing Address: __________________________________________________________

Business Telephone Number: ______________________________________________________

Email Address: __________________________________________________________________

Insurance License # ______________________________

CLIENT INFORMATION (“You”, “Your”)

First Name: ________________________________ Last Name: __________________________

INSURANCE AUTHORIZATION

I am licensed and authorized to sell insurance products, including annuities in [State] in accordance with state laws. I offer the following products:

- Fixed or Fixed Index Annuities
- Variable Annuities
- Options
- Other Investments
- Mutual Funds
- Stocks/Bonds
- Certificates of Deposits

I am authorized and contracted or appointed or have access to offer:

- Products from ONLY ONE INSURER or Insurance Holding Company Group
- Products from Multiple Insurers
- Products from Multiple Insurers although I am primarily contracted with one insurer

NOTE: THE WORKING GROUP REQUESTS COMMENTS ON WHAT ADDITIONAL INFORMATION (OR BOXES), IF ANY, SHOULD BE ADDED BELOW TO REFLECT THE PROVISIONS OF SECTION 6A(2), THE DISCLOSURE OBLIGATION, TO DESCRIBE THE SCOPE AND TERMS OF THE RELATIONSHIP BETWEEN THE PRODUCER AND THE CONSUMER.

My Relationship with You:

- One-Time Transaction
On-Going Relationship

My Compensation Structure:

- Commissioned Transaction
- An asset under management fee
- Other, please describe: ________________________________

I am likely to be compensated by the following sources for this relationship:

- Insurance Company
- The Consumer
- Third parties such as an Independent Marketing Organization (IMO) related to the Insurer

Other Sources ____________________________

ADDITIONAL INFORMATION

You may obtain further information regarding the cash compensation paid to me.

NOTE: THE WORKING GROUP REQUESTS COMMENTS ON WHETHER THE CONSUMER SHOULD SIGN AND ACKNOWLEDGE THIS FORM AND/OR SHOULD THIS FORM BE RETAINED BY THE PRODUCER OR GIVEN TO THE CONSUMER, OR BOTH.

________________________________________________________________________

Client Signature

________________________________________________________________________

Date
APPENDIX B

CONSUMER REFUSAL TO DISCLOSE ALL OR PARTIAL CONSUMER PROFILE INFORMATION FORM

I understand that should I decline to provide the requested information or should I provide inaccurate information, I am limiting the protection afforded me by the Insurance Code of this [state] regarding this purchase.

___ I REFUSE to provide this information at this time.

___ I have chosen to provide LIMITED information at this time.

___ My annuity purchase IS NOT BASED on the recommendation of this producer or the insurer.

__________________________________
Client Signature

__________________________________
Date

W:\Drafts\04-Model Laws, Regulations & Guidelines\# 275 - Suitability in Annuity Transactions Model Regulation\Model #275-4 Draft.docx
The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call Sept. 17, 2019. The following Working Group members participated: Jillian Froment, Chair (OH); Doug Ommen, Vice Chair (IA); Steve Ostlund (AL); Jodi Lerner (CA); Fleur McKendell (DE); Dean L. Cameron (ID); Tate Flott (KS); Nour Benchaaboun (MD); Renee Campbell (MI); Matt Holman (NE); Denise Lamy (NH); James Regalbuto (NY); Elizabeth Kelleher Dwyer, Matt Gendron and Sarah Neil (RI); Lorrie Brouse and Rachel Jade-Rice (TN); and Richard Wicka (WI).

1. Discussed and Exposed the Technical Group Draft of Proposed Revisions to Model #275

Director Froment reminded the Working Group of its goals for its June 20 meeting and its subsequent meetings, which was to develop a framework for revising the *Suitability in Annuity Transactions Model Regulation (#275)* to include a best interest standard of conduct that is more than the model’s current suitability standard, but not a fiduciary standard. She said that based on the developed framework and as discussed at the Working Group’s meeting at the Summer National Meeting, the Working Group’s technical drafting group met in September and developed a draft of proposed revisions to Model #275 (Attachment Two-E1). She said the purpose of this call is to allow the Working Group to review, comment and offer suggested revisions to the draft in order to develop a Working Group draft for exposure for public comment. She explained that although it is an open call, only Working Group members will be allowed to comment. She noted that all stakeholders would have sufficient time to comment on the draft during the public comment period and subsequent Working Group calls to review and discuss the comments received.

   a. Section 1—Purpose

Director Froment reviewed the proposed revisions to Section 1—Purpose. She said the revisions make it clear that Model #275’s purpose is to require producers to act in the consumer’s best interest when making a recommendation of an annuity and require insurers to establish and maintain systems to supervise these recommendations. She requested comments from the Working Group. There were no comments.

   b. Section 2—Scope

Director Froment reviewed the proposed revisions to Section 2—Scope. Mr. Regalbuto asked if it is appropriate to discuss whether Model #275 should apply to in-force recommendations. After discussion, the Working Group decided to defer that discussion until the Working Group discusses the definition of “recommendation” in Section 5L. There were no additional Working Group comments on this section.

   c. Section 3—Authority

Director Froment said no revisions were made to Section 3—Authority. There were no comments from Working Group members on this section.

   d. Section 4—Exemptions

Director Froment said no revisions were made to Section 4—Exemptions. There were no comments from Working Group members on this section.

   e. Section 5—Definitions

Director Froment reviewed the proposed revisions to Section 5—Definitions. Mr. Wicka asked about the proposed revisions to the definition of “recommendation” in Section 5L. He said the proposed revisions adding the language “is intended to result” creates an element of intent, which must be proven in a hearing. He suggested striking the language and substituting “does result” in order to avoid having to prove intent. After additional discussion, the Working Group decided to revise the definition as follows: “was intended to result and does result.”
Mr. Regalbuto asked the Working Group to consider adding language to the definition of “recommendation” to have Model #275 apply to “in-force” sales when a modification is made to the in-force annuity contract or the consumer elects a contractual option, which generates cash or non-cash compensation for the producer providing the advice. The Working Group discussed Mr. Regalbuto’s suggestion. Some Working Group members expressed caution for including such language, and others expressed some hesitation to include such language in the draft until additional information and specific language is provided for the Working Group’s review. After additional discussion, the Working Group decided to defer making a decision until it could receive additional comments from stakeholders.

f. Section 6—Duties of Insurers and Producers

Director Froment reviewed the provisions of Section 6A—Duties of Insurers and Producers, Best Interest Obligations. She explained that Section 6A requires a producer to act in the consumer’s best interest in making a recommendation without placing the producer’s or the insurer’s financial interest ahead of the consumer’s interest and outlines how a producer or insurer would comply with this requirement by satisfying the care, disclosure, conflict of interest and documentation obligations. She asked the Working Group for comments. There were no comments.

Director Froment pointed out a potential provision for inclusion in Section 6A from New York, which would extend the model’s requirements to every producer who has materially participated in the making of a recommendation and received compensation as a result of the sales transaction regardless of whether the producer has had any direct contact with the consumer. Mr. Regalbuto explained his reasoning for suggesting the inclusion of this language. He said inclusion of this provision is particularly important with respect to new producers or recommendations involving complex products where another producer with more knowledge may be brought in to assist. Director Froment said the technical draft group discussed New York’s concerns and its reasoning for suggesting the language but struggled with whether this language was the way to address it or if there was another approach it should consider. Ms. Brouse suggested another approach could be to revise Model #275’s supervision provisions to address it. Commissioner Ommen suggested the Working Group receive additional comments on New York’s suggested language. The Working Group agreed.

Director Froment reviewed Section 6B, Transactions Not Based on a Recommendation. She asked the Working Group for comments. There were no comments.

Director Froment reviewed Section 6C, Supervision System. She asked the Working Group for comments. Ms. Lerner asked why Section 6C(2)(h) requires an insurer to establish and maintain “minimum” procedures. After discussion, the Working Group agreed to delete the word “minimum” for consistency with similar language in Section 6C.

g. Appendix A—Producer Relationship Disclosure Form

Director Froment reviewed Appendix A—Producer Relationship Disclosure Form. She asked for comments from the Working Group. With respect to the heading “Insurance Authorization,” Ms. Brouse discussed the issue of a producer being authorized to “sell” versus “offer” certain annuities. After discussion, the Working Group decided to add the language “or have access to offer.” The Working Group discussed the purpose of the form and whether it included all of the information that should be disclosed in accordance with Section 6A(2) with respect to the producer and consumer relationship. After additional discussion, the Working Group decided to request specific comments on the issue.

Mr. Benchaboun asked if consumers should be required to sign the form and acknowledge receipt. After discussion, the Working Group decided to ask for specific comments on this issue.

h. Appendix B—Consumer Refusal to Disclose All or Partial Consumer Profile Information Form

Director Froment reviewed Appendix B—Consumer Refusal to Disclose All or Partial Consumer Profile Information Form. She asked the Working Group for comments. There were no comments.

Director Froment exposed the draft of proposed revisions to Model #275, as discussed during the conference call, for a 13-day public comment period ending Sept. 30.
2. **Discussed the Working Group’s Next Steps**

Director Froment discussed the Working Group’s next steps. She said the Working Group will discuss any comments received on the draft of proposed revisions to Model #275 via conference call beginning in early October through November. The Working Group’s goal is to present a draft to the Life Insurance and Annuities (A) Committee for its consideration prior to or at the Fall National Meeting.

Having no further business, the Annuity Suitability (A) Working Group adjourned.

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SUITABILITY IN ANNUITY TRANSACTIONS
MODEL REGULATION

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Appendix B. Consumer Refusal to Disclose All or Partial Consumer Profile Information

Section 1. Purpose

A. The purpose of this regulation is to require producers to act in the best interest of the consumer when making a recommendation of an annuity and to require insurers to establish and maintain a system to supervise recommendations and to set forth standards and procedures for recommendations to consumers that result in transactions involving annuity products so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately effectively addressed.

B. Nothing herein shall be construed to create or imply a private cause of action for a violation of this regulation.

Drafting Note: The language of subsection B comes from the NAIC Unfair Trade Practices Act. If a State has adopted different language, it should be substituted for subsection B.

Drafting Note: Section 989J of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 ("Dodd-Frank Act") specifically refers to this model regulation as the “Suitability in Annuity Transactions Model Regulation.” Section 989J of the Dodd-Frank Act confirmed this exemption of certain annuities from the Securities Act of 1933 and confirmed state regulatory authority. This regulation is a successor regulation that exceeds the requirements of the 2010 model regulation.

Section 2. Scope

This regulation shall apply to any sale or recommendation to purchase, exchange or replace of an annuity made to a consumer by an insurance producer, or an insurer where no producer is involved, that results in the purchase, exchange or replacement recommended.

Section 3. Authority

This regulation is issued under the authority of [insert reference to enabling legislation].

Drafting Note: States may wish to use the Unfair Trade Practices Act as enabling legislation or may pass a law with specific authority to adopt this regulation.

Section 4. Exemptions
Unless otherwise specifically included, this regulation shall not apply to transactions involving:

A. Direct response solicitations where there is no recommendation based on information collected from the consumer pursuant to this regulation;

B. Contracts used to fund:
   (1) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);
   (2) A plan described by sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the Internal Revenue Code (IRC), as amended, if established or maintained by an employer;
   (3) A government or church plan defined in section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax-exempt organization under section 457 of the IRC; or
   (4) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

C. Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

D. Formal prepaid funeral contracts.

Section 5. Definitions

A. “Annuity” means an annuity that is an insurance product under State law that is individually solicited, whether the product is classified as an individual or group annuity.

B. “Cash compensation” means any discount, concession, fee, service fee, commission, sales charge, loan, override, or cash benefit received by a producer in connection with the recommendation or sale of an annuity from an insurer, intermediary, or directly from the consumer.

C. “Consumer profile information” means information that is reasonably appropriate to determine whether a recommendation addresses the consumer’s financial situation, insurance needs and financial objectives, including, at a minimum, the following:
   (1) Age;
   (2) Annual income;
   (3) Financial situation and needs, including debts and other obligations;
   (4) Financial experience;
   (5) Financial objectives;
   (6) Intended use of the annuity;
   (7) Financial time horizon;
   (8) Existing assets or financial products, including investment, annuity and insurance holdings;
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(9) Liquidity needs;

(10) Liquid net worth;

(11) Risk tolerance, including willingness to accept non-guaranteed elements in the annuity, including variability in premium, death benefit or fees;

(12) Financial resources used to fund the annuity; and

(13) Tax status.

BD. “Continuing education credit” or “CE credit” means one continuing education credit as defined in [insert reference in State law or regulations governing producer continuing education course approval].

CE. “Continuing education provider” or “CE provider” means an individual or entity that is approved to offer continuing education courses pursuant to [insert reference in State law or regulations governing producer continuing education course approval].

DF. “FINRA” means the Financial Industry Regulatory Authority or a succeeding agency.

EG. “Insurer” means a company required to be licensed under the laws of this state to provide insurance products, including annuities.

F. “Insurance producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities.

H. “Intermediary” means an entity contracted directly with an insurer or with another entity contracted with an insurer to facilitate the sale of the insurer’s annuities by producers.

I. (1) “Material conflict of interest” means a financial interest of the producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation.

(2) “Material conflict of interest” does not include cash compensation or non-cash compensation.

J. “Non-cash compensation” means any form of compensation that is not cash compensation, including, but not limited to, health insurance, office rent, office support and retirement benefits.

K. “Producer” means a person or entity required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities. For purposes of this regulation, “producer” includes an insurer where no producer is involved.

GL. (1) “Recommendation” means advice provided by an insurance producer, or an insurer where no producer is involved, to an individual consumer that is intended to result in a purchase, an exchange or a replacement of an annuity in accordance with that advice.

(2) Recommendation does not include general communication to the public, generalized customer services assistance or administrative support, general educational information and tools, prospectuses, or other product and sales material.

HM. “Replacement” means a transaction in which a new policy or contract annuity is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is whether or not a producer is involved, that by reason of the transaction, an existing insurance policy or contract has been or is to be any of the following:
(1) Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

(2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(4) Reissued with any reduction in cash value; or

(5) Used in a financed purchase.

Drafting Note: The definition of “replacement” above is derived from the NAIC Life Insurance and Annuities Replacement Model Regulation. If a State has a different definition for “replacement,” the State should either insert the text of that definition in place of the definition above or modify the definition above to provide a cross-reference to the definition of “replacement” that is in State law or regulation.

I. “Suitability information” means information that is reasonably appropriate to determine the suitability of a recommendation, including the following:

(1) Age;

(2) Annual income;

(3) Financial situation and needs, including the financial resources used for the funding of the annuity;

(4) Financial experience;

(5) Financial objectives;

(6) Intended use of the annuity;

(7) Financial time horizon;

(8) Existing assets, including investment and life insurance holdings;

(9) Liquidity needs;

(10) Liquid net worth;

(11) Risk tolerance; and

(12) Tax status.

N. “SEC” means the United States Securities and Exchange Commission.

Section 6. Duties of Insurers and of Insurance Producers

A. Best Interest Obligations. A producer, when making a recommendation of an annuity, shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the producer’s or the insurer’s financial interest ahead of the consumer’s interest. A producer is deemed to comply with this subsection by satisfying the following obligations regarding care, disclosure, conflict of interest and documentation:
A. In recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer’s suitability information, and that there is a reasonable basis to believe all of the following:

   (1) (a) Care Obligation. The producer, in making a recommendation shall exercise reasonable diligence, care and skill to:

      (i) Know the consumer’s financial situation, insurance needs and financial objectives;

      (ii) Understand the available recommendation options after making a reasonable inquiry into options available to the producer;

      (iii) Have a reasonable basis to believe the recommended option effectively addresses the consumer’s financial situation, insurance needs and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and

      (iv) Communicate the basis or bases of the recommendation.

(b) The requirements under subparagraph (a) of this paragraph include making reasonable efforts to obtain consumer profile information from the consumer prior to the recommendation of an annuity.

(c) The requirements under subparagraph (a) of this paragraph require a producer to consider the types of products the producer is authorized and licensed to recommend or sell that address the consumer’s financial situation, insurance needs and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation.

(d) The requirements under this subsection do not create a fiduciary obligation but create a regulatory obligation as established in this regulation.

(e) The consumer profile information, characteristics of the insurer, and product costs, rates, benefits and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer’s financial situation, insurance needs and financial objectives, but the level of importance of each factor under the care obligation of this paragraph may vary depending on the facts and circumstances of a particular case. However, each factor may not be considered in isolation.

(f) The requirements under subparagraph (a) of this paragraph include having a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit or other insurance-related features.

(g) The requirements under subparagraph (a) of this paragraph apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar producer enhancements, if any.
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(h) The requirements under subparagraph (a) of this paragraph do not mean the annuity with the lowest one-time or multiple occurrence compensation structure shall necessarily be recommended.

(i) The requirements under subparagraph (a) of this paragraph do not mean the producer has ongoing monitoring obligations under the care obligation under this paragraph, although such an obligation may be separately owed under the terms of a fiduciary, consulting, investment advising or financial planning agreement between the consumer and the producer.

(j) In the case of an exchange or replacement of an annuity, the producer shall consider the whole transaction, which includes taking into consideration whether:

(i) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, such as death, living or other contractual benefits, or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;

(ii) The replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and

(iii) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 60 months.

2 Disclosure obligation.

(a) Prior to or at the time of the recommendation or sale of an annuity, the producer shall prominently disclose to the consumer on a form substantially similar to the “Producer Relationship Disclosure Form” in Appendix A:

(i) A description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction;

(ii) Any limitations the producer or the insurer has concerning the following:

(I) The type of products that the producer is authorized and licensed to recommend or sell; and

(II) Whether only products issued by a specific insurer or an otherwise limited range of annuity products may be offered;

(iii) A description of the sources and types of cash compensation and non-cash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission as part of premium or other remuneration received from the insurer, intermediary or other producer or by fee as a result of a contract for advice or consulting services; and

(iv) A notice of the consumer’s right to request additional information regarding cash compensation described in subparagraph (b) of this paragraph:

Drafting Note: If a state approves forms, a state should add language to subparagraph (a) reflecting such approvals.

(b) Upon request, the producer shall disclose:

Drafting Note: If a state approves forms, a state should add language to subparagraph (a) reflecting such approvals.
(i) A reasonable estimate of the amount of cash compensation, which may be stated as a range of amounts or percentages; and

(ii) Whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts or percentages; and

(c1) Prior to or at the time of the recommendation or sale of an annuity, the producer shall have a reasonable basis to believe that the consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, any annual fees, potential charges for and features of riders or other options of the annuity, limitations on interest returns, potential changes in non-guaranteed elements of the annuity, insurance and investment components and market risk.

Drafting Note: If a State has adopted the NAIC Annuity Disclosure Model Regulation, the State should insert an additional phrase in paragraph (1) subparagraph (c) above to explain that the requirements of this section are intended to supplement and not replace the disclosure requirements of the NAIC Annuity Disclosure Model Regulation.

(2) The consumer would benefit from certain features of the annuity, such as tax deferred growth, annuitization or death or living benefit;

(3) The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information, and

(4) In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:

(a) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;

(b) The consumer would benefit from product enhancements and improvements; and

(c) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

(3) Conflict of interest obligation. A producer shall identify and avoid or otherwise reasonably manage material conflicts of interest, including material conflicts of interest related to an ownership interest.

(4) Documentation obligation. A producer shall at the time of recommendation or sale:
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(a) Make a written record of any recommendation and the basis for the recommendation subject to this regulation;

(b) Obtain a customer signed statement on a form substantially similar to the “Consumer Refusal to Disclose All or Partial Consumer Profile Information” form in Appendix B documenting:
   (i) A customer’s refusal to provide the consumer profile information, if any; and
   (ii) A customer’s understanding of the ramifications of not providing his or her consumer profile information or providing insufficient consumer profile information; and

(c) Obtain a customer signed statement acknowledging the annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the producer’s recommendation.

Drafting Note: If a state approves forms, a state should add language to subparagraph (b) of this paragraph reflecting such approvals.

B. Prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain the consumer’s suitability information.

C. Except as permitted under subsection D, an insurer shall not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity is suitable based on the consumer’s suitability information.

NOTE: THE PROVISION BELOW IS STILL UNDER CONSIDERATION. THE WORKING GROUP IS REQUESTING COMMENT ON IT.

[? Any requirement applicable to a producer under this section shall apply to every producer who has materially participated in the making of a recommendation and received compensation as a result of the sales transaction, regardless of whether the producer has had any direct contact with the consumer, provided that product wholesaling or product support based on generic client information, or the provision of education or marketing material, does not constitute participating in the making of a recommendation.]

DB. Transactions not based on a recommendation.

(1) Except as provided under paragraph (2) of this subsection, neither an insurance producer, nor an insurer, shall have any obligation to a consumer under subsection A(1) or C related to any annuity transaction if:

(a) No recommendation is made;

(b) A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer;

(c) A consumer refuses to provide relevant suitability consumer profile information and the annuity transaction is not recommended; or

(d) A consumer decides to enter into an annuity transaction that is not based on a recommendation of the insurer or the insurance producer.
(2) An insurer’s issuance of an annuity subject to paragraph (1) shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

C. Supervision system.

(1) Except as permitted under subsection B, an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would effectively address the particular consumer’s financial situation, insurance needs and financial objectives based on the consumer’s consumer profile information.

E. An insurance producer or, where no insurance producer is involved, the responsible insurer representative, shall at the time of sale:

(1) Make a record of any recommendation subject to section 6A of this regulation;

(2) Obtain a customer signed statement documenting a customer’s refusal to provide suitability information, if any; and

(3) Obtain a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer’s or insurer’s recommendation.

F. (1) An insurer shall establish and maintain a supervision system that is reasonably designed to achieve the insurer’s and its insurance producers’ compliance with this regulation, including, but not limited to, the following:

(a) The insurer shall maintain reasonable procedures to inform its insurance producers of the requirements of this regulation and shall incorporate the requirements of this regulation into relevant insurance producer training manuals;

(b) The insurer shall establish standards for insurance producer product training and shall maintain reasonable procedures to require its insurance producers to comply with the requirements of section 7 of this regulation;

(c) The insurer shall provide product-specific training and training materials which explain all material features of its annuity products to its insurance producers;

(d) The insurer shall maintain procedures for review of each recommendation prior to issuance of an annuity that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. The recommended annuity would effectively address the particular consumer’s financial situation, insurance needs and financial objectives. Such review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

(e) The insurer shall establish and maintain reasonable procedures to detect recommendations that are not suitable in compliance with subsections A, B, D and E. This may include, but is not limited to, confirmation of the consumer’s suitability consumer profile information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this
subparagraph by applying sampling procedures, or by confirming the suitability consumer profile information after issuance or delivery of the annuity; and

(f) The insurer shall establish and maintain reasonable procedures to assess, prior to or upon issuance or delivery of an annuity, whether a producer has provided to the consumer the information required to be provided under this section;

(g) The insurer shall establish and maintain reasonable procedures to identify and address potentially suspicious consumer refusals to provide consumer profile information;

(h) The insurer shall establish and maintain minimum procedures to identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities or specific types of annuities within a limited period of time; and

(i) The insurer shall annually provide a written report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

(2)(3) (a) Nothing in this subsection restricts an insurer from contracting for performance of a function (including maintenance of procedures) required under paragraph (1) of this subsection. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to section 8 of this regulation regardless of whether the insurer contracts for performance of a function and regardless of the insurer’s compliance with subparagraph (b) of this paragraph.

(b) An insurer’s supervision system under paragraph (1) of this subsection shall include supervision of contractual performance under this subsection. This includes, but is not limited to, the following:

(i) Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and

(ii) Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

(2)(4) An insurer is not required to include in its system of supervision an insurance producer’s recommendations to consumers of products other than the annuities offered by the insurer.

GD. Prohibited Practices. Neither a producer nor an insurer shall An insurance producer shall not dissuade, or attempt to dissuade, a consumer from:

(1) Truthfully responding to an insurer’s request for confirmation of the suitability consumer profile information;

(2) Filing a complaint; or

(3) Cooperating with the investigation of a complaint.

HE. Safe harbor.

(1) Sales made in compliance with SEC regulations and applicable FINRA requirements, rules pertaining to suitability best interest obligations and supervision of annuity transactions shall satisfy the
requirements under this regulation. This subsection applies to FINRA broker-dealer sales of annuities if, in connection with the sale of an annuity, the broker-dealer and the producer, who also is appropriately registered as a representative with FINRA, have complied with the business rules, controls and procedures for securities transactions; the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the insurance commissioner’s ability to investigate and enforce (including investigate) the provisions of this regulation.

**Drafting Note:** Non-compliance with SEC and FINRA requirements means that the broker-dealer transaction is subject to compliance with the suitability requirements of this regulation.

(2) For paragraph (1) to apply, an insurer shall:

(a) Monitor the FINRA member broker-dealer using information collected in the normal course of an insurer’s business; and

(b) Provide to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

**Section 7. Insurance Producer Training**

A. An insurance producer shall not solicit the sale of an annuity product unless the insurance producer has adequate knowledge of the product to recommend the annuity and the insurance producer is in compliance with the insurer’s standards for product training. An insurance producer may rely on insurer-provided product-specific training standards and materials to comply with this subsection.

B. (1) (a) An insurance producer who engages in the sale of annuity products shall complete a one-time four (4) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider.

(b) Insurance producers who hold a life insurance line of authority on the effective date of this regulation and who desire to sell annuities shall complete the requirements of this subsection within six (6) months after the effective date of this regulation. Individuals who obtain a life insurance line of authority on or after the effective date of this regulation may not engage in the sale of annuities until the annuity training course required under this subsection has been completed.

(2) The minimum length of the training required under this subsection shall be sufficient to qualify for at least four (4) CE credits, but may be longer.

(3) The training required under this subsection shall include information on the following topics:

(a) The types of annuities and various classifications of annuities;

(b) Identification of the parties to an annuity;

(c) How product specific annuity contract features affect consumers;

(d) The application of income taxation of qualified and non-qualified annuities;

(e) The primary uses of annuities; and

(f) Appropriate standard of conduct, sales practices, replacement and disclosure requirements.
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(4) Providers of courses intended to comply with this subsection shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer’s products. Additional topics may be offered in conjunction with and in addition to the required outline.

(5) A provider of an annuity training course intended to comply with this subsection shall register as a CE provider in this State and comply with the rules and guidelines applicable to insurance producer continuing education courses as set forth in [insert reference to State law or regulations governing producer continuing education course approval].

(6) Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with [insert reference to State law or regulations governing producer continuing education course approval].

(7) Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with [insert reference to State law or regulations governing producer continuing education course approval].

(8) The satisfaction of the training requirements of another State that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this State.

(9) The satisfaction of the components of the training requirements of any course or courses with components substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this State.

(10) An insurer shall verify that an insurance producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

Section 8. Compliance Mitigation; Penalties

A. An insurer is responsible for compliance with this regulation. If a violation occurs, either because of the action or inaction of the insurer or its insurance producer, the commissioner may order:

(1) An insurer to take reasonably appropriate corrective action for any consumer harmed by a failure to comply with this regulation by the insurer’s, an entity contracted to perform the insurer’s supervisory duties or by its insurance producer’s, violation of this regulation by the producer;

(2) A general agency, independent agency or the insurance producer to take reasonably appropriate corrective action for any consumer harmed by the insurance producer’s violation of this regulation; and

(3) Appropriate penalties and sanctions.

B. Any applicable penalty under [insert statutory citation] for a violation of this regulation may be reduced or eliminated [, according to a schedule adopted by the commissioner,] if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice.

Drafting Note: Subsection B above is intended to be consistent with the commissioner’s discretionary authority to determine the appropriate penalty for a violation of this regulation. The language of subsection B is not intended to require that a
commissioner impose a penalty on an insurer for a single violation of this regulation if the commissioner has determined that such a penalty is not appropriate.

Drafting Note: A State that has authority to adopt a schedule of penalties may wish to include the words in brackets. In that case, “shall” should be substituted for “may” in the same sentence. States should consider inserting a reference to the NAIC Unfair Trade Practices Act or the State’s statute that authorizes the commissioner to impose penalties and fines.

Section 9. [Optional] Recordkeeping

A. Insurers, general agents, independent agencies and insurance producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer, disclosures made to the consumer, including summaries of oral disclosures, and other information used in making the recommendations that were the basis for insurance transactions for [insert number] years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

Drafting Note: States should review their current record retention laws and specify a time period that is consistent with those laws. For some States this time period may be five (5) years.

B. Records required to be maintained by this regulation may be maintained in paper, photographic, micro-process, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

Drafting Note: This section may be unnecessary in States that have a comprehensive recordkeeping law or regulation.

Section 10. Effective Date

The amendments to this regulation shall take effect [six (6)X] months after the date the regulation is adopted or on [insert date], whichever is later.
APPENDIX A

PRODUCER RELATIONSHIP DISCLOSURE FORM

Date: ________________________

INSURANCE AGENT/PRODUCER INFORMATION (“Me”, “I”, “My”)

First Name: ______________________________ Last Name: __________________________
Firm Name: ______________________________ Website: _____________________________
Insurance License # _________________________

CLIENT INFORMATION (“You”, “Your”)

First Name: ________________________________Last Name: __________________________

INSURANCE AUTHORIZATION

I am licensed and authorized to sell insurance products, including annuities in [State] in accordance with state laws. I offer the following products:

- [ ] Fixed or Fixed Index Annuities
- [ ] Variable Annuities
- [ ] Options
- [ ] Other Investments

- [ ] Mutual Funds
- [ ] Stocks/Bonds
- [ ] Certificates of Deposits

I am authorized and contracted or appointed to sell:

- [ ] Products from ONLY ONE INSURER or Insurance Holding Company Group
- [ ] Products from Multiple Insurers

My Relationship with You:

- [ ] One-Time Commissioned Transaction
- [ ] On-Going Relationship with an asset under management fee
- [ ] Other Investments: ________________________________

I am likely to be compensated by the following sources for this relationship:

- [ ] Insurance Company
- [ ] The Consumer
- [ ] Third parties such as an Independent Marketing Organization (IMO) related to the Insurer

Other Sources ____________________________

ADDITIONAL INFORMATION
You may obtain further information regarding the cash compensation paid to me.
APPENDIX B

CONSUMER REFUSAL TO DISCLOSE ALL OR PARTIAL CONSUMER PROFILE INFORMATION FORM

I understand that should I decline to provide the requested information or should I provide inaccurate information, I am limiting the protection afforded me by the Insurance Code of this state laws regarding this purchase.

____ I REFUSE to provide this information at this time.

____ I have chosen to provide LIMITED information at this time.

____ My annuity purchase IS NOT BASED on the recommendation of this producer or the insurer.

__________________________________
Client Signature

__________________________________
Date

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Annuity Suitability (A) Working Group
Conference Call
July 29, 2019

The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call July 29, 2019. The following Working Group members participated: Jillian Froment, Chair (OH); Doug Ommen, Vice Chair (IA); Steve Ostlund (AL); Jodi Lerner (CA); Dean L. Cameron (ID); Tate Flott and Shannon Lloyd (KS); Nour Benchaaboun (MD); Renee Campbell (MI); Matt Holman (NE); Keith Nyhan (NH); Andrew Schallhorn (OK); Elizabeth Kelleher Dwyer, Matt Gendron and Sarah Neil (RI); Lorrie Brouse (TN); and Richard Wicka (WI).

1. Discussed “Parking Lot” Issues Related to Proposed Revisions to Model #275

Director Froment reminded the Working Group of its goal from its July 23 conference call, which is to continue to discuss at a high level a framework for revising the Suitability in Annuity Transactions Model Regulation (#275) to include a best interest standard of conduct that is more than the model’s current suitability standard, but not a fiduciary standard. She reminded the Working Group that a series of questions involving some of the highlighted issues discussed during its June 20 meeting was distributed for comment during its July 23 call. She said the Working Group finished discussion of the questions related to the conflict of interest topic during its July 23 call. During this call, the Working Group would discuss the questions related to the care obligation.

The Working Group discussed whether the care obligation should include a requirement for the producer to exercise “prudence” in developing a recommendation. Ms. Lerner said she had submitted comments on this issue suggesting retaining the “prudence” requirement. Director Froment asked Ms. Lerner if her comment would change given that the Working Group is not looking to include a fiduciary standard in the Model #275 revisions. Ms. Lerner said she would still recommend retaining the requirement because the producer or insurer is dealing with a consumer’s retirement savings.

Commissioner Ommen discussed the Iowa Department of Insurance’s (DOI) reasoning for including “prudence” in its suggested revisions to Model #275 and why it recommends removing the requirement. He explained that the Iowa DOI included “prudence” in its suggested revisions because the U.S. Securities and Exchange Commission (SEC) included it in its proposed best interest regulation. However, the final best interest regulation removed it. Commissioner Ommen also explained that in Iowa, and most likely other states, “prudence” is tied to the “prudent investor rule,” which encourages the conservation of assets. He said its use creates a legal standard such that a producer or insurer could not recommend a variable annuity because a fixed annuity would be the prudent recommendation under the conservation of assets concept. The Working Group discussed the issue.

Birny Birnbaum (Center for Economic Justice—CEJ) encouraged the Working Group to include “prudence.” He said its use would elevate the model to a best interest standard. He suggested that the comments against including it concerned securities law and as such, this concern can be addressed by defining “prudence.” Mr. Gendron asked Mr. Birnbaum to provide an example that state insurance regulators could not prosecute if the word “prudence” is not included. Mr. Birnbaum said at this point, there is nothing in the proposed Model #275 revisions requiring a producer or insurer to make a recommendation in the consumer’s best interest without using the word “prudence.” Ms. Lerner asked Mr. Birnbaum for a definition of “prudence.” Mr. Birnbaum said he would provide this information in written comments later. Gary A. Sanders (National Association of Insurance and Financial Advisors—NAIFA) said NAIFA does not believe “prudence” should be included in Model #275.

The Working Group discussed the issue further, including a few scenarios and other potential revisions to Model #275, such as the use of the words “best suited,” as a potential language to address Mr. Birnbaum’s concern. Commissioner Ommen said as the proposed revisions to Model #275 reflect, there is more to the best interest obligation than the care obligation.

The Working Group discussed whether it is an appropriate standard to require a producer when making a recommendation, the recommendation be considered reasonable for an “ordinary” producer to make in a similar circumstance. Commissioner Ommen explained why the Iowa DOI included this language in its suggested revisions. Ms. Lerner said she believes an “ordinary” producer standard is too low. After additional discussion, the Working Group agreed not to include this suggested language in the next Model #275 draft revisions.
The Working Group discussed whether a producer should provide an **oral or written** description of the basis of the recommendation to the consumer or whether a producer should provide an **oral and written** description of the basis of the recommendation to the consumer. Ms. Lerner said the consumer should receive both an oral and written description of the producer’s basis of the recommendation. She said the written description should be understandable and expressed support for developing a form or template for producers to use to satisfy this requirement. Director Froment discussed the concerns some Working Group members expressed during the Working Group’s June 20 meeting with requiring a written description because a producer’s recommendation could be based on oral conversations with the consumer during initial client meetings. Commissioner Ommen also voiced potential difficulties with a written requirement. He expressed support for giving producers the option of oral or written. He also pointed out that there is a requirement for producers to provide a written documentation related to the recommendation under the documentation obligation. Director Cameron expressed support for giving producers the option.

The Working Group discussed the issue further, debating the challenges of requiring a producer to provide a written description of the basis of the recommendation as part of the producer’s communications with the consumer during initial client meetings, particularly in light of the requirement for the producer to document the basis of the recommendation under the documentation obligation. The Working Group also discussed the value of written documentation as compared to effective communication and the importance of effective communication, whether oral or written.

Having no further business, the Annuity Suitability (A) Working Group adjourned.
Annuity Suitability (A) Working Group
Conference Call
July 23, 2019

The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call July 23, 2019. The following Working Group members participated: Jillian Froment, Chair, and Michelle Brugh Rafeld (OH); Doug Ommen, Vice Chair, Johanna Nagel and Lindsay Bates (IA); Steve Ostlund (AL); Jodi Lerner (CA); Dean L. Cameron and Geoff Baker (ID); Nour Benchaaboun, Tate Flott and Shannon Lloyd (KS); Nour Benchaaboun (MD); Randall Gregg (MI); Bob Harkins (NE); James Regalbuto (NY); Denise Lamy (NH); Andrew Schellhorn (OK); Elizabeth Kelleher Dwyer, Matt Gendron and Sarah Neil (RI); Michael Humphreys and Lorrie Brouse (TN); and Richard Wicka (WI). Also participating were: Vincent Gosz (AZ); Chris Struk (FL); Mike Chrysler (IL); Robert Wake and Lindsay Laxon (ME); Daniel Morris (SC); Travis Jordan (SD); Melissa Gerachis (VA); and Scott Bird (WA).

1. Discussed “Parking Lot” Topics from July 10 Comments

Director Froment provided an overview of the discussion from the Working Group meeting held June 20 in Columbus, OH. She explained that, following the meeting, the Working Group received eight comment letters by the July 10 deadline on the two “parking lot” topics from that meeting, including “conflict of interest” and “care obligation,” and the questions posted under each topic.

Director Froment stated that the goal of the Working Group is to define “best interest.” She explained that “best interest” is something more than suitability and something less than fiduciary. She said that because there are parties that must comply with the U.S. Security and Exchange Commission’s (SEC) best interest regulation in addition to insurance law, the Working Group will need to harmonize the Suitability in Annuity Transactions Model Regulation (#275) with the SEC regulation.

Director Froment said that as the Working Group drafts further revisions, she wants to use, as a starting point, Iowa’s proposed draft revisions to Model #275, dated May 30, 2019, because they were drafted in an attempt to harmonize with the SEC best interest regulation.

2. Discussed the Conflict of Interest Topic

a. Question 1: What constitutes a material conflict of interest when recommending annuities?

Director Froment explained that, based on the comment letters, there are two situations in which there is a potential material conflict of interest: 1) a financial conflict, based on the producer’s fees, payment or commissions; and 2) a producer with ownership interest in a parent, subsidiary or affiliate of the insurer offering the annuity.

Commissioner Ommen suggested separating extraordinary compensation (including sales contests, quotas and bonuses) from typical compensation such as common commissions or fee structures.

Ms. Lerner said even typical compensation practices could be concerning. She said the higher the commission, the greater potential conflict.

Mr. Gregg agreed with Commissioner Ommen that compensation creates a per se conflict of interest.

Ms. Neil stated that Rhode Island is also concerned about the manner in which agents are paid. She asked, once the commission is paid, what incentivizes an agent to advise that a consumer hold an investment, rather than replace it in order to obtain another commission.

Director Froment explained that there might be conflicts the producer can control and some that only the insurer can the control.

Commissioner Ommen said insurers should be responsible for managing a producer’s conflicts and incentivizing them appropriately.
Ms. Brouse said the mere fact that an agent is being compensated does not necessarily create a conflict. But insurers need to have processes in place to determine whether producers are manipulating the program to the disadvantage of the consumers.

Director Cameron said producers rarely know what compensation is for a particular product. Therefore, the regulation should not penalize agents from being compensated for selling products that help consumers achieve retirement. He stated that everyone expects agents to be paid. He recommended including a section of the model prohibiting an agent from considering non-cash compensation when recommending a product.

Director Froment summarized the discussion by explaining that there are three levels of what could create a conflict of interest, but not all of them rise to the level of a material conflict of interest: 1) a producer’s basic fees and commissions; 2) sales, quotas, bonuses and non-cash compensation that incentivizes sales of a specific product within a certain time frame; and 3) a producer’s ownership interest.

Director Froment continued by explaining that, as part of the disclosure obligation, producers should disclose that they earn a commission. Further, the ownership interest rises to the material level and probably needs its own disclosure, although that conflict would not apply to many producers. Finally, carriers should be responsible for supervising and monitoring any potential conflicts related to non-cash compensation to ensure that the incentives are not causing conflicts.

Ms. Lerner expressed her belief that disclosure of compensation should be dealt with in the supervisory section. It should be up to the insurers to notify the agents and intermediaries as to what their duties and obligations are.

Commissioner Ommen said he does not want insurers to be obligated to sit down with other insurers to determine what the compensation structure should look like, but insurers should manage the incentives.

Mr. Gendron said he would like to narrow the issue of when sales quotas create a conflict and leave this to the carriers. Director Froment agreed that the Working Group should refine that issue, because it could include a number of things.

Director Cameron explained that carriers can have an increased role in supervising, but there needs to be a better understanding of how that would work. A carrier might have overlapping incentives occurring at once, for varying lengths of time. He said if a carrier is required to disclose the incentives, the agent would need to figure out a way to explain that to the consumer. The real issue, he said, is that consumers do not want to be directed to a product because the agent would make more money. He said it would be counterproductive to force an independent agent to find out what incentives each carrier is providing.

Commissioner Ommen clarified his position on sales quotas, explaining that if sales quotas are generalized, and not tied to a specific product, it would not hinder an agent’s ability to find the best product on their shelves, based on the consumer’s profile. The insurance company is in the best position to address this.

Director Froment summarized the discussion, explaining that a producer has only so much control over certain items and the insurer is the only party that can control specific commissions, quotas and sales. She noted the Working Group’s agreement that: 1) producers should disclose that they are receiving a commission; 2) the potential for conflict in the context of incentives, which she said is about insurer supervision; and 3) producers should disclose if they have an ownership interest in a company.

Director Froment then asked for comments from interested regulators.

Mr. Wake explained that the Working Group is working to craft a standard that is more than suitability but less than fiduciary. He said producers are salespeople who work for insurance companies and insurers are in the business of giving incentives to producers to sell their product. He said it would be unrealistic to demand that insurers and producers be disinterested, but there is a need for consumers to understand clearly why insurers and producers are not fiduciaries. He said some material conflicts of interest are abusive and some are “baked” into the system. He said just because something is permissible does not mean it is not in the category of a conflict that needs to be disclosed. Separately, insurers are going to incentivize producers to sell their products, so there needs to be standards for determining when this is inappropriate. The issues that need to be addressed are when to disclose and when to mitigate. Simple commissions are currently being called a conflict and prevent agents from being totally disinterested.

Director Froment then asked to hear from interested parties.
Jason Berkowitz (Insured Retirement Institute—IRI) said that with respect to the middle “bucket” (i.e., providing guidance on how insurers should supervise) is helpful and asked that as Working Group members think about how to provide that guidance, the Working Group should keep in mind that there are producers selling products for multiple carriers. He stated his concern that the Working Group is sure not to impose supervisory responsibilities on one carrier that would extend to them supervising other carriers.

Gary Sanders (National Association of Insurance and Financial Advisors—NAIFA) agreed that regular commissions should be part of disclosure obligation. He explained that the way NAIFA members conduct business, there is a strong disincentive to go after the highest commission all the time. He said most agents are not transaction-based but relationship-based, so it is in their own best interest to look after their client’s best interest or they would lose that client relationship.

Birny Birnbaum (Center for Economic Justice—CEJ) said it is important to keep in mind that people are turning over their lifetime savings. Therefore, he said, any comparisons to auto insurance and other types of insurance are not applicable. He stated his disagreement with what he called an artificial demarcation between different types of compensation. He said the idea of focusing on bonuses or sales contests, rather than the fundamental commission structure, is misplaced. It is insurers and insurance marketing organizations (IMOs) that should have the responsibility for developing and deploying compensation structures that do not conflict with a best interest standard of care. He explained that if a producer must disclose this, it would have to be with information provided by the insurer or the IMO.

Commissioner Ommen stated that, regarding independent agents, one of the challenges is how a single carrier can manage different levels of compensation in that distribution structure.

Mr. Birnbaum answered that a carrier is responsible for developing its compensation arrangement with a particular producer. And if a producer uses several companies, that producer should get the same information from each company. It should not be the agent’s responsibility to disclose more than what the insurance company provides regarding the compensation they are receiving.

Director Froment asked Mr. Birnbaum to clarify his position on disclosure, as there is some confusion over whether the CEJ believes disclosure is helpful or a hinderance.

Mr. Birnbaum explained that there are situations where disclosure would empower a consumer and situations where it would not. He said annuities are extremely complex products that include illustrations. He said the CEJ’s concern is that adding another set of disclosures would not be effective. The disclosure should be simple and comparative between different products the producer offers. Mr. Birnbaum said there should be a requirement in the regulation that insurance companies or IMOs should employ a compensation scheme that does not undermine a best interest standard of care. Further, he stated that compensation schemes should be designed to avoid churning or unsuitable sales. And that compensation schemes should be designed to compensate or reward a producer for selling a product that stays in force to reflect the long-term investment nature of annuities.

Kim O’Brien (Fixed Annuity Consumer Choice—FACC) expressed her view that the Working Group should work on creating an objective standard and that the conversation has focused on subjective components. She said carriers and producers need to know what the standards are and what they are required to disclose, stating that a template would be helpful.

Director Froment agreed that there needs to be objective standards that both producers and insurers can comply with and regulators can enforce. She explained that the Working Group needs to coalesce around the broader ideas first and then it will drill down to the specifics.

Director Froment turned back to the Working Group, explaining that the Working Group has set forth the idea of three “buckets” that constitute the potential conflicts of interest. She explained that the first one, commissions, has been addressed in the disclosure obligation, noting that the Working Group still needs to determine if there is anything further to do under that area. Then, she explained that there is a second category, incentive compensation, which the Working Group has agreed is the insurer’s role under supervision. Finally, she explained that there is the ownership interest, which would require disclosure of the conflict so a consumer could decide whether to proceed with that producer.

Director Froment then asked whether any other regulators had thoughts on what else might constitute a material conflict of interest.
Ms. Lerner sought clarification as to whether it is the producer’s job or the insurer’s job to reveal fees, commissions and incentives. Director Froment said the disclosure obligation includes the scope and terms of the relationship; i.e., that the producer is paid when he or she sells a product. But that the producer has no ability to influence incentive compensation, so that obligation falls to insurer. Finally, she said the producer would need to disclose to the consumer if there is any ownership interest. Ms. Lerner then stated that she did not see it as the insurer’s obligation to disclose but the insurer should tell the agent what to reveal.

Commissioner Ommen agreed with Ms. Lerner that the suggestion that the middle “bucket” is a management, supervisory and structural responsibility of the insurer takes the producer off the hook for disclosure. He said the Working Group needs to look at what the producer’s disclosure should look like. He said the problem is incentives are tied to specific products. Director Froment said these would go under supervision. Commissioner Ommen agreed.

Director Froment asked whether there were any additional material conflicts of interest that do not fit into one of the three “buckets.”

Director Cameron said that some might perceive the ability for a carrier to provide office space as a potential conflict. He said he did not think office space fits in the compensation or bonus “bucket,” but it might be a subcomponent of incentives. He further explained that there are some property/casualty (P/C) carriers that incentivize their agents to sell life insurance and retirement products.

Ms. Lerner asked whether P/C carriers incentivize them with higher commissions. Director Cameron said it is part of their overall package. It might be a requirement that in order to qualify for a trip, a producer would have to sell a percentage of life and annuities.

Mr. Ostlund said it sounds like a quota system, as opposed to an incentive, and asked for clarification. Director Cameron said it depends on the company; some are quotas and some are incentives and some classifications have different commission structures. Mr. Ostlund said these would fit into the second category and he would prefer not having a fourth category. Director Cameron agreed.

Director Froment said that in following up from this call, she would like to take the broad category of conflicts and start identifying what is in the second “bucket.”

b. **Question 2:** When a material conflict of interest exists, how should an insurer and/or a producer avoid or otherwise reasonably manage the conflict?

Director Froment said that some of the discussion on the call included answering the second question under “Conflicts: When a material conflict of interest exists, how should an insurer and/or a producer avoid or otherwise reasonably manage the conflict?” But because she did not specifically ask the second question, she asked whether anyone in the Working Group had final comments on this question.

No one responded, so Director Froment concluded by saying she would circulate a chart and outline to members of the Working Group. She said the Working Group would look at questions under “Care Obligation” on the next call, which is scheduled for July 29.

Having no further business, the Annuity Suitability (A) Working Group adjourned.
Mr. Yanacheak reminded the Working Group that it had last met July 29 via conference call, shortly before the Summer National Meeting. During that conference call, the Working Group considered outstanding issues remaining with revisions to the Annuity Disclosure Model Regulation (#245). Mr. Yanacheak summarized where the Working Group ended up on these issues. First, the Working Group settled on allowing the illustration of an index that has not been in existence for at least 15 years if certain criteria are met. Second, the Working Group agreed to require any algorithm or other method of combining the indices to be fixed from the creation of the index, without an exception for changes made pursuant to the index provider’s corporate governance rules and procedures. Third, the Working Group agreed that there should be visual differentiation between indexed returns that are based on historical performance prior to the existence of the index and indexed returns that are based on historical performance thereafter.

Mr. Yanacheak said there are two remaining issues that he would like the Working Group to discuss and resolve. The first issue is whether to allow the illustration of indices made up of only other indices, or to allow the illustration of indices made up of indices or “other financial instruments.” He explained that this issue was discussed during the Working Group’s July conference call, but because there was no working understanding of what was meant by “other financial instruments,” efforts to reach a real resolution were unsuccessful. Mr. Yanacheak explained that he had received feedback from state insurance regulators at the Summer National Meeting indicating that there needs to be a clear understanding of what is meant to be included in the index if it is more than an index made up of other indices. The second issue is whether the algorithm should be made available to the consumer for inspection, or is making it available to the insurance commissioner sufficient.

2. Discussed Availability of the Algorithm to Consumers

Mr. Yanacheak explained that over the past several years, there has been a discussion of the need for indices to be auditable. Many indices have straightforward rules that can be seen and understood and can be challenged if there is a disagreement as to what the closing value of an index is. He explained that some of the newer indices that this Working Group is charged with reviewing in the context of Model #245 are not widely used, and in some cases are only used in insurance products. He said this raises the question as to who has the ability to audit such an index and verify that the index is calculated correctly and the amount being credited to consumers is the correct amount. Mr. Yanacheak said there was a concern among state insurance regulators that if an insurance company is seeing a match between its hedging and the increase in it is having to fund, the insurance company would be satisfied as long as that was within its tolerances and may not feel the need to do a routine audit. Therefore, someone else needs to have that ability. He said the initial suggestion was to make the algorithm available to the insurance commissioner for review to audit the index that is being published to make sure it is accurate. He said there was also the suggestion that the algorithm should be made available to the consumer upon request.

Mr. Struk said he supports making the algorithm available to the insurance commissioner. Mr. Benchaaboun said Maryland also supports making the algorithm available to the insurance commissioner. He said Maryland has statutes and regulations that allow for the collection of documents in the context of market conduct exams, but he believes that in this context, it is important for the insurance commissioner to explicitly have access to this information for audit purposes. Robbie Meyer (American Council of Life Insurers—ACLI) said the ACLI supports making this information available to the insurance commissioner because, as Mr. Benchaaboun stated, there are multiple avenues under existing authority whereby the insurance commissioner could obtain this information. She said the ACLI has concerns about making this information broadly available to consumers upon request. Ms. Meyer said that while some rule books for some indices are in the public domain, the vast majority of rule books for custom indices are not in the public domain, and insurers have entered into licensing agreements that prohibit or limit the distribution of rule books because often the rule books contain intellectual property of the index provider.
She said the ACLI fully supports consumers understanding what they are purchasing through meaningful disclosure of the features and benefits. She said consumers can obtain information that is more meaningful than the algorithm from disclosures already required under other sections of Model #245. She said the ACLI would like to eliminate the reference to making the algorithm available to the consumer upon request.

Birny Birnbaum (Center for Economic Justice—CEJ) noted the contradiction in the ACLI argument that consumers should have disclosures so that they understand the product, but not have the right to see how actual changes to the index that determine the value of their product are made. He said it is necessary and reasonable to have access to methodology by which the value of an index changes so they can verify that the account value is an accurate calculation of the changes in the index. He said the CEJ thinks it is unrealistic to expect state insurance regulators to monitor and audit algorithms for a variety of insurers and products on a routine and timely basis. He said that is pretend consumer protection, not real consumer protection. He said there is no reason for the use of complex proprietary algorithms in fixed indexed annuities. Mr. Birnbaum said there is plenty of reasons why companies may want to use hedging programs that involve a variety of complex algorithms, but there is no reason for their use in indexes for fixed indexed annuities. He said the concept of using volatility-controlled indexes in a product that is structurally designed by itself to be a volatility-controlled device does not make sense. He said the idea that a licensing agreement somehow prevents disclosure to consumers is completely false. He said licensing agreements prevent use of the information for commercial purposes; they do not prevent the disclosure to a consumer to understand how the value of their product is determined. One example of the broader problem is allowing these data mined indexes to be used based on obscure and complex algorithms. This is destined to be a huge scandal for the industry and problem for state insurance regulators.

Ms. Neil said she shares some of Mr. Birnbaum’s concerns. She said a history that only exists within a particular illustration is different from something public like the S&P 500, which can be researched. She said she is not convinced that consumers can understand an algorithm, and she does not want to disclose trade secrets, but the only choice for consumers should not be to take a company’s word for it. She said it is important that consumers are able to independently verify information.

Ms. Meyer said the ACLI struggles with the breadth of this particular provision, which requires that “any algorithm or other method that is supporting such an index and is included in the illustration shall be made available ….” She said it is important for consumers to understand, but we need to be sure that disclosure is legal and that the information disclosed is meaningful. She said she supports retaining Section 6G(4)(b)(ii)(IV), which states that “[t]he consumer may request further explanation of the algorithm used to determine the weights.” She said there are other existing requirements in Model #245 that also allow the consumer to get more detailed information about the product, including the disclosure document and the Buyer’s Guide.

Mr. Birnbaum said a fundamental selling point for these products is their ability to accumulate assets over time. He said it is illogical not to share the method by which the accumulated value is calculated. He said it is inadequate disclosure to tell a consumer that a proprietary methodology is used and that it will periodically change. He said it is a false argument to assert that a licensing agreement prohibits insurers from providing basic information about a product to a consumer. Mr. Robinson proposed making the algorithm available to consumers if it is readily available. He explained that the reason is because if consumers ask to see the algorithm, and it is unavailable, that will factor into their purchasing decision. Consumers may decide if it cannot be explained to them, then they will not buy it. Mr. Struk said he likens purchasing this product to buying a mutual fund. He said a mutual fund may use an algorithm, but he would not share it with consumers because it is a proprietary investment method. Mr. Birnbaum said there is a difference between buying a security or a managed product where there is no guarantee, floor, cap or limit. He said buying an insurance product is different because there are guarantees made based on references to a specific index or indexes. Mr. Struk said he sees a similarity between the algorithm and the fund manager, which both react to changes in the market and take it outside the passive investment arena.

Mr. Yanacheak said his concern is that if the hedging is working out for the insurance company, but the consumer has a question because his or her account value is not increasing as expected, is there a way to challenge the calculation. He said, in his mind the insurance commissioner has to be able to, at a minimum, intervene to explain. He said this is not an issue with a public index that is used more than just in an insurance product. Mr. Yanacheak said where there is no use case for the index, it becomes problematic. Mr. Birnbaum said changes to the disclosure requirements will change insurer behavior. He said if the algorithms must be disclosed to consumers, insurers will respond with products that are more transparent and that will better meet consumer needs. He said this is the result of manipulating historical experience to create a fabulous illustration. He said this creates an unusually large disconnect between past experience and future performance because the past is a product of data mining, and there is no way that will work on a going forward basis. Ms. Meyer pointed out that Model #245 already requires a disclosure that states that past performance is not an indication of future performance.
Mr. Struk suggested including a drafting note suggesting that states may want to consider making the algorithm available to consumers upon request. Mr. Benchaaboun noted that algorithms are not required to be filed during the product approval process. Mr. Yanacheak asked Working Group members how they want to handle this issue. Florida, Kansas, Maryland and Minnesota said they would like the algorithm to be made available to the insurance commissioner only, with a drafting note stating that states may want to consider making the algorithm available to consumers upon request. Rhode Island and Texas indicated they would like the algorithm to be made available to the insurance commissioner and to consumers upon request. Mr. Yanacheak said the next draft would have the algorithm available to the insurance commissioner, with a drafting note to the states.

3. Discussed How to Describe What Is Meant by “a Combination of Indices or Other Financial Instruments”

Mr. Yanacheak said he would like to discuss what the Working Group thinks should and should not be allowed to be illustrated, whether that is called “indices” or “other financial instruments.” Ms. Meyer suggested allowing the illustration of indices or other financial instruments, each of which has its own verifiable and published performance history and has been in existence for 15 years. Mr. Birnbaum suggested a minimum requirement that a daily value is published. Mr. Yanacheak gave some examples of financial reference points used in certain products to see whether the Working Group thought it should be allowed to illustrate. He said there are products that have used the closing price on gold or other commodities, like oil. He said other products use currency or a blend of currency exchange rates. He said exchange-traded fund (ETF) closing prices are also used and wondered whether they should be allowed. He said he is not sure any of these could be considered indices. Pat Reeder (ACLI) said he could take this issue back to the ACLI membership.

Mr. Robinson said there are lots of financial instruments that can be used as a referent to come up with a credited rate. He said the question is whether anything should be disallowed from an illustration perspective. Mr. Robinson pointed out that the indices or financial instruments used are not totally random; they are limited by what hedges are available. Mr. Yanacheak said a revised draft based on the Working Group’s recent discussions would be distributed to Working Group members, interested state insurance regulators and interested parties and posted on the Working Group’s web page. He requested comments and suggestions on the issue of how to bring clarity to what indices or other financial instruments should be allowed to be illustrated.

Having no further business, the Annuity Disclosure (A) Working Group adjourned.
Accelerated Underwriting (A) Working Group
Austin, Texas
December 8, 2019

The Accelerated Underwriting (A) Working Group of the Life Insurance and Annuities (A) Committee met in Austin, TX, Dec. 8, 2019. The following Working Group members participated: Robert H. Muriel, Chair, Mike Chrysler, Patrick Hyde and Bruce Sartain (IL); Grace Arnold, Vice Chair, and Fred Andersen (MN); Doug Ommen and Mike Yanacheak (IA); Rich Piazza (LA); Cynthia Amann (MO); Chris Aufenthie (ND); Matt Holman and Rhonda Ahrens (NE); Mark Hamlin (OH); Sarah Neil (RI); and Mark Afable, Rickard Wicka and Lauren Van Buren (WI). Also participating were: Steve Ostlund (AL); Cuc Nguyen (OK); Michael Humphreys (PA); and Rachel Hemphill (TX).

1. Adopted its Oct. 2 Minutes

Director Muriel said the Working Group met Oct. 2. During this meeting, the Working Group developed a work plan for completing its charge by the 2020 Fall National Meeting.

Ms. Amann made a motion, seconded by Commissioner Ommen, to adopt the Working Group’s Oct. 2 minutes (Attachment Four-A). The motion passed unanimously.

2. Heard a Presentation on Accelerated Underwriting in Life Insurance

Patrick Brockett (The University of Texas at Austin) gave a presentation on accelerated underwriting in life insurance. He explained that life insurance is based on three concepts: 1) pooling many similar risk exposures into a relatively homogeneous group; 2) accumulating a fund through contributions (premiums) from the members of the group; and 3) paying from this fund for the losses of those who die each year. He said that life insurance underwriting is the process of deciding which life insurance applicants to accept, how to group them, and how to charge them appropriate premiums for their risk class. He explained that this traditionally involves assessing a person’s physical health, usually by blood work, urine analysis, doctor’s notes, physical exams, etc.

Mr. Brockett explained that the premium that an insurance company charges reflects more than just the risk class of the insured. He said the premium actually charged by the insurer takes into account multiple factors, including the probability that a person will die during the year, the face value of the policy, projected losses, commissions and administrative expenses, risk charge, taxes, and any investment income on premiums.

Mr. Brockett explained that accelerated underwriting is a fully underwritten life insurance program that allows some applicants to forgo having a medical or paramedical exam and providing fluids if they meet certain requirements and/or meet a certain pre-determined threshold, as is stated in the Klein & Rudolph, June 2019 SOA Report. He said that accelerated underwriting generally makes use of new data together with algorithmic tools and modeling techniques to risk group applicants quickly without the necessity of bodily fluids, physician’s notes, etc. For those who qualify, the use of available digital data can reduce the underwriting decision time from two to 12 weeks down to no more than 48 hours.

Mr. Brockett explained that accelerated underwriting is used by many companies, and it is most commonly used to issue term life insurance policies. He said policyholders usually pay the same rate as standard underwritten policies, but the underwriting decision is made much more quickly. He said if an applicant is in very good shape and could qualify for preferred rate pricing, standard underwriting might result in a lower priced product. He said accelerated underwritten insurance is not a guaranteed issue, and it differs from simplified issue insurance, which is insurance with no requirement for a physical exam. He explained that with accelerated underwriting, there is an assessment of physical fitness obtained from digital data. He said simplified issue premiums are expected to be more expensive than if the applicant had undergone a full underwriting process. He said accelerated underwriting premiums are equivalent to standard rates through regular underwriting.

Mr. Brockett said accelerated underwriting replaces the use of bodily fluids and doctor’s notes with the use of algorithms and data sources, such as prescription histories, motor vehicle records (MVRs), Medical Information Bureau (MIB) information, applications, interviews, consumer data, and credit scores. He said certain non-health factors, such as certain non-health factors

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are considered, they and vary by insurer. He said some insurers require no history of bankruptcy in the last five to 10 years, no history of driving recklessly or driving while intoxicated (DWI) within five years, no more than two moving violations in the past three years, and no felony charges or convictions. He said the minimum benefit amount is usually around $100,000, and the maximum benefit amount is usually around $1,000,000. He said that applicants may still need to go through regular underwriting if certain risk factors show up in accelerated underwriting.

Mr. Brockett listed some of the advantages of accelerated underwriting as opposed to regular underwriting: 1) it allows for faster decisions; 2) it is less costly to insurer, less invasive, easier way of doing business, standard or better underwriting, easier to file data, possibly more accurate underwriting, attracts younger clients, and eliminates personal bias. Conversely, he said there are limitations to be considered, like the differing state laws governing insurance and procurement data make it difficult to streamline underwriting practices. He said increased digitalization opens insurers up to new data for underwriting use, but also possibly more fraud. He said careful attention will have to be given to data privacy and security concerns. He said care must be taken when using machine learning and artificial intelligence (AI) techniques to avoid “learned” statistical biases. He said models will have to be continuously updated to maintain accuracy.

Professor Brockett also pointed out some potential areas of controversy. He said the use of complicated underwriting algorithms raises the possibility of unknown or unrecognized proxy discrimination and makes underwriting decisions more difficult to explain to clients and regulators. He said social data is more susceptible to high variances and heteroskedasticity in estimated model weights. He said another concern may be adverse selection against applicants that forego certain fluid testing.

Professor Brockett spoke about the use of credit history and other financial data in life insurance. He said credit scores are widely accepted in the P&C industry, and certain aspects of financial history have long been used in life insurance (e.g., the applicant will have to justify if the amount of insurance desired is very much more than their income level). Nevertheless, he said, because better credit scores correlate with a longer life, it may be a useful predictor. He said other uses of credit history variables in life insurance may require further study to show independent predictive value. He said a credit-mortality score can be created just like a credit insurance claim score was created for auto insurance.

Mr. Brockett said the Society of Actuaries (SOA) hired Milliman to conduct a survey of the accelerated underwriting practices of direct insurers and reinsurers. The Klein & Rudolph, June 2019 SOA Report presenting preliminary results of the survey is available on the SOA website. 27 life companies and five reinsurers responded to the survey on their accelerated underwriting programs related to data between Jan. 1, 2017, to Sept. 30, 2018.

Commissioner Ommen asked Mr. Brockett what kind of information is included in “consumer data” and what the data sources are used for. Mr. Brockett said consumer data includes credit data and data from social media platforms. He said social media data is currently used in claims verification. He said he did not think scanner data from grocery stores was being used, but it may be in the future. As far as the extent to which this kind of data is being used, he said he got his information from the preliminary data in the Klein & Rudolph, June 2019 SOA Report. He said more information will be available in the final report.

Ms. Hemphill asked Mr. Brockett how accelerated underwriting reduced bias. Mr. Brockett said that people have cognitive biases and may focus on one thing and reach different decisions with identical facts, while modeling and algorithms will always reach the same decision with the same data. He said that there may be some bias because machines are trained to emulate humans, but people can also train machines to remove human biases. Ms. Hemphill said there are some states that do not allow the use of credit scores in underwriting. Mr. Brockett agreed that there are states that prohibit the use of credit scoring in underwriting; there was a 2005 study in Texas that looked at credit score and race and concluded that credit scoring could not be used to accurately predict race.

Birny Birnbaum (Center for Economic Justice—CEJ) questioned whether someone rejected under the accelerated underwriting process could credibly expect to be accepted through the regular underwriting process. He also disagreed with Mr. Brockett with respect to the use of credit scores as a proxy for race, and he said there is a disparate impact on people of color when credit scoring is used in underwriting. He said he is also concerned about the use of facial analytics in underwriting, which has been shown to have disproportionately high error rates for women and people of color. Mr. Brockett said facial analytics can be useful in estimating life expectancy. Brendan Bridgeland (Center for Insurance Research—CIR) said using facial analytics to track aging makes sense, but the technology is not ready yet. He also asked why bankruptcy would be an automatic denial. He said he suspected that it was because there may be medical bills or risky behavior in financial aspects of one’s life, suggesting risky behavior in other aspects of life. In that case, it is duplicative of credit scoring.
Mr. Sartain asked whether reinsurers used their own underwriting algorithms and which company’s algorithms apply if there is a conflict with a ceding insurer. Donna Megregian (SOA) said that reinsurers do not re-underwrite; they accept the ceding insurers conclusions.

3. Discussed Next Steps

Director Muriel reminded the Working Group that the work plan contemplates three phases to its work. He said that Mr. Brockett’s presentation initiated the first phase—information gathering. He asked Working Group members, interested state insurance regulators, and interested parties to email any articles or presentation suggestions to Jennifer Cook (NAIC) at jcook@naic.org. He said the Working Group plans to meet via conference call during the third week of January 2020.

Having no further business, the Accelerated Underwriting (A) Working Group adjourned.
Accelerated Underwriting (A) Working Group
Conference Call
October 2, 2019

1. Discussed its Draft Work Plan

The Working Group members introduced themselves. There were a variety of divisions within the departments represented, as well as varying areas of expertise, years of service and levels of familiarity with the topics of accelerated underwriting and big data. Director Muriel explained that the Working Group received its charge “to consider the use of external data and data analytics in accelerated life underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue and, if appropriate, drafting guidance for the states” from the Life Insurance and Annuities (A) Committee at the Summer National Meeting in response to a referral from the Big Data (EX) Working Group. He explained that the Big Data (EX) Working Group looked at how the use of data models for life insurance underwriting has become more common and identified a couple of issues initially, such as: 1) whether state insurance regulators should be examining vendors that are supplying data to insurers; and 2) whether vendors are supplying similar data and models to multiple insurers. He said that the Life Actuarial (A) Task Force is also focusing on the actuarial soundness of the new data being used and potential long-term solvency issues.

Director Muriel said the draft work plan sets an ambitious schedule for the Accelerated Underwriting (A) Working Group to complete its charge by the 2020 Fall National Meeting. He explained that the work plan starts with the Working Group spending the time between the 2019 Fall National Meeting and the 2020 Spring National Meeting gathering information. He said this phase is critical to ensuring that everyone participating in the process has a certain level of understanding, especially given the make-up of this Working Group. He said the Working Group will start with hearing a presentation at the Fall National Meeting from Patrick L. Brockett (The University of Texas at Austin), an accomplished academic in this area. Following this initial meeting in Texas, Director Muriel said he anticipated hearing additional presentations offering different perspectives, such as actuarial, industry, consumer and also other states. He suggested reaching out to Jennifer Cook (NAIC) with any suggestions for presenters. Director Muriel said the second phase of the work plan, between the 2020 Spring National Meeting and 2020 Summer National Meeting, has the Working Group identifying issues and discussing whether or what issues need to be addressed and the best ways to address them, whether that is a white paper, model bulletin, model law or something else. He said the last phase of the work plan envisions the Working Group developing a work product to bring to the Life Insurance and Annuities (A) Committee by the 2020 Fall National Meeting.

Director Muriel referenced the comment letter on the work plan submitted by Birny Birnbaum (Center for Economic Justice—CEJ), which raised the concern that the work plan contemplates spending too much time gathering information and revisiting issues that have been the subject of presentations and discussions at other NAIC groups over the past several years. Director Muriel said he appreciates Mr. Birnbaum’s comments and said the timing contemplated in the work plan is flexible and can be adjusted if, for example, the information gathering phase progresses more quickly. Additionally, Director Muriel offered to have Ms. Cook post on the Working Group’s web page materials from other groups that have spent time working on this issue, such as the Big Data (EX) Working Group and the Life Actuarial (A) Task Force.

Mr. Crofton said this Working Group should coordinate with the Artificial Intelligence (EX) Working Group in case there are areas of overlap. Ms. Amann said she participated in an InsurTech conference where there were presentations from a number of start-up companies and suggested working with Denise Matthews (NAIC) to obtain some of the presentations that were particularly informative. Leonard Mangini (American Academy of Actuaries—Academy) said the Working Group should be
aware of activities going on in other NAIC groups that touch on accelerated underwriting, such as APF 2018-17, which was
added to the *Valuation Manual* and says when aggregating mortality experience, that experience must be based on the same or
similar underwriting processes. Mr. Robinson asked whether the Working Group anticipates developing a work product in
conjunction with the Life Actuarial (A) Task Force since the Working Group’s charge talks about coordination with the ongoing
work of the Life Actuarial (A) Task Force.

Mr. Birnbaum explained his background and said that he has been involved in the myriad efforts at the NAIC in this area over
the past several years. He asked the Working Group to consider moving more quickly than the time frames set out in the work
plan. He said the Working Group should be able to gather sufficient information to get up to speed on these issues in a short
amount of time because the practice of accelerated underwriting and the consumer issues implicated by the practice are well-
known. He encouraged state insurance regulators to review the materials from the other NAIC groups that have been looking
at these issues and move towards taking regulatory action as soon as possible.

Commissioner Ommen explained that this Working Group’s charge is explicitly mindful of the fact that there are other NAIC
groups working on this issue. He said this Working Group’s charge has less to do with solvency, which is the purview of the
Life Actuarial (A) Task Force, and more to do with equity and focusing beyond the responsibilities of the actuaries to evaluate
whether consumers are being treated fairly. Commissioner Ommen said this Working Group has an important task, but he
cautioned the group to do things correctly rather than just focus on moving quickly.

Having no further business, the Accelerated Underwriting (A) Working Group adjourned.
Life Insurance Illustration Issues (A) Working Group
Conference Call
October 21, 2019

The Life Insurance Illustration Issues (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call Oct. 21, 2019. The following Working Group members participated: Richard Wicka, Chair, and Barbara Belling (WI); Perry Kupferman (CA); Chris Struk (FL); Teresa Winer (GA); Mike Yanacheak and Russ Gibson (IA); Mary Mealer (MO); Bob Harkins (NE); Brian Hoffmeister (TN); and Deanna Osmanson and John Carter (TX). Also participating were: Tate Flott (KS); Gary Jones (PA); and David Hippen (WA).

1. Reviewed its Charge and Work Plan

Mr. Wicka reminded the Working Group of its charge to “explore how the narrative summary required by Section 7B of the Life Insurance Illustrations Model Regulation (#582) and the policy summary required by Section 5A(2) of the Life Insurance Disclosure Model Regulation (#580) can be enhanced to promote consumer readability and understandability of these life insurance policy summaries, including how they are designed, formatted and accessed by consumers.”

Mr. Wicka reminded the Working Group that it had initially decided to add a requirement for a policy overview document in both Model #580 and Model #582 to fulfill the Working Group’s charge. However, in September 2018, the Working Group agreed to simplify the approach it had been working on by revising just Model #580 to include the requirement of a policy overview document to accompany all life insurance policies for delivery with the Life Insurance Buyer’s Guide (Buyer’s Guide). This new approach eliminates the need for revisions to Model #582.

Mr. Wicka explained that the purpose of this conference call is to continue the discussions regarding the May 20 draft revisions to Model #580 (see NAIC Proceedings – Fall 2019, Life Insurance and Annuities (A) Committee, Attachment Eight-A) from its Sept. 3 conference call.

2. Discussed the May 20 Draft of Model #580

a. Subparagraph 5A(2)(e)(iv) and Subparagraph (v)

The Working Group continued to discuss Section 5A(2)(e) “Policy Information” which shall include the following information, as applicable.” The Working Group discussed the suggestion that Birny Birnbaum (Center for Economic Justice—CEJ) submitted to combine 5A(2)(e)(iv) and (v), which both provide information about the death benefit. The Working Group agreed to the following revision:

(iv) A yes or no indication of whether the death benefit can change, and if yes, a description of the reasons and timing for a change in the death benefit;

b. Section 5A(2)(e)(vi)

The Working Group agreed to delete Section 5A(2)(e)(vi) “policy effective date” because the information is not available pre-underwriting, and the information is readily available elsewhere post-underwriting.

c. Section 5A(2)(f)

The Working Group discussed revising the “additional policy benefits” listed under Section 5A(2)(f)(i) – (ix) into “yes or no” questions. The Working Group also discussed relocating (vii) “option to lower benefits to reduce premiums” to Section 5A(2)(d), which is the section on costs. The Working Group agreed to move (viii) and to revise Section 5A(2)(f) as follows:

(f) “Additional Policy Benefits” which shall include the following information, as applicable:

(i) A yes or no indication whether a waiver of premium or deductions option is available;
(ii) A yes or no indication of whether policy conversion options exist and, if yes, a brief description of conversion options available;

(iii) A yes or no indication of options to extend the term of the coverage;

(iii) A yes or no indication of any available optional riders as requested by the insured, and if yes, an indication if there is an additional cost;

(vi) A yes or no indication of any living benefit option(s);

(vii) A yes or no indication as to whether the policy can accumulate cash value;

(viii) A yes or no indication of whether there are guaranteed interest rates on fixed accounts and any indexed account options as requested by the insured.

3. Discussed its Next Steps

Mr. Wicka said that a revised draft would be posted and that he would take additional comments on the structure and wording. He said he thinks it would be easier to consider those comments once the agreed upon revisions are incorporated into a revised draft.

Mr. Wicka said he plans to ask the Life Insurance and Annuities (A) Committee to provide guidance to the Working Group on the issue of timing for the delivery of the policy overview. He asked for comments to be sent via email to Jennifer Cook (NAIC) by Nov. 15 to give sufficient time to review them prior to the Fall National Meeting.

Mr. Wicka asked for comments to express a preference for one of the following timing options: 1) keep the timing in the current draft – delivery of the policy overview at the same time as the Buyer’s Guide, which is before the purchase of a policy, or if there is a “free look period,” at the same time or prior to delivery of the policy; 2) change the timing for the delivery of the policy overview and the Buyer’s Guide – both delivered before the purchase of a policy; or 3) separate timing requirements for the policy overview and the Buyer’s Guide – keep the same timing for the Buyer’s Guide and require delivery of the policy overview prior to purchase of a policy. He said comments on whether the policy overview should be a stand-alone document or a cover page could be included. Mr. Wicka said the comments will inform the Working Group report to the Life Insurance and Annuities (A) Committee.

Michael Lovendusky (American Council of Life Insurers—ACLI) said the ACLI will plan to submit a comprehensive comment letter. He said the ACLI has reviewed the entire work effort of the Life Insurance Illustration Issues (A) Working Group and concluded that it has fulfilled it charge to “explore” how the narrative and policy summary can be enhanced. He said any further work with respect to the larger issue of timing is beyond the scope of the current charge.

Ms. Winer said that it may be possible to untether the policy overview from the Buyer’s Guide, but it needs to remain connected to the illustration.

Mr. Birnbaum said the Working Group charge refers to the narrative summary required by Section 7B of Model #582 and the policy summary required by Section 5A(2) of Model #580. He said the narrative summary is tied to the illustration, but the policy overview serves a different purpose; it is a review of the basic features of the policy. He said the narrative summary explains the illustration, and illustrations are provided before purchase, so it should not be a stretch to provide a policy overview before purchase, especially because one of its purposes is to help consumers shop for insurance.

Having no further business, the Life Insurance Illustration Issues (A) Working Group adjourned.
The Life Insurance Illustration Issues (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call Sept. 17, 2019. The following Working Group members participated: Richard Wicka, Chair (WI); Jodi Lerner (CA); Chris Struk (FL); Teresa Winer (GA); Mike Yanacheak (IA); Mary Mealer (MO); Bob Harkins (NE); Brian Hoffmeister (TN); and Doug Danzeiser (TX). Also participating were: Tate Flott (KS); Denise Lamy (NH); Tom Kilcoyne (PA); Tanji Northrup (UT); James Young (VA); and David Hippen (WA).

1. **Reviewed its Charge and Work Plan**

Mr. Wicka reminded the Working Group of its charge to “explore how the narrative summary required by Section 7B of the Life Insurance Illustrations Model Regulation (#582) and the policy summary required by Section 5A(2) of the Life Insurance Disclosure Model Regulation (#580) can be enhanced to promote consumer readability and understandability of these life insurance policy summaries, including how they are designed, formatted and accessed by consumers.”

Mr. Wicka reminded the Working Group that it had initially decided to add a requirement for a policy overview document in both Model #580 and Model #582 to fulfill the Working Group’s charge. However, in September 2018, the Working Group agreed to simplify the approach it had been working on by revising just Model #580 to include the requirement of a policy overview document to accompany all life insurance policies for delivery with the Life Insurance Buyer’s Guide (Buyer’s Guide). This new approach eliminates the need for revisions to Model #582.

Mr. Wicka explained that the purpose of this conference call is to continue the discussions about the May 20 draft revisions to Model #580 (see NAIC Proceedings – Fall 2019, Life Insurance and Annuities (A) Committee, Attachment Eight-A) from its Sept. 3 conference call.

2. **Discussed May 20 Draft of Model #580**

   a. **Revising the “Cost Information” Definition**

Mr. Wicka said that following the Working Group’s Sept. 3 conference call, he suggests the following revisions to Section 5A(2)(d):

   (d) “Cost Information” which shall include the following information, as applicable:

   (i) Initial premium or estimated premium at the time of application and premium mode selected;

   (ii) A short statement describing yes or no indication if the premium varies can vary after the first year, and, if so, a statement as to where the insured can find information a brief explanation as to how the premium will be determined after the first year;

   (iii) Available options for premium funding such as policy payment periods, any dividend options or lump sum payments options;

He explained that the revision to (i) allows for flexibility in the information included in the Policy Summary in case it were to be delivered prior to underwriting.

Birny Birnbaum (Center for Economic Justice—CEJ) agreed with this revision and suggested adding language saying the premium is based on initial information and is subject to change.

Mr. Wicka said the suggested revision to (ii) is to simplify the requirement, and the suggestion to delete (iii) was made in several comments. The Working Group agreed to make these revisions.
b. **Moving the Reference to “Waiver of Premium or Deductions Option” from “Cost Information” to “Additional Policy Benefits”**

The Working Group discussed whether the information required in Section 5A(2)(d)(iv)—“A yes or no indication whether a waiver of premium or deductions option is available”—would better fit in the information required under Section 5A(2)(f) “Additional Policy Benefits, which shall include the following information, as applicable.” The Working Group agreed that it made sense to relocate (iv) to Section 5A(2)(f).

c. **Rewording Section 5A(2)(d)(v)**

The Working Group discussed streamlining (v) to a yes or no indication of whether there are surrender charges, which is consistent with the formatting elsewhere. The Working Group discussed whether in this instance, yes or no provides enough information.

Mr. Birnbaum said the goal is to provide key information for comparison purposes and suggested providing a schedule of charges.

Ms. Winer said that disclosure is helpful, but only if it is meaningful. She said that providing too much information is confusing and not helpful.

Brian Lessing (AXA Equitable) said surrender charges are complicated and are based on a formula that can differ based on premiums paid.

Mr. Wicka said he would like consumers to be aware that there are surrender charges, but he said is not convinced that there needs to be a high level of detail included.

Ms. Lerner said it is important for consumers to know what the surrender charges are before they purchase a product and suggested a basic summary of the surrender charge, how long it lasts and when it is highest, like in the first five years.

Ms. Mealer suggested perhaps the yes or no question and how long are there surrender charges, and then direct them to the policy for details. Mr. Birnbaum said he is concerned that consumers need this information before purchasing the policy.

Ms. Lerner agreed to provide the Working Group with an example of a disclosure of this information.

The Working Group agreed to make the following change to Section 5A(2)(d)(v):

\[(v) \text{ A description of yes or no indication of whether there are surrender charges and, if so, the period of time that surrender charges apply;} \]

d. **Revising the “Cost of Insurance” Information**

The Working Group discussed Section 5A(2)(d)(vi): “A narrative description of the cost of insurance and other fees needed to keep the policy in force and how those fees may change over time.”

Ms. Winer expressed concern that the information included would be overwhelming to consumers and would defeat the purpose of having a summary. She said the purpose of the summary is to alert consumers to information so they can know to look deeper, not to provide exhaustive detail.

Mr. Wicka agreed that the intent is for consumers to understand how they are going to be charged, short of putting everything in the summary.

Mr. Birnbaum said he wants more explicit disclosure of the charges and fees. He said he would like to see an itemization like one included in the discussion about *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest* (AG 49). He said it would be easy to include this information here: What is the cost of insurance? How much is it? Can it change? How much can it change?

Ms. Mealer agreed with Mr. Birnbaum on this point.
Michael Lovendusky (American Council of Life Insurers—ACLI) said the Life Actuarial (A) Task Force’s work on indexed universal life and AG 49 is at the other end of the spectrum from this discussion about a Policy Summary. He said this is a simple “front porch” document and that cost of insurance fees in policies are hotly litigated. He said the idea that the Policy Summary could tease out the elemental pieces of the cost of insurance will lead to useless information at best or so much information it would not be helpful. He suggested including a statement that the cost of insurance exists and that there is a cap beyond which it cannot exceed and leave it at that.

Ms. Winer said cost of insurance depends on cash value and multipliers and is complicated.

Mr. Birnbaum said there is no need to get too caught up in the details; he said just include enough information that a consumer could compare one policy to another and say, for example: The cost of insurance is between 1% of cash value up to 3% of cash value.

Mr. Lovendusky suggested including what the cost of insurance is and how high it can go up, but get no more granular.

Mr. Wicka suggested including three elements: 1) cost of insurance charge; 2) net amount at risk; and 3) maximum allowable charge.

The Working Group agreed to the following revision to Section 5A(2)(d)(vi):

- (vi) If applicable, a narrative explanation of the cost of insurance fee, a narrative explanation of the net amount of risk to which the fee will apply, and other fees needed to keep the policy in force and how those fees may change over time the maximum allowable cost of insurance fee allowed under the policy.

- Deleting “Product Type (Including Single or Joint Policy)”

Mr. Wicka said the CEJ suggested removing the requirement for indicating “product type (including single or joint policy)” in Section 5A(2)(e)(i).

Ms. Lerner said the information should be included, although she said she does not have a preference about location.

The Working Group observed that this information was included at the top of the sample policy overview and agreed to look at it again when reviewing the sample.

- Deleting “Form Number”

Mr. Wicka said the ACLI suggested, and the Working Group agreed, to the following revision to Section 5A(2)(e)(ii) because the form number is not necessary information for a consumer:

- (ii) Product name and form number

- Clarifying “Coverage Period Description”

The Working Group discussed what information is intended to be included.

Mr. Yanacheak said this is intended to capture how long a policy’s term is; i.e., a term of years or for life. Mr. Birnbaum said it is intended to answer the question: If I pay my premium, this policy will cover x amount of time.

Mr. Yanacheak asked whether this encompasses a term policy that is annually renewable for a much higher cost after the initial term. He said this could be how the policy is worded or available through a rider. He said the final language just needs to be clear.

Mr. Wicka suggested, and the Working Group agreed, to the following revised language to Section 5A(2)(e)(iii):

- (iii) Indicate whether it is a term or permanent policy. If it is a term policy, indicate the length of the initial term.
3. **Discussed its Next Steps**

Mr. Wicka said the Working Group will review a revised draft and consider the suggestions of Mr. Birnbaum to put the data elements in a different order during its next conference call.

Having no further business, the Life Insurance Illustration Issues (A) Working Group adjourned.

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The Life Insurance Illustration Issues (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call Sept. 3, 2019. The following Working Group members participated: Richard Wicka, Chair, and Justine Bellamy (WI); Jodi Lerner (CA); Chris Struk (FL); Teresa Winer (GA); Mike Yanacheak and Russ Gibson (IA); Mary Mealer (MO); Robert E. Harkins (NE); Jana Jarrett (OH); Rachel Jade-Rice (TN); and John Carter and Doug Danzeiser (TX). Also participating were: Steve Oslund (AL); Mike Chrysler (IL); Tate Flott (KS); Denise Lamy (NH); James Young (VA); and David Hippen (WA).

1. Reviewed its Charge and Work Plan

Mr. Wicka reminded the Working Group of its charge to “explore how the narrative summary required by Section 7B of the Life Insurance Illustrations Model Regulation (#582) and the policy summary required by Section 5A(2) of the Life Insurance Disclosure Model Regulation (#580) can be enhanced to promote consumer readability and understandability of these life insurance policy summaries, including how they are designed, formatted and accessed by consumers.”

Mr. Wicka reminded the Working Group that it had initially decided to add a requirement for a policy overview document in both Model #580 and Model #582 to fulfill the Working Group’s charge. However, in September 2018, the Working Group agreed to simplify the approach it had been working on by revising just Model #580 to include the requirement of a policy overview document to accompany all life insurance policies for delivery with the Life Insurance Buyer’s Guide (Buyer’s Guide). This new approach eliminates the need for revisions to Model #582.

Mr. Wicka explained that the purpose of this conference call is to continue the discussions about the May 20 draft revisions to Model #580 (see NAIC Proceedings – Fall 2019, Life Insurance and Annuities (A) Committee, Attachment Eight-A) started during its July 30 conference call.

Michael Lovendusky (American Council of Life Insurers—ACLI) said the ACLI had submitted comments on the general direction of the Working Group. He said the ACLI was happy to continue with developing the policy overview for the three types of life insurance policies, but he observed that it would be challenging to finish by the Fall National Meeting. He said moving the time frame for delivery of the policy overview to before the time when personal information has been gathered and underwriting has occurred defeats the purpose of the document. He said the ACLI suggests that, if the time frame for delivery is going to be changed, rather than continue developing a policy overview, the Working Group should align this effort with the Life Insurance Online Guide (A) Working Group that is currently working on an online buyer’s guide for consumers.

2. Discussed May 20 Draft of Model #580 and May 16 Sample Overview Form

a. Discussed “Illustration” Definition

The May 20 draft includes the following definition:

“Illustration” means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years that is subject to [insert state equivalent to Model #582].

Mr. Lovendusky said the ACLI made two alternative recommendations for revising the definition of “Illustration” in Model #580. The first suggestion was to simplify the definition so that it points to the state law equivalent to Model #582: “‘Illustration’ means a presentation or depiction of a policy of life insurance that is subject to [insert state equivalent to Model #582].” He said an alternative suggestion is for the definition to exactly duplicate the definition in Model #582.

Birny Birnbaum (Center for Economic Justice—CEJ) said referencing the state law equivalent to Model #582 would only work if a state has adopted something exactly like the model. He suggested adding a reference to guaranteed elements in addition to non-guaranteed elements because Model #582 provides that illustrations include guaranteed and non-guaranteed elements.
Mr. Wicka said the definition in the May 20 draft is the exact language from Model #582, without the description of the three types of illustrations. The Working Group agreed to keep the language from the May 20 draft.

b. **Discussed “Policy Overview” Definition**

The May 20 draft includes the following definition:

> “Policy Overview” means a brief summary of the policy prepared in accordance with this regulation, and an example may be found in Appendix A.

Mr. Birnbaum suggested revising this definition to include language mirroring the purpose of the model and requiring that a policy overview is substantially similar to the sample documents being developed, as follows:

> “Policy Overview” means a document describing the basic features of the policy presented in a manner to facilitate the purposes of this model, containing the elements required in section 5.A., and substantially similar to the model forms found in Appendix A.

Mr. Birnbaum said the narrative and policy summaries created by the insurance companies to comply with the requirements in Model #580 and Model #582 were wildly different from each other, and the substantially similar language is need in order to not end up with the same problem that led to the charge of the Working Group.

Mr. Wicka reminded the Working Group that the intention from the beginning was to develop sample templates for policy overviews that would not be required. He asked the Working Group if there was a desire to revisit this issue.

Ms. Mealer said she preferred having the templates serve as examples, not be a required form.

Ms. Lerner said she would like for the samples to be mandatory because there should be a way for consumers to compare policies easily.

Mr. Lovendusky said assisting consumers to compare products is outside the scope of the Working Group’s charge, and it would limit innovation and harm consumers.

Mr. Birnbaum said the Working Group’s charge specifically includes how the summaries are “designed, formatted and accessed” by consumers, and the stated purpose of Model #580 is to “require insurers to deliver to purchasers of life insurance information that will improve the buyer’s ability to select the most appropriate plan of life insurance for the buyer’s needs.”

The Working group agreed to keep the language from the May 20 draft.

c. **Discussed Allowing Insurers to Combine the Guaranteed Premium and Benefit Patterns Summary with the Policy Overview When There is No Illustration**

Mr. Wicka said the ACLI comment letter and the Pacific Life comment letter both suggested allowing an insurer to combine the “Policy Overview” with the “Guaranteed Premium and Benefit Patterns Summary” when a policy will not be marketed with an illustration. The comment letters suggested the following definition:

> “Guaranteed Premium and Benefit Patterns Summary” is a separate document that accompanies the Policy Overview where the insurer has identified the policy as one that will not be marketed with an illustration. The insurer may combine the Guaranteed Premium and Benefit Patterns Summary and Policy Overview into a single document.

Mr. Wicka explained the evolution of the Policy Overview document from a cover page to the policy and narrative summaries to a stand-alone document to be delivered at the same time as the Buyer’s Guide.

Ms. Mealer said she is not opposed unless there is an identifiable harm to combining the documents.

Ms. Lerner said she was hesitant to do anything that would make documents longer, and therefore, less consumer friendly.
Mr. Danzeiser said he does not object to combining the documents.

Mr. Birnbaum said this proposal would recreate the problems that gave rise to the need for the charge. He said the initial proposal of a one-to-two-page cover document that explains the key features of the policy is not the same as the proposal to allow insurers to combine these two documents. He said allowing insurers to combine the documents is counter-productive to the goals of the Working Group to improve consumers’ ability to compare products.

Mr. Lovendusky said it was never the goal of the Working Group to have a template to help consumers compare policies.

Mr. Birnbaum said the format will change if the two documents are combined, and there is no evidence that combining the documents will make them any shorter or easier to understand. He said it is more likely that they will be less consumer friendly.

Ms. Lerner said the Working Group’s charges are to promote consumer readability and understandability through consideration of how they are designed, formatted and accessed by consumers. She said the way it is set out in the May 20 draft promotes consumer understandability through a consistent format.

Ms. Mealer made motion, seconded by Mr. Harkins, to replace the definition of “Guaranteed Premium and Benefit Patterns Summary” in the May 20 draft with the language proposed by the ACLI. Missouri and Texas voted in favor of the motion. California, Iowa, Nebraska and Tennessee voted against the motion. The motion failed. The definition of “Guaranteed Premium and Benefit Patterns Summary” will not change from the May 20 draft.

d. Discussed Timing for Delivery of Policy Overview

Mr. Wicka explained that Section 5A(1) requires insurers to provide a Buyer’s Guide to all prospective purchasers, prior to accepting the applicant’s initial premium or premium deposit, except when there is a “free look” period of at least 10 days, in which case, the Buyer’s Guide may be delivered with the policy or prior to delivery of the policy. Section 5A(2) requires that the Policy Overview is delivered at the same time as the Buyer’s Guide. Ms. Lerner said she would like to see the Buyer’s Guide and the Policy Overview delivered at the time of application. She said if the Buyer’s Guide and Policy Overview are intended to help people understand the type of insurance they would like to purchase, getting it at the time of policy delivery is too late. She said if either of these documents are to be meaningful, consumers need them earlier.

Mr. Struck said it would be preferable for people to get information to help them understand what they are purchasing, rather than what they have already purchased.

Mr. Lovendusky said a change in the timing for providing the Buyer’s Guide would create a substantial change in operations for insurers, and it is beyond the scope of what the Working Group should be trying to achieve. He said if the delivery requirements are changed, the Policy Overview cannot include some of the detailed consumer-specific information contemplated.

Mr. Wicka reiterated that the Working Group’s charge specifically contemplates how summaries are “designed, formatted and accessed” by consumers, which encompasses the delivery requirement.

Ms. Winer said information is largely, if not exclusively, online, so it may be time to revisit the delivery timing requirements.

Mr. Wicka said another option is to separate the Buyer’s Guide delivery requirements from the Policy Overview. Mr. Birnbaum said they could be separated, but it makes sense to deliver them at the same time. He said with respect to the Buyer’s Guide, it is a static document that can be easily delivered electronically. He said the Policy Overview should also be delivered before consumers have paid their premium. He said industry’s position ensures that consumers cannot shop before they apply.

Randy Foster (American International Group—AIG) said it would be extremely burdensome to have to provide the Policy Overview at the time of application. He said there is no policy at the time of application and consumers may end up with something completely different after underwriting. He said while much is unknown at the time of application, at the time of policy delivery, things are set, and consumers have the free look period to assess the details. He said if something is provided earlier in the process, it will be more difficult to prove up compliance.
Mr. Wicka said the Working Group needs to have additional discussion before changing the timing requirements for delivery of the Policy Overview. The Working Group agreed.

Having no further business, the Life Insurance Illustration Issues (A) Working Group adjourned.
Life Insurance Illustration Issues (A) Working Group
Conference Call
July 30, 2019

The Life Insurance Illustration Issues (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call July 30, 2019. The following Working Group members participated: Richard Wicka, Chair (WI); Jodi Lerner (CA); Chris Struk (FL); Teresa Winer (GA); Mike Yanacheak (IA); Mary Mealer (MO); Robert E. Harkins (NE); Brian Hoffmeister (TN); and Doug Danzeiser (TX). Also participating were: Tate Flott (KS); Denise Lamy (NH); Tom Kilcoyne (PA); Tanji Northrup (UT); James Young (VA); and David Hippen (WA).

1. Reviewed its Charge and Work Plan

Mr. Wicka reminded the Working Group of its charge to “explore how the narrative summary required by Section 7B of the Life Insurance Illustrations Model Regulation (Model #582) and the policy summary required by Section 5A(2) of the Life Insurance Disclosure Model Regulation (Model #580) can be enhanced to promote consumer readability and understandability of these life insurance policy summaries, including how they are designed, formatted and accessed by consumers.”

Mr. Wicka reminded the Working Group that it had initially decided to add a requirement for a policy overview document in both Model #580 and Model #582 to fulfill the Working Group’s charge. However, in September 2018, the Working Group agreed to simplify the approach it had been working on by revising just Model #580 to include the requirement of a policy overview document to accompany all life insurance policies for delivery with the Life Insurance Buyer’s Guide (Buyer’s Guide). This new approach eliminates the need for revisions to Model #582.

Mr. Wicka explained that the purpose of this conference call is to discuss the May 20 draft revisions to Model #580 (Attachment Eight-A) that was exposed for a public comment period ending June 21. He said comments were posted on the Annuity Disclosure (A) Working Group web page.

2. Discussed the May 20 Draft of Model #580 and May 16 Sample Overview Form

   a. Discussed the “Illustration” Definition

The May 20 draft includes the following definition: “Illustration” means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years that is subject to [insert state equivalent to Life Insurance Illustrations Model Regulation].

Michael Lovendusky (American Council of Life Insurers—ACLI) said the ACLI made two alternative recommendations for revising the definition of “illustration” in Model #580. The first suggestion was to simplify the definition so it points to the state law equivalent to Model #582: “Illustration means a presentation or depiction of a policy of life insurance that is subject to [insert state equivalent to Life Insurance Illustration Model Regulation].” He said an alternative suggestion is for the definition to exactly duplicate the definition in Model #582.

Birny Birnbaum (Center for Economic Justice—CEJ) said referencing the state law equivalent to Model #582 would only work if a state has adopted something exactly like the model. He suggested adding a reference to guaranteed elements in addition to nonguaranteed elements because Model #582 provides that illustrations include guaranteed and nonguaranteed elements.

Mr. Wicka said that the definition in the May 20 draft is the exact language from Model #582, without the description of the three types of illustrations. The Working Group agreed to keep the language from the May 20 draft.

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Mr. Wicka said the ACLI comment letter and the Pacific Life comment letter both suggested allowing an insurer to combine the “Policy Overview” with the “Guaranteed Premium and Benefit Patterns Summary” when a policy will not be marketed with an illustration. They suggested the following definition: “‘Guaranteed Premium and Benefit Patterns Summary’ is a separate document that accompanies the Policy Overview where the insurer has identified the policy as one that will not be marketed with an illustration. The insurer may combine the Guaranteed Premium and Benefit Patterns Summary and Policy Overview into a single document.”

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d. Discussed Timing for Delivery of the Policy Overview

Mr. Wicka explained that Section 5A(1) requires insurers to provide a Buyer’s Guide to all prospective purchasers, prior to accepting the applicant’s initial premium or premium deposit, except when there is a “free look” period of at least 10 days. In that case, the Buyer’s Guide may be delivered with the policy or prior to delivery of the policy. Section 5A(2) requires that the Policy Overview is delivered at the same time as the Buyer’s Guide.

Ms. Lerner said that she would like to see the Buyer’s Guide and the Policy Overview delivered at the time of application. She said if the Buyer’s Guide and Policy Overview are intended to help people understand the type of insurance they would like to purchase, getting it at the time of policy delivery is too late. She said if either of these documents are to be meaningful, consumers need them earlier.

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Mr. Lovendusky said a change in the timing would create a substantial change in operations for insurers and is beyond the scope of what the Working Group should be trying to achieve. He said changes to the timing for the Buyer’s Guide are beyond the scope of the Working Group’s charge. He said if the delivery requirements are changed, the Policy Overview cannot include some of the detailed consumer-specific information contemplated.

Mr. Wicka reiterated that the Working Group’s charge specifically contemplates how summaries are “designed, formatted and accessed” by consumers, which encompasses the delivery requirement. Ms. Winer said information is largely, if not exclusively, online, so it may be time to revisit the delivery timing requirements.

Mr. Wicka said another option is to separate the Buyer’s Guide delivery requirements from the Policy Overview.

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Mr. Wicka said the Working Group needs to have additional discussion before changing the timing requirements for delivery of the Policy Overview. The Working Group agreed.

Having no further business, the Life Insurance Illustration Issues (A) Working Group adjourned.
Revision marks show changes to existing model. Comments are requested by close of business June 21, 2019

DRAFT 5-20-19

LIFE INSURANCE DISCLOSURE MODEL REGULATION

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Section 2. Purpose
Section 3. Scope
Section 4. Definitions
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Section 1. Authority

This rule is adopted and promulgated by the commissioner of insurance pursuant to [insert state equivalent to Section 4A(1) of the Unfair Trade Practices Act] of the Insurance Code.

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

Section 2. Purpose

A. The purpose of this regulation is to require insurers to deliver to purchasers of life insurance information that will improve the buyer’s ability to select the most appropriate plan of life insurance for the buyer’s needs and improve the buyer’s understanding of the basic features of the policy that has been purchased or is under consideration.

B. This regulation does not prohibit the use of additional material that is not a violation of this regulation or any other [state] statute or regulation.

Section 3. Scope

A. Except for the exemptions specified in Section 3B, this regulation shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. Section 5B shall apply only to an existing nonexempt policy held by a policyowner residing in this state. This regulation shall apply to any issuer of life insurance contracts including fraternal benefit societies.

B. This regulation shall not apply to:

(1) Individual and group annuity contracts;

(2) Credit life insurance;

(3) Group life insurance (except for disclosures relating to preneed funeral contracts or prearrangements; these disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy);

(4) Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Section 1001 et seq. as amended; or
(5) Variable life insurance under which the amount or duration of the life insurance varies according to the investment experience of a separate account.

Section 4. Definitions

For the purposes of this regulation, the following definitions shall apply:

A. “Buyer’s Guide” means the current Life Insurance Buyer’s Guide adopted by the National Association of Insurance Commissioners (NAIC) or language approved by the commissioner.

B. “Current scale of nonguaranteed elements” means a formula or other mechanism that produces values for an illustration as if there is no change in the basis of those values after the time of illustration.

C. “Generic name” means a short title that is descriptive of the premium and benefit patterns of a policy or a rider.

C. “Illustration” means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years that is subject to [insert state equivalent to Life Insurance Illustrations Model Regulation].

D. “Nonguaranteed elements” means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

E. “Policy data” means a display or schedule of numerical values, both guaranteed and nonguaranteed for each policy year or a series of designated policy years of the following information: illustrated annual, other periodic, and terminal dividends; premiums; death benefits; cash surrender values and endowment benefits.

F. “Policy summary Overview” means a written statement describing the elements of the policy, including, but not limited to brief summary of the policy prepared in accordance with this regulation and an example may be found in Appendix A.

G. “Guaranteed Premium and Benefit Patterns Summary” is a separate document that accompanies the Policy Overview where the insurer has identified the policy as one that will not be marketed with an illustration.

G. “Preneed funeral contract or prearrangement” means an agreement by or for an individual before that individual’s death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

Section 5. Duties of Insurers

A. Requirements Applicable Generally

(1) The insurer shall provide a Buyer’s Guide to all prospective purchasers, prior to accepting the applicant’s initial premium or premium deposit. However, if the policy for which application is made contains an unconditional refund provision of at least ten (10) days, the Buyer’s Guide may be delivered with the policy or prior to delivery of the policy.

(2) The insurer shall provide a Policy Overview to all prospective purchasers. Delivery of the Policy Overview shall be consistent with the time for delivery of the Buyer’s Guide as specified in Paragraph (1). Insurers should endeavor to limit the length of the Policy Overview to the minimum length necessary to reasonably inform consumers of the information required to be included in the Policy Overview. The Policy Overview is not required to be in a specific format beyond the requirements of the Section. The Policy Overview must be prepared in language and in a format that would be understood by a typical person within the segment of the public to which the policy is
directed. A sample Policy Overview that meets the requirements of this Section is provided in Appendix A. A Policy Overview shall include the following sections labeled with the following headings:

(a) An introductory section containing the following language: “This document lists this product’s key features, benefits and costs. You can get a similar summary of key product features from other insurance companies to help you compare similar products. If you have questions about this particular life insurance product, ask the agent, broker, advisor, or a company representative offering this product for clarification. If you have questions about life insurance products generally or about company or agent licensing, contact [insert reference to state department of insurance].”

(b) The name and address of the insurance agent or, if no agent is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the Policy Overview. The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written;

(c) “Information about the Insured” which shall include the following information, as applicable:

(i) Gender of insured or insureds;

(ii) Issue age of insured or insureds;

(iii) Risk class with a statement as to where the insured can find additional information regarding risk classes;

(iv) The following statement: “In the course of considering an insured’s application, an insurer may request or collect health information about the insured in variety of ways.” The statement shall indicate whether a physical examination or questionnaire will be required.

(d) “Cost Information” which shall include the following information, as applicable:

(i) Initial premium and premium mode;

(ii) A short statement describing if the premium varies after the first year, and, if so, a statement as to where the insured can find information as to how the premium will be determined after the first year;

(iii) Available options for premium funding such as policy payment periods, any dividend options or lump sum payments options;

(iv) A yes or no indication whether a waiver of premium or deductions option is available;

(v) A description of surrender charges and the period of time that surrender charges apply;

(vi) A narrative description of the cost of insurance and other fees needed to keep the policy in force and how those fees may change over time.

(e) “Policy Information” which shall include the following information, as applicable:

(i) Product type (Including single or joint policy);
(ii) Product name and form number;

(iii) Coverage period description;

(iv) Initial death benefit and a yes or no indication as to whether the death benefit can change;

(v) Death benefit option;

(vi) Policy effective date;

(vii) State of issue;

(viii) Policy loan option and applicable charges;

(f) “Additional Policy Benefits” which shall include the following information, as applicable:

(i) Eligibility for a dividend;

(ii) Conversion options that may be exercised;

(iii) Options to extend the term of the coverage;

(iv) Any available optional riders as requested by the insured, and an indication if there is an additional cost;

(vi) Living benefit option(s);

(vii) Option to lower benefits to reduce premium;

(viii) A yes or no indication as to whether the policy can accumulate cash value;

(ix) Guaranteed interest rates on fixed accounts and any indexed account options as requested by the insured.

(2)(3) The insurer shall provide a policy summary Guaranteed Premium and Benefits Patterns Summary to prospective purchasers where the insurer identified the policy form as one that will not be marketed with an illustration. Delivery of the Guaranteed Premium and Benefits Patterns Summary shall be consistent with the time for delivery of the Buyer’s Guide as specified in Paragraph (1). The policy summary Guaranteed Premium and Benefits Pattern Summary shall show guarantees only. It shall consist of a separate document with and include all required information set out in a manner that does not minimize or render any portion of the summary obscure. Any amounts that remain level for two (2) or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in Section 4F(5) shall be listed in total, not on a per thousand or per unit basis. If more than one insured is covered under one policy or rider, death benefits shall be displayed separately for each insured or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as a blank space. Delivery of the policy summary shall be consistent with the time for delivery of the Buyer’s Guide as specified in Paragraph (1). The following amounts, where applicable, for the first five (5) policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns; including at least one age from sixty (60) through sixty-five (65) and policy maturity:

(a) The annual premium for the basic policy:
(b) The annual premium for each optional rider;

(c) The amount payable upon death at the beginning of the policy year regardless of the cause of death, other than suicide or other specifically enumerated exclusions, that is provided by the basic policy and each optional rider; with benefits provided under the basic policy and each rider shown separately;

(d) The total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;

(e) Any endowment amounts payable under the policy that are not included under cash surrender values above;

(f) The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is adjustable, the Guaranteed Premium and Benefits Patterns Summary shall also indicate that the annual percentage rate will be determined by the company in accordance with the provisions of the policy and the applicable law.

B. Requirements Applicable to Existing Policies.

(1) Upon request by the policyowner, the insurer shall furnish either policy data or an in force illustration as follows:

(a) For policies issued prior to the effective date of [insert state equivalent to Life Insurance Illustrations Model Regulation], the insurer shall furnish policy data, or, at its option, an in force illustration meeting the requirements of [insert state equivalent to Life Insurance Illustrations Model Regulation].

(b) For policies issued after the effective date of the illustration regulation that were declared not to be used with an illustration, the insurer shall furnish policy data, limited to guaranteed values, if it has chosen not to furnish an in force illustration meeting the requirements of the regulation.

(c) If the policy was issued after the effective date of the illustration regulation and declared to be used with an illustration, an in force illustration shall be provided.

(d) Unless otherwise requested, the policy data shall be provided for twenty (20) consecutive years beginning with the previous policy anniversary. The statement of policy data shall include nonguaranteed elements according to the current scale, the amount of outstanding policy loans, and the current policy loan interest rate. Policy values shown shall be based on the current application of nonguaranteed elements in effect at the time of the request. The insurer may charge a reasonable fee, not to exceed $[insert amount], for the preparation of the statement.

(2) If a life insurance company changes its method of determining scales of nonguaranteed elements on existing policies; it shall, no later than when the first payment is made on the new basis, advise each affected policy owner residing in this state of this change and of its implication on affected policies. This requirement shall not apply to policies for which the amount payable upon death under the basic policy as of the date when advice would otherwise be required does not exceed $5,000.

(3) If the insurer makes a material revision in the terms and conditions under which it will limit its right to change any nonguaranteed factor; it shall, no later than the first policy anniversary following the revision, advise each affected policy owner residing in this state.
Section 6. Preneed Funeral Contracts or Prearrangements

The following information shall be adequately disclosed at the time an application is made, prior to accepting the applicant’s initial premium or deposit; for a preneed funeral contract or prearrangement that is funded or to be funded by a life insurance policy:

A. The fact that a life insurance policy is involved or being used to fund a prearrangement;

B. The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person;

C. The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

D. The impact on the prearrangement:

   (1) Of any changes in the life insurance policy including but not limited to, changes in the assignment, beneficiary designation or use of the proceeds;

   (2) Of any penalties to be incurred by the policyholder as a result of failure to make premium payments;

   (3) Of any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy;

E. A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;

F. All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement;

G. Any penalties or restrictions, including but not limited to geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and

Drafting Note: States should consider whether the insurance regulator has the authority to enforce the provisions of Subsections E, F and G.

H. If so, the fact that a sales commission or other form of compensation is being paid and the identity of the individuals or entities to whom it is paid.

Section 7. General Rules

A. Each insurer shall maintain, at its home office or principal office, a complete file containing one copy of each document authorized and used by the insurer pursuant to this regulation. The file shall contain one copy of each authorized form for a period of three (3) years following the date of its last authorized use unless otherwise provided by this regulation.

B. An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he or she is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which the agent is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

C. An insurance producer shall not use terms such as “financial planner,” “investment advisor,” “financial consultant,” or “financial counseling” in such a way as to imply that he or she is primarily engaged in an advisory business in which compensation is unrelated to sales unless that is actually the case. This provision
is not intended to preclude persons who hold some form of formal recognized financial planning or consultant designation from using this designation even when they are only selling insurance. This provision also is not intended to preclude persons who are members of a recognized trade or professional association having such terms as part of its name from citing membership, providing that a person citing membership, if authorized only to sell insurance products, shall disclose that fact. This provision does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

D. Any reference to nonguaranteed elements shall include a statement that the item is not guaranteed and is based on the company’s current scale of nonguaranteed elements (use appropriate special term such as “current dividend” or “current rate” scale.) If a nonguaranteed element would be reduced by the existence of a policy loan, a statement to that effect shall be included in any reference to nonguaranteed elements. A presentation or depiction of a policy issued after the effective date of the [insert citation to state equivalent to Life Insurance Illustrations Model Regulation] that includes nonguaranteed elements over a period of years shall be governed by that regulation.

Section 8. Failure to Comply

Failure of an insurer to provide or deliver a Buyer’s Guide, an in force illustration, a policy summary or policy data as provided in Section 5 shall constitute an omission that misrepresents the benefits, advantages, conditions or terms of an insurance policy.

Section 9. Separability

If any provisions of this rule be held invalid, the remainder shall not be affected.

Section 10. Effective Date

This rule shall become effective [insert a date at least 6 months following adoption by the regulatory authority].

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The Retirement Security (A) Working Group met via conference call Nov. 13, 2019. The following Working Group members participated: Stephen C. Taylor, Chair (DC); Doug Ommen represented by Sonya Sellmeyer (IA); Al Redmer Jr. represented by Joy Hatchette (MD); Steve Kelley represented by Fred Andersen (MN); Linda A. Lacewell represented by Peter Thaisz (NY); and Elizabeth Kelleher Dwyer represented by Sarah Neil (RI). Also participating were: Bruce Sartain (IL); Tate Flott (KS); Denise Lamy (NH); Cuc Nguyen (OK); Deanna Osmonson (TX); and Janelle Dvorak (WI). Also participating were: Bruce Sartain (IL); Tate Flott (KS); Denise Lamy (NH); Cuc Nguyen (OK); Deanna Osmonson (TX); and Janelle Dvorak (WI).

1. Heard Presentations on Retirement Security Education

   a. NFEC

   Commissioner Taylor explained the purpose and goals of the Working Group. He said the Working Group’s goal is to examine ways to promote retirement security consistent with the NAIC’s continuing “Retirement Security Initiative.” He said the Working Group would be discussing education issues, consumer protection and product innovation.

   Commissioner Taylor recapped the last conference call of the Working Group and then introduced Vince Shorb (National Financial Educators Council—NFEC) to open the discussion. Mr. Shorb discussed how the financial problems in the country are at an epidemic level. He said retirement security affects more than the pocketbook; it also affects the personal life. He discussed employee wellness programs with the focus on preparation for the future.

   Mr. Shorb said it is important to understand the past in order to understand the future. He said children pick up the habits of parents. He said if children see how their parents act and react to money and finances, they are more than likely to adopt those practices. He also said the old adage of “keeping up with the Joneses” has morphed into today’s social media infusion and celebrity endorsements and influences. He said there is no counteracting to that type of assault.

   Mr. Shorb said some states are tackling early education, such as Utah, but most kids are leaving home, such as to college, behind the proverbial “8-ball.” He said too many parents and educators are looking at the short-term and not the long-term. He said all the time, one hears the basic calls for saving more and if you borrow you need to repay. He said the focus should be on financial behavior, sentiments and systems.

   Mr. Shorb said that financial behavior means more than just telling people to save more. People need to understand what that means for the long-term and how to adapt behavior to the understanding. He said that sentiments mean understanding and knowing the hope and confidence for the future. He said the less hope and confidence people have about the future; the less likely people will work toward an end goal of financial security. He also said the fear of understanding money and how to use money properly prevents working toward that end goal. He said systems are meant to help with the earlier points of behavior and sentiments. He said an example would be auto-save programs.

   Mr. Shorb offered five tips to aid in financial literacy and retirement security: 1) quality educators; 2) segmentation of the audience; 3) time; 4) multiple methods of instruction; and 5) objectives. He said too many educators lack the educational methodology, utilizing mostly lectures and power point presentations. He said more sophisticated methodologies and practices are needed to address behavior and sentiment.

   Mr. Shorb explained that segmentation of the audience means that a financial literacy program or class needs to be tailored to the audience. For example, he said the socio-economic status is a factor to consider. He said that the warehouse worker who works at a lower hourly salary is different than the higher salary office worker. He said how financial literacy or retirement security is explained needs to be focused on retaining the interest of the employee and if a course is talking about options that are beyond the employee, the interest, if any, is lost.

   Mr. Shorb explained the trans-theoretical model where one gauges the interest level of each employee and then tailor classes or information to that interest level. He gave an example of a simple survey, and depending on the answer, one can help
determine the level of interest of that employee in retirement security. He said if an employee wants to learn, they will; if they do not, then develop the material to raise the level of interest.

Mr. Shorb said more time is needed than the typical courses currently offered. He said standard courses can help, especially if they can offer the tools to aid the employee to help themselves. He said multiple methods of instruction is key to educating employees and utilizing the best methods to those employees. He said other methods than the usual live lecture or an online course would be useful. He said employers or educators need to understand what the objectives are with a retirement security or financial literacy program. For example, he asked what the objectives are to help employees reduce their debt or encourage employees to learn and utilize the company’s retirement programs.

Mr. Shorb said educators should also pay attention to their audience. He said sometimes you see that aha moment in someone’s eyes, and they get the importance of planning for their future. He said it is also important to motivate those that do not have that aha moment and import the need for long-term thinking when it comes to one’s financial retirement security. He said the earlier one starts educating, the better for the future of the person, and they can see results down the line.

Commissioner Taylor asked Mr. Shorb how early such education should start. Mr. Shorb said that a Brown University study showed that habits are formed as early as at the age of nine, and kids will pick up the habits of their parents. He said if parents are frivolous or spend-thrifty, it will be picked up by children. He said the earlier one starts educating about financial security and literacy, the better. He said this is especially important with the massive influence of social media in conjunction with mass consumption. He said reaching kids before high school is probably best. Commissioner Taylor asked if schools can play a role. Mr. Shorb said schooling, historically, was meant to educate on self-sufficiency and being prepared for the future. He said schools can play an important role.

Ms. Neil asked if educating the parents will help the kids down the line. Mr. Shorb said the more a parent can improve their own socio-economic position, the better for the children, and the children can and will learn from their parents’ work to improve themselves. He said, statistically, kids will remain in the same socio-economic status as their parents.

Commissioner Taylor asked for an elaboration on segmentation. Mr. Shorb said simple, direct questions are best. He suggested asking a general question if the employee has interest in financial security and a more direct question if the employee has any interest in personal finances. Survey questions of that nature can help segment employees into levels of interest and then lead to the development of the right program. Commissioner Taylor asked what to do about those showing no interest. Mr. Shorb suggested helping those reluctant to focus on the topic as it could apply to them. For example, he said not to provide assignments, but provide case studies and ask what advice they would give to the subject in the case study. He said people are more inclined to give advice if it does not personally involve them. He said for many of those reluctant employees, case studies get them thinking about their own situation without feeling that they are being lectured.

Commissioner Taylor asked what size businesses the NFEC works with. Mr. Shorb said all sizes. He said the NFEC develops programs to scale and meet the needs of that specific business. Karrol Kitt (The University of Texas at Austin) said she wanted to thank Mr. Shorb and the chair for this resonation. She said, as an educator, she was very pleased to hear about teachable moments and the importance of education.

Commissioner Taylor asked the Working Group if anyone had any comments on the work plan he developed and had sent out prior to the conference call. Birny Birnbaum (Center for Economic Justice—CEJ) asked what role state insurance regulators and the NAIC have in the first three points under the education section of the work plan. He said there are other entities and groups that have more expertise and are working in this area. He asked what value is added in the NAIC and state insurance regulators examining this area. Commissioner Taylor replied that insurance has a large role to play and is part of an overall retirement security plan, and he believes the NAIC has and can play a role in helping Americans in their financial literacy and retirement security. He asked Mr. Birnbaum to submit any edits or suggestions to the work plan.

Commissioner Taylor asked the Working Group to submit any comments or edits to the work plan to David Torian (NAIC) by close of business (COB) Dec. 4.

Having no further business, the Retirement Security (A) Working Group adjourned.
The Retirement Security (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call Oct. 23, 2019. The following Working Group members participated: Stephen C. Taylor, Chair (DC); Doug Ommen represented by Sonya Sellmeyer (IA); Al Redmer Jr. represented by Joy Hatchette (MD); Steve Kelley represented by Fred Andersen (MN); Linda A. Lacewell represented by Peter Thaisz (NY); Elizabeth Kelleher Dwyer represented by Sarah Neil (RI); and Todd E. Kiser represented by Tanji Northrup (UT). Also participating were: Bruce Sartain (IL); Tate Flott (KS); Annette James (NV); Cuc Nguyen (OK); and Doug Danzeiser (TX).

1. **Heard Presentations on Retirement Security Education**

Commissioner Taylor explained the purpose and goals of this Working Group. He said the Working Group’s goal is to examine ways to promote retirement security consistent with the NAIC’s continuing “Retirement Security Initiative.” He said the Working Group would be discussing education issues, consumer protection and product innovation.

   a. **AARP**

Commissioner Taylor asked Joe Valenti (AARP) and Sarah Mysiewicz Gill (AARP) to open the discussion. Mr. Valenti discussed two programs that AARP promotes: 1) the Saving for Retirement campaign; and 2) the Work and Save campaign. He said one of the keys to effective retirement security education is to reach people before key moments in their lives. He pointed out that just providing people with calculations tends to scare them off but providing guidance and comprehensive information is more helpful.

Mr. Valenti said that four out of 10 heads of households, age 55 to 64, have no savings. He said the median savings is $120,000. Most believe they will simply work longer, but they do not take into account events that may prevent them to work longer. He said the Saving for Retirement campaign focuses on getting people into the conversation. He said the campaign offers a quick and easy retirement planning resource that enables users to chat with a friendly digital retirement coach to get their personalized action plan.

Ms. Gill said she works with the states and their legislatures. She said nearly 55 million workers do not have a way to save through their work. She said small business retirement plans cost much more than those available to larger employers. She said AARP has been working on a public/private partnership, similar to a 529 college savings plan. She said it is a contract with the private sector but administered by the state.

Ms. Gill said this design allow small businesses to offer simple, low-cost retirement savings plans to their employees, enabling more workers to provide for themselves rather than rely on taxpayer-paid services. Workers in businesses with fewer than 100 workers were much less likely to have access to a plan than workers in firms with more workers. She said some 30 states are considering retirement savings plans for small business employees, and seven states are already implementing them. She said the data shows that nearly 30 million workers are new savers.

Mr. Valenti said it is important to get people to think about lifetime income. He mentioned three bucket of funds and said people should look at money for now, such as for emergencies, periodic managed payouts and look at their longevity.

Commissioner Taylor asked if this partnership is voluntary to states and businesses. Ms. Gill said it is and said the programs are tailored to individual states. She said some states have businesses go through the private sector rather than a state plan.

Ms. Hatchette asked if there are target audiences or age groups. Ms. Gill said there is no specific targeting of any particular age group but said that millennials are a focus.

Commissioner Taylor asked about the costs of the partnership. Ms. Gill said there are costs upfront, but eventually it becomes self-sustaining and there is no cost to the business.
Mr. Thaisz noted that AARP discussed three buckets of funds for the decumulations stage, with the first one being emergency funds. He asked if AARP promotes saving for emergency funds during the accumulation phase of saving for retirement.

Mr. Valenti responded that AARP does support and promote saving up an emergency fund as part of financial wellness. He referenced recent studies that indicate a significant percentage of U.S. households would be unable to handle an unexpected $400 expense out of savings. He said that AARP believes everyone should save for an emergency fund.

b. IRI

Commissioner Taylor asked Chelsea Crucitti (Insured Retirement Institute—IRI) and Frank O’Connor (IRI) to give their presentations. Ms. Crucitti said there are two parts of the retirement crisis: 1) a funding crisis; and 2) an income crisis. She said longevity is one of the reasons for the crisis. She said workers tend to overestimate how long they will work, and many retire sooner than they expected.

Ms. Crucitti said a retiree needs 85% of their income for 20 years for retirement. People do not take into account the cost of living in retirement, such as health care and long-term care (LTC). She said most Americans do not have a grasp on the costs of health care and LTC. She said most workers with 401(k) accounts do not have the knowledge on how to use their money. She said six in 10 baby boomers do not take any action or even review their 401(k) accounts. She said that many respond to the amounts in their 401(k) similar to big lottery winners and that without education and guidance, they tend to spend it all.

Ms. Crucitti said more information does not necessarily mean there will be a better outcome. She said education is needed in every stage of life. She said industry tries to be innovative on the type of products that can help the consumer toward planning for and living through retirement. She pointed out a regulatory barrier where nearly 45% do not have access to a traditional 401(k) account. She said consumers need the right educational tools.

Ms. Crucitti also said there should be agent education and said IRI is partnering with the National Council on Aging (NCOA) to help educate agents on retirement and how to discuss retirement with consumers. She said the Setting Every Community Up for Retirement Enhancement (SECURE) Act of 2019 (H.R. 1994) is an important legislative tool to help Americans. The act would allow, among many provisions, more part-time workers to have the opportunity to participate in a 401(k) plan and would allow for multi-employer 401(k) plans. It would also require benefit statements provided to defined contribution plan participants to include a lifetime income disclosure at least once during any 12-month period.

Mr. O’Connor said people cannot overstate the need for education. He said IRI’s research shows that collectively all people know they have to save for the future, but they do not know what to do to get there nor what to do when they get there.

Mr. O’Connor cited research on millennials. He said 72% of millennials believe they will be set for retirement, whereas only 18% are concerned about retirement. However, 50% of those who are confident about the future are not saving and say they plan to do it later. Sixty-five percent are confident that they can save enough of their own income, and 55% said Social Security will provide enough along with savings.

Commissioner Taylor asked when retirement education should start. Mr. O’Connor said basic financial literacy should begin in high school or entry into college. He said additional education is needed, such as at a first job. He said first-time employees need more than just being handed a 401(k) without some education about how it works and how to use it best for their needs.

Mr. O’Connor gave an example of a person who is moving from a large employer to a small employer and what to do with the 401(k) with the large employer. He said without proper education, that person may not know that it may be better to keep the 401(k) with the large employer.

Commissioner Taylor asked about producer education. Mr. O’Connor said not all agents or producers work in annuities, and conversely annuities are not right for everyone. He said producers need to be well-versed in all products for the right client. Ms. Sellmeyer asked when the IRI research will be available. Mr. O’Connor said it should be published next month.

Mr. Thaisz asked about the research on the hesitation by Americans of converting lump sums into annual income. Mr. O’Connor said their research shows there is some psychological barrier with retirees about taking their lump sum amount of money that they have saved and converting it into long-term annual income. He said there is no quick fix and that it is unclear how to change this barrier.
Jason Berkowitz (IRI) pointed out that the SECURE Act could help with that hesitation. He said this legislation would expand and preserve opportunities to save for retirement and help savers make more informed decisions about their retirement finances.

Brenda J. Cude (University of Georgia) said it is important for the Working Group to look at what is happening now in the area of education. She said that in order to move forward, it is important to know and understand what is being done currently.

Karrol Kitt (The University of Texas at Austin) said she would like to participate in that discussion.

Having no further business, the Retirement Security (A) Working Group adjourned.
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The Life Actuarial (A) Task Force met in Austin, TX, Dec. 5–6, 2019. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Jacob Lauten (AK); Jim L. Ridling represented by Steve Ostlund (AL); Andrew N. Mais represented by Wanchin Chou (CT); Steve Kelley represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); John G. Franchini represented by Anna Krylova (NM); Linda A. Lacewell represented by Bill Carmello (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA). Also participating was: Rachel Hemphill (TX).


The Task Force met Oct. 17, Oct. 3, Sept. 26, Sept. 19 and Sept. 12 and took the following action: 1) adopted its Summer National Meeting minutes; 2) adopted its 2020 proposed charges; 3) adopted the 2020 Generally Recognized Expense Table (GRET); 4) provided direction to the IUL Illustration (A) Subgroup on revising Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49); 5) adopted the American Academy of Actuaries (Academy) Life Experience Committee and the Society of Actuaries (SOA) Preferred Mortality Oversight Group Valuation Basic Table Team (Joint Committee) Individual Life Insurance Mortality Improvement Scale Recommendation—for Use with (AG 38) and VM-20; 6) heard updates on the Yearly Renewable Term (YRT) Field Test from the Academy YRT Field Test Project Oversight Work Group.

Mr. Yanacheak made a motion, seconded by Mr. Ostlund, to adopt the Task Force’s Oct. 17 (Attachment One), Oct. 3 (Attachment Two), Sept. 26 (Attachment Three), Sept. 19 (Attachment Four), and Sept 12 (Attachment Five) minutes. The motion passed unanimously.

2. **Heard an Update on the YRT Field Test**

Jason Kehrberg (Academy YRT Field Test Project Oversight Work Group) presented an update on the YRT Field Test (Attachment Six), which included a revised timeline and a graphical presentation of the workstreams. He said Oliver Wyman has been engaged to assist in the analysis of field test results. He said calls with field test participants will begin once legal agreements have been executed.

Chris Whitney (Oliver Wyman) presented the details of the design of the analysis models for the field test and some initial insights (Attachment Seven). He said that, in addition to the field test, the Academy is working on a “Range of Interpretations” survey to be distributed to all companies, regardless of whether they are field test participants. The survey seeks further understanding of the range of interpretations from a company participation base that is larger than the field test, which might be used to model the various YRT reinsurance proposals in the field test. Mr. Whitney said the analysis model and its associated tools will be delivered to the NAIC when it is completed. He noted that a secondary benefit of the project is that the NAIC will be able to use the model to analyze the long-term impact of other principle-based reserving (PBR) issues, as needed. He said the model provides a robust projection of PBR over time while unlocking assumptions to observe the impact of the various reserve components.

Ms. Hemphill asked if the model considers any interaction with the post-level term profits restriction. Mr. Whitney said the issue is being considered. Mr. Chupp asked if mortality improvement is built into the current YRT scale. Mr. Whitney said the current scale is equal to best estimate mortality with mortality improvement in future years. Dylan Strother (Oliver Wyman) discussed the mortality and PBR prescribed margins and their impacts on the PBR. He noted that the lack of including a future mortality improvement beyond the valuation date results in an implicit margin. Mr. Andersen asked whether it is important to differentiate the explicit margins from the implicit margins. Mr. Strother said the implicit margin was indicated because some of the amendment proposals that will be considered in the field test allow for the use of mortality improvement in the rates charged by reinsurers. Mr. Whitney said identifying the implicit margin provides a better understanding of what is affecting the overall margin at the various durations. Mr. Strother noted that scenarios reflecting reinsurer reactions can produce reserve
credits in excess of \( \frac{1}{2} c_x \). He also noted the importance of looking at long-term reserve projections when evaluating the impact of reinsurance modeling approaches because of the unlocking of mortality improvements and the impact of the margin changes over time.

Katie van Ryn (Oliver Wyman) discussed the scope of the field test, the amendment proposals being considered under various assumptions, and the results of the initial Oliver Wyman analysis. Mr. Whitney noted that modeled reinsurer reactions lag the ceding mortality experience by one year. He broadly discussed possible reinsurer reactions to a number of possible scenarios posed by Task Force members. He noted that, while there are no reinsurers participating in the field test, reinsurers are expected to respond to the “Range of Interpretations” survey. He said the reinsurer responses to the survey are expected to inform assumptions on reinsurer reaction to some of the scenarios of concern to Task Force members.

Mr. Whitney discussed the next steps for the analysis and field test. He said that assuming field test results are received by year-end: 1) point-in-time reserve results from the field test will be confirmed and shared with the Task Force in February 2020; 2) results for each of the specified amendment proposals will be ready for Task Force discussion in March 2020; and 3) company projected reserves will be developed and shared with the Task Force in April 2020.

Mr. Boerner said that given the dates of milestones and next steps, there is a chance that the Task Force could have an amendment proposal in May 2020 to consider for exposure, but the timeframe for an adoption that could be included in the 2021 Valuation Manual would be very tight.

3. **Adopted the Minutes of the VM-22 (A) Subgroup**

Mr. Sartain said the VM-22 (A) Subgroup did not meet subsequent to the Summer National Meeting, but several members have been participating on conference calls of the Academy Annuity Reserves Work Group (ARWG) and the SVL Interest Rate Modernization Work Group (SVLIRMWG). He said Subgroup discussions in the past year were focused on reinvestment risk issues. He said that because of developments in Academy discussions, the conversation on that issue has changed. The Subgroup will be revisiting the reinvestment risk discussions in the first quarter of 2020.

Mr. Sartain said the ARWG is working on PBR for non-variable annuities, including payout annuities. He said the SVLIRMWG is updating the rates and methodologies for the Commissioners’ Annuity Reserve Valuation Method (CARVM), including consideration of an exclusion test.

Mr. Sartain made a motion, seconded by Mr. Weber, to adopt the VM-22 (A) Subgroup’s report. The motion passed unanimously.

4. **Heard an Update from the Academy Annuity Reserves Work Group**

Ben Slutsker (ARWG) discussed some elements of the ARWG proposal for a revised non-variable annuity reserve framework (Attachment Eight). He said the elements are only representative, and a more comprehensive proposal will be developed in the coming months. He said the ARWG plan is to propose a PBR approach for non-variable annuities that utilizes a Conditional Tail Expectation (CTE) 70 reserve calculation. He said the baseline of the methodology is the recent revisions to VM-21, Requirements for Principle-Based Reserves for Variable Annuities, with deviations and enhancements, as needed, to handle product complexities. The complexities include guaranteed living benefits (GLBs), fixed deferred or fixed index annuities, and reinvestment risks. Mr. Slutsker said the target date for Task Force adoption of the proposed framework is Spring 2022. He said the ARWG is looking for Task Force feedback on: 1) asset assumptions related to spreads, default costs and reinvestment methodology; 2) exclusion test methodology; and 3) any concerns on the scope of the proposed framework, including possible retrospective application of the methodology to existing contracts, regardless of issue date.

Mr. Slutsker said the ARWG recommends hedging requirements consistent with VM-21, without the clearly defined hedging strategy (CDHS) distinction. Ms. Hemphill said that it would be helpful if the ARWG noted when its recommendation is not consistent with VM-21. She said the notes should be accompanied by a brief explanation of the reasons for deviating from the VM-21 framework.

Mr. Slutsker said the ARWG recommends applying the VM-21 methodology to fixed annuity PBR. The ARWG also recommends using a modified version of the VM-20, Requirements for Principle-Based Reserves for Life Products, exclusion testing methodology for fixed annuity PBR. Mr. Tsang asked if the exclusion test would be applied before or after reinsurance. Mr. Slutsker responded that the ARWG has not explored that question. He suggested that the VM-20 methodology, which applies the exclusion test both pre- and post-reinsurance ceded, would most likely prevail.
Mr. Slutsker asked for Task Force feedback on the ARWG recommendation to use the VM-21 discount rate and starting asset methodology for fixed annuity PBR. He said the ARWG position is that company specific spreads and defaults are more appropriate because fixed annuity investments tend to be heavily dependent on general account returns. Ms. Hemphill asked what kind of guardrail would be applied for these assumptions given how dependent the reserves are on these returns, and asked how the framework would assess the credibility of company-specific spread and default assumptions. Mr. Slutsker said that this would be considered further as the framework was developed.

Mr. Boerner said retroactive application of the revised framework to contracts issued prior to the effective date of the Valuation Manual would require actuarial guideline changes and could have tax implications. Paul S. Graham (American Council of Life Insurers—ACLI) said the tax code no longer considers the date of issue, but it is instead tied to the valuation methodology. He said that should alleviate any concern about retroactivity. He said whether there might be issues that may arise by making the changes optional will require more study.

Mr. Tsang asked if there will be a floor reserve, similar to the VM-20 net premium reserve (NPR). Mr. Slutsker said there is a cash surrender value (CSV) floor and potentially a separate floor for guaranteed living income benefits (GLIBs). Ms. Hemphill said she would like to hear how the proposal handles the VM-21 standard scenario. Mr. Slutsker said the focus has been on the modeled reserve, and the floor has not yet been discussed; but it will be considered. Mr. Slutsker stated that the Academy is generally in favor of the CTEPA approach for the standard scenario, as a disclosure item.

5. Heard an Update from the Academy SVL Interest Rate Modernization Work Group

Chris Conrad (SVLIRMWG) gave an update on the work of the SVLIRMWG (Attachment Nine). He said the SVLIRMWG is working closely with the ARWG to develop valuation rates to be used by products that pass the exclusion test that the ARWG is developing. He said valuation rates will be determined by finding the single discount rate that produces the same present value of benefits and expenses at time zero as discounting the cashflows at the quarterly portfolio yields, including realized gains and losses. He said the plan is to determine the discount rate under assumptions of rising rates, falling rates and level rates. He noted that the group has yet to determine how to weight the three scenarios and whether the final rate will be locked at issue. Once calculated, the rates will be used to develop a formula which relates the initial portfolio yield and the ultimate single valuation rate. The formula will be used to update the valuation rates quarterly. Mr. Conrad noted that the proposed framework will use U.S. treasuries plus VM-20 spreads as a reference index.

6. Discussed Considerations for Changes to the Life Mortality Improvement Factor Process

Marianne Purushotham (Joint Committee) said a presentation was made to the Task Force last year to make it aware of the methodology used to annually update the mortality improvement scale used for VM-20 and AG 38. She said the purpose of the presentation was to give the Task Force an opportunity to understand and ask questions about the Joint Committee process. She said the process entails annually looking at recent historical and current projected mortality improvements and applying a set methodology to update the scale. She said the improvements are used to move the Valuation Basic Table (VBT) from the date of the table to the current valuation date (e.g., the 2019 mortality improvement scale will be used to update the 2015 VBT from mid-2015 to the end of 2019). She noted that the methodology has not changed since 2013. She provided several slides (Attachment Ten) describing the current methodology, including some of its limitations and other considerations. She said the methodology uses U.S. Social Security Administration (SSA) data as a consistent source of population mortality data. She said that population mortality data tends to be more stable than insured mortality data. She said the population data is forecasted over a 20-year period to create an unsmoothed mortality improvement scale. She said actuarial judgment is used in the process of peer reviewing the unsmoothed scale to determine whether the scale should be changed that year. She said that after the peer review, the final step is to apply smoothing to the scale. She said the process is limited in that it looks at age and gender as basis risk due to the use of population data, and it is not intended for long-term projections. She noted that mortality improvement scales for insured mortality tables generally use population data.

Ms. Purushotham said that over the next two to three years, the mortality methodology will be changing as a common tool is being developed, which will allow practitioners from life, annuity and pension to share a consistent framework for producing mortality improvement scales. She said that in the short term, the Joint Committee will be looking to revise the methodology to remove more actuarial judgment by defining clear thresholds that would trigger a change in the scale. She said another consideration is whether the updates should require the formal approval of the Task Force. She said the Valuation Manual does not require Task Force approval. She suggested that once the actuarial judgment is removed from the methodology, the improvement scale methodology could be added to the Valuation Manual. That would allow the annual update to be automatically adopted if no changes are made to the prescribed methodology.
Mr. Sartain asked if there could be a process that would allow the Task Force to formally adopt the mortality improvement factors annually. Mr. Boerner said that if the factor adoption is to be considered a Valuation Manual update, the mortality improvement factors may not be available until the subsequent year’s Valuation Manual. However, if the mortality improvement follows a process adopted in the Valuation Manual then annual improvements could be applied for the current valuation year. He also said there are other issues related to the timing of the availability of the population data and the availability of the scale for industry use that will need to be considered. Ms. Purushotham said companies have indicated that they would like the scale to be published earlier in the year. She said the scale can be published earlier, but that would require sacrificing an additional year of data. She said the Joint Committee is working with a three year time lag, such that the SSA data through 2016 is used for the 2019 mortality improvement scale. She said the SOA accesses Medicare data in July, provides an updated scale at the end of August, and publishes the mortality improvement scale by the end of September. She said that if the Joint Committee uses a four year time lag, the mortality improvement scale could be published earlier in the year, but it would lose the benefit of the recent mortality trends.

Ms. Purushotham summarized three possible options: 1) continue with the present process of using actuarial judgment to determine whether to change the scale; 2) have the scale change every year regardless of how immaterial the change might be; and 3) apply the current methodology, but make the changes subject to set thresholds. Mr. Boerner said Task Force members should consider the three options, as well as whether increasing the time lag might be acceptable.

7. Exposed Amendment Proposal 2019-33

Mary Bahna-Nolan (Academy Life Reserves Work Group—LRWG) discussed the presentation (Attachment Eleven) recommending revised PBR treatment for individually underwritten group insurance. She said amendment proposal 2019-33 proposes subjecting certain group life certificates that are marketed, underwritten and solicited in a manner similar to individual life policies to the same Valuation Manual requirements as individual life policies. She said the Statement of Statutory Accounting Principles (SSAP) No. 50—Classifications of Insurance or Managed Care Contracts (SSAP No. 50) provides a definition of group life that is not fully applicable to the group certificates under consideration, as individually underwritten group certificates do not preclude individual selection and are for the benefit of policyholder. She said VM-51, Experience Reporting Formats, scopes out individually solicited group life policies from the mandatory data collection. She reviewed each of the eight recommended changes proposed by amendment proposal 2019-33.

Mr. Chou made a motion, seconded by Mr. Leung, to expose amendment proposal 2019-33 (Attachment Twelve) for a public comment period ending Feb. 7, 2020. The motion passed unanimously.


Linda Lankowski (LRWG) said amendment proposal 2019-62 recommends requirements for disclosure and the reporting of conversion reserves.


9. Exposed Amendment Proposal 2019-60

Ms. Hemphill said VM-20 requires a single credibility method for all business subject to PBR. She said that because Buhlmann credibility factors are not currently available for simplified issue (SI) business, companies are forced to use the Limited Fluctuation credibility method for their SI business; therefore, they are required to use the Limited Fluctuation method for fully underwritten business subject to VM-20 as well, even if the Buhlmann credibility method is more appropriate. She said amendment proposal 2019-60 proposes to: 1) remove the single credibility method restriction from Section 9.C.5.a of VM-20 for all business, regardless of the type of underwriting; and 2) add a Guidance Note to Section 9.C.7.b.ii of VM-20.

Ms. Ahrens made a motion, seconded by Mr. Chou, to expose amendment proposal 2019-60 (Attachment Fourteen) for a public comment period ending Jan. 31, 2020. The motion passed unanimously.

10. Exposed Amendment Proposal 2019-61

Ms. Hemphill said amendment proposal 2019-61 clarifies that the life PBR exemption cannot be applied to a policy with a material secondary guarantee, regardless of whether the secondary guarantee is a rider or part of the base policy.
Ms. Eom made a motion, seconded by Mr. Leung, to expose amendment proposal 2019-61 (Attachment Fifteen) for a public comment period ending Jan. 31, 2020. The motion passed unanimously.

11. Heard an Update on SOA Research and Education

Dale Hall (SOA) provided a presentation (Attachment Sixteen) identifying recent and upcoming topics that he thought would be of interest to life insurance regulators. Referencing the earlier discussion on mortality improvement, he noted that the SOA is conducting a mortality improvement survey to gather information on how companies make assumptions for life and annuity financial projections and what factors they consider in that process. He said the report will be available in early 2020. He said another report that will be available in January 2020 is the Centers for Disease Control and Prevention (CDC) population mortality observations report, updated for 2018 experience. He said the 2018 experience shows considerable improvement over the prior three to four years.

Mr. Hall said the SOA is hosting an accelerated underwriting expert panel forum on Dec. 11 to discuss best practices for validating algorithms used for underwriting life insurance products. He said the SOA expects to issue a report of best practices and other insights gathered from the forum.

Mr. Hall said the SOA launched its Mortality & Longevity Strategic Research Program in October. He said one of the research items released is a study on the economic impact of opioid abuse. He said that while the main insurance impact is associated with healthcare, there is an economic impact on other insurance lines from premature mortality and increases in group disability and workers’ compensation claims.

Ms. Ahrens asked for more information on the report on Public Perception of Longevity and Its Drivers. Mr. Hall said the report resulted from surveys asking participants to evaluate their longevity. He said most people either underestimated or overestimated their life expectancy by four to five years. He said the report provides insights on the impact of individuals misestimating their longevity.


Ms. Ahrens said the Subgroup met on Nov. 25, Nov. 4, Oct. 7, Sept. 30 and Sept. 18. The minutes of these conference calls are included in the minutes of the Life Risk-Based Capital (E) Working Group. Ms. Ahrens said the Subgroup will recommend the Academy Longevity Risk Task Force (LRTF) proposed C-2 factors for longevity risk to the Working Group. She noted that the Subgroup is not comfortable with the application of the proposed factors to longevity risk transfer. They will ask that longevity risk transfers be scoped out of the application of the C-2 factors and that they receive a charge to continue studying longevity risk transfers.

Ms. Ahrens said the LRTF submitted recommendations to the Working Group in August for a correlation component for C-2 mortality and C-2 longevity in the final calculation. She said the Subgroup is not comfortable making the decision, and it will forward the issue to the Working Group.

Ms. Ahrens made a motion, seconded by Mr. Yanacheak, to adopt the Longevity Risk (A/E) Subgroup’s report. The motion passed unanimously.

13. Recommended to the Life Insurance and Annuities (A) Committee the Formation of a GI Valuation Subgroup

Ms. Ahrens said a new guaranteed issue (GI) table is needed to replace the 2001 Commissioners’ Standard Ordinary (CSO) table as the mortality standard for GI business. She said the 2001 CSO was used as an interim solution after the rescission of the 2017 Commissioners’ Standard Guaranteed Issue (CSGI) table upon discovering that it produced excessive deficiency reserves for some companies. She asked the Task Force to recommend that the Life Insurance and Annuities (A) Committee form a subgroup of the Task Force to address the issue. She said the recommendation to form the subgroup (Attachment Seventeen) provides a proposed charge that is aligned with an existing Task Force charge and provides justification for the subgroup formation. She said Nebraska has been asked to chair the Subgroup. Alabama, Connecticut, Illinois, New York, Ohio and Texas will be the initial members of the Subgroup, with other state insurance regulators welcome to join. Mr. Boerner proposed a more concise version of the recommendation (Attachment Eighteen).

Mr. Ahrens made a motion, seconded by Mr. Ostlund, to forward the concise version of the recommendation to form a GI subgroup of the Task Force to the Life Insurance and Annuities (A) Committee. The motion passed unanimously.
14. Heard an Update from the Academy PBR Governance Work Group

Donna Claire (Academy PBR Governance Work Group) gave a presentation (Attachment Nineteen) on PBR resources available from the Academy. She said the Academy PBR practice page on the Academy website provides the PBR toolkit, Academy comments on PBR, links to NAIC PBR resources, and Academy publications on PBR. She noted that Actuarial Standard of Practice (ASOP) No. 52, Principle-Based Reserves for Life Products under the NAIC Valuation Manual and other ASOPs apply to actuaries responsible for doing or reviewing PBR work. She said the Boot Camp following the Fall National Meeting will include a variable annuities track. She said there will also be a series of Academy webinars on variable annuity reserves. She noted that a practice note on PBR projections is soon to be released, and a “PBR Checklist” that lists important characteristics to consider for PBR valuations was released in October. Other publications referenced by Ms. Claire are the PBR analysis template and an updated VM-20 practice note reflecting changes effective in the 2020 Valuation Manual.

15. Heard an Update on the RFP for the ESG

Pat Allison (NAIC) presented an update (Attachment Twenty) on the request for proposal (RFP) for a new economic scenario generator (ESG) requested by the Task Force and the Life Risk-Based Capital (E) Working Group earlier this year. The RFP is being developed and will result in the selection of a vendor to provide a new ESG to be prescribed for life and annuity reserves and capital. More specifically, the ESG will be used for VM-20, VM-21, C-3 Phase I and C-3 Phase II. She said the target date for completion of the RFP is the first quarter of 2020. She noted that implementation of the ESG will be no earlier than 2022.

16. Heard an Update on the Cessation of LIBOR

Ms. Allison provided an update (Attachment Twenty-One) on the cessation of the London Interbank Offered Rate (LIBOR). She said LIBOR will no longer be available after 2021. She said the replacement of LIBOR is due to: 1) LIBOR becoming less suitable as a benchmark; 2) the reduction of LIBOR-based borrowing; 3) the unsecured nature of LIBOR; and 4) the reluctance of banks to submit LIBOR rates based on judgment rather than actual transactions.

Ms. Allison said the Alternative Reference Rates Committee (ARRC) was formed in 2014 by the Board of Governors of the Federal Reserve and the Federal Reserve Bank of New York in response to risks related to LIBOR. She said the ARRC has identified the Secured Overnight Financing Rate (SOFR) as the rate representing best practice for use in derivatives and other financial contracts. The presentation lists a number of reasons for the selection of the SOFR and the risks associated with moving to the SOFR. The Federal Reserve Bank of New York began daily publication of the SOFR in April 2018. Ms. Allison encouraged companies to consider actions that they may need to take to accommodate the replacement of LIBOR. She also noted that changes to the Valuation Manual and the Accounting Practices and Procedures Manual (AP&P Manual) will be necessary.

17. Heard an Update on Life Insurance Mortality Experience Reporting

Ms. Allison provided an update (Attachment Twenty-Two) on life insurance experience reporting for 2020. She said that beginning the fourth quarter of 2019, companies can begin to submit data using the Regulatory Data Collection (RDC) tool. Companies are also able to request exemptions or communicate exclusions from the data collection requirements. Ms. Allison said the initial data call begins in the second quarter of 2020, with a Sept. 30, 2020, deadline for submission. She noted that companies must correct any identified data errors by Dec. 31. She said the deadline for NAIC submission of aggregate experience data to the SOA is May 31, 2021.

Ms. Allison said the company selection process was limited because the lack of granularity of annual statement data made it difficult to exclude the lines of business outside the scope identified in the Valuation Manual. She said the selection process focused on groups of affiliated companies and individual companies large enough to be subject to PBR in 2020. She said the process resulted in the selection of 176 companies from 31 different domiciliary states. She noted that 107 of the selected companies have participated in the Kansas or New York data calls.

Ms. Allison said no state insurance regulator decision is necessary to determine that a company is able to meet available exclusions. She said exemptions require the NAIC to consult with a company’s domestic regulator before being granted or disallowed. She said after potential exclusions and exemptions, 148 companies are currently selected to participate in the data call. She said the NAIC is providing a number of resources to support companies in the data submission process. She also
discussed data checks currently in place to provide controls for the submission process, and she reviewed some frequently asked questions (FAQs).

18. **Discussed PBR Mortality Aggregation**

Ms. Hemphill said the mortality aggregation presentation (Attachment Twenty-Three) from the Summer National Meeting is provided for reference. She said there were no formal comments submitted when the materials were previously exposed. She cautioned that, even when there are no written prohibitions against the aggregation of particular segments, actuarial judgment as to the relevance and appropriateness of data is still applicable and should prevail. She noted that one informal comment suggested adding a guidance note to the *Valuation Manual* that would direct readers to the aggregation examples provided on the Industry tab of the NAIC webpage.

David Neve (Academy LRWG) said one of the principles of PBR is that the same assumptions should be used across all company applications. He said that developing new mortality assumptions for PBR based on VM-20’s aggregation requirements seem to be inconsistent with that principle. Ms. Hemphill said the intent of the examples was to provide general principles or dos and don’ts for aggregating, not to specifically dictate how the aggregation should be executed.

19. **Heard an Update from the Compact**

Jeanne Daharsh (Interstate Insurance Product Regulation Commission—Compact) provided an update (Attachment Twenty-Four) on the activities of the Compact. She said the Commission Officers and Management Committee will meet on Dec. 9 to consider approval of uniform standards for: 1) group policyholder application; 2) group annuity certificate for employer groups; and 3) group guaranteed interest contracts (GICs) for non-variable annuities for employer groups.

She said the single premium group fixed annuity contract standards adopted by the Compact will be effective for filing Jan. 14, 2020. She noted that the Product Standards Committee continues to address the gaps in uniform standards for individual life and annuity. She said a referral was sent to the Actuarial Working Group to consider developing standards for index-linked variable annuity products.

Ms. Daharsh said the Compact has received 1,367 filings through October, of which 1,305 have been approved. She said the average wait time for review of a filing is 33 days. The median number of states on a Compact filing is 43. The number of mix-and-match filings has continued to decrease and now comprises 28% of filings. She said 69% of the filings are for life products, 18% of the filings are for annuity products, and the remaining filings are for long-term care (LTC) and disability income. She noted that there has been a 50% increase in life filings due to the 2017 CSO filings.

19. **Adopted the Report of the IUL Illustration (A) Subgroup**

Mr. Andersen made a motion, seconded by Mr. Chou, to adopt the Nov. 14 (Attachment Twenty-Five), Nov. 1 (Attachment Twenty-Six) and Sept. 16 (Attachment Twenty-Seven) minutes of the IUL Illustration (A) Subgroup. The motion passed unanimously.

Mr. Andersen said the Task Force voted that illustrations for indexed universal life (IUL) policies with multipliers and product enhancements should illustrate no better than IUL policies without multipliers. He said one of the product enhancements of concern to the Task Force is the cap buy-up, which allows a policyholder to receive returns in excess of the investment return cap specified in the policy. He noted that there are charges associated with multipliers and product enhancements, but the net return on policies are in excess of the returns for IUL products without those features.

Mr. Andersen said the Task Force decision produced a number of comments from industry members. He said some of the letters offered opinions on what to do with the cap buy-up feature. Before considering the comment letters, he asked Task Force members to confirm that their intent was to have IUL policies with cap buy-ups illustrate no better than IUL policies without cap buy-up features. Mr. Serbinowski said his intent was to quote in that manner. He followed by saying that unless there is a restriction placed on the underlying investments returns, companies will continue to design products to circumvent the limitation. Mr. Chupp said that he no longer supports the position taken in his comment letter (Attachment Twenty-Eight). He said his preference is for the recommendation submitted by Nationwide Insurance (Attachment Twenty-Nine). Mr. Andersen discussed the table of numerical examples provided in the Nationwide recommendation. He said the recommendation differentiates between an index bonus charge, which covers the cost related to the multiplier, and an index parameter charge, which are applicable to the benchmark index account. Ms. Ahrens said the charges should be treated in a similar manner to avoid the company circumvention efforts spoken of by Mr. Serbinowski. Birny Birnbaum (Center for Economic Justice—CEJ) said cap buy-ups should be treated in the same manner as multipliers because the same principles hold for both features. He
said the multipliers, bonuses and buy-ups all show up as increased returns without demonstrating increased risks. Mr. Boerner asked if Mr. Birnbaum believes that AG 49 could be revised to show downside risk. Mr. Birnbaum said he does not believe that the current illustration model, and by extension AG 49, is able to reflect the downside risk. He also suggested that the issue with illustrations should be addressed by the Life Insurance and Annuities (A) Committee instead of the Task Force. Ms. Ahrens said that some of the actions of the Task Force seem to be aimed at stomping out product innovation. She said actions to limit product design should be the purview of the Life Insurance and Annuities (A) Committee. Mr. Birnbaum said he is in favor of the Task Force addressing this issue with illustrations, but he also thinks that the Life Insurance and Annuities (A) Committee should take a broader look at illustrations.

Tom Doruska (Global Atlantic) said the Global Atlantic comments (Attachment Thirty) recommend that cap buy-ups and multipliers should be treated the same. He also said the necessary changes should be accomplished in Section 5 of AG 49. Mr. Boerner agreed and said the inclusion of downside risk in illustrations can be considered as Phase 2. The Task Force voted to direct the IUL Illustration (A) Subgroup to revise AG 49 to subject cap buy-ups and index return enhancements to constraints reasonably similar to the constraints to be applied to multipliers, with Mr. Chupp dissenting.

Mr. Serbinowski made a motion, seconded by Ms. Ahrens, to adopt the IUL Illustration (A) Subgroup’s report. The motion passed unanimously.

20. Discussed the VBT and Expiring Experience

Ms. Bahna-Nolan introduced the VBT analysis process (Attachment Thirty-One). She plans to have the analysis completed for discussion with the Task Force at the 2020 Summer National Meeting. She said the 2015 VBT and the relative risk (RR) tables were based on 2002–2009 industry data projected forward with mortality improvement to 2015. She said the 2015 VBT, projected to the valuation date with the mortality improvement scale that Ms. Purushotham previously discussed with the Task Force, is used as the best estimate mortality. She said starting in 2020, the number of companies contributing to the mandatory data collection will grow significantly. She said the Joint Committee would like to develop analytics to determine when there is sufficient differentiation to warrant development of a new table. She said an approach has been developed that is based on a normal distribution and uses confidence intervals to determine whether to develop a new table.

Ms. Bahna-Nolan said the Joint Committee will work with MIB, Inc. and the NAIC to add calculation fields and credibility calculations to the individual mortality data. She said Task Force and industry feedback is welcome.

21. Discussed Comments Received on Amendment Proposal 2019-56

Ms. Bahna-Nolan said comments from Allstate (Attachment Thirty-Two), the ACLI (Attachment Thirty-Three) and the CEJ (Attachment Thirty-Four) were submitted on amendment proposal 2019-56 (Attachment Thirty-Five), which recommended the addition of data elements to the mandatory data call that would assist in segmenting and differentiating experience by underwriting programs. She said the comments shared concerns related to data privacy and security, data complexity, the costs of compliance, and timing. She said they are working with the NAIC Legal staff to address the data privacy issue, which is a primary concern. Dan Schelp (NAIC) said the new data elements being requested do not add to the data privacy issue. He said work was done last year to ensure that personally identifiable information was not being collected. He agreed to look at any of the new data fields about which there is concern.

22. Adopted the Report of the Experience Reporting (A) Subgroup

Mr. Andersen said it is time to begin collection of variable annuities (VA) policyholder behavior data. He said that due to the market rising since 2008, the need for the policyholder behavior data has not been as critical. He said it is important that the structure for data collection be put in place to prepare for the future.

Mr. Andersen made a motion, seconded by Mr. Yanacheak, to adopt the Experience Reporting (A) Subgroup’s report. The motion passed unanimously.

23. Heard an Update from the Academy Council on Professionalism

Kathy Riley (Academy) said the Actuarial Standards Board (ASB) has completed its review of ASOP No. 11, Financial Statement Treatment of Reinsurance Transactions Involving Life Insurance or Health Insurance. ASOP No. 11 will be posted on the ASB webpage soon, with comments due by Feb. 28, 2020. Ms. Riley said the ASB expects to complete its revisions to ASOP No. 22, Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life or Health Insurers in February
2020. She said the guidance in ASOP No. 22 has been expanded with changes to the language on discount rates and assumptions, and additional guidance on reinsurance and separate account assets. She said comments from the exposure draft of ASOP No. 2, *Nonguaranteed Charges or Benefits for Life Insurance Policies and Annuity Contracts* are being reviewed. ASOP No. 56, *Modeling* has been finalized after four exposure drafts.

David Ogden (Academy) said the Actuarial Board for Counseling and Discipline (ABCD) provided general descriptions of the life requests for guidance. He encouraged actuaries to utilize the process if they have questions.

Having no further business, the Life Actuarial (A) Task Force adjourned.
The Life Actuarial (A) Task Force met via conference call Oct. 17, 2019. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Jacob Lauten (AK); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce. R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); John G. Franchini represented by Mark Hendrick (NM); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA). Also participating was: Rachel Hemphill (TX).

1. Provided Direction on AG 49 Revisions to the IUL Illustration (A) Subgroup

Mr. Andersen said that during the Sept. 16 IUL Illustration (A) Subgroup conference call, the Subgroup discussed five possible ways to address concerns related to the crediting rate applied to indexed universal life (IUL) illustrations. The possibilities were narrowed down to possibility 2, eliminating any difference between the illustrated rate for products with index multipliers and products without index multipliers, and possibility 3, allowing a heavily constrained difference between products with multipliers and products without multipliers. Mr. Andersen noted that separate drafts of edits to Actuarial Guideline XLIX, The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49) to reflect possibility 2 (Attachment One-A) and possibility 3 (Attachment One-B) have been prepared. He said the language addressing the illustrated rate applicable to policy loans is the same in both drafts. He said disclosure issues will be addressed in phase 2 of this project.

Austin Bichler (Allianz Life) said Allianz Life’s comment letter (Attachment One-C) supports limits on the illustrated rates for multiplier policies, as proposed in the AG 49 edits for possibility 3. He proposed a mandatory ledger that would show all policy charges and credits on an annual basis. He also proposed a numerical disclosure displaying the impact of the non-level sequence of credits. Mr. Andersen said the Subgroup can determine whether the non-level sequence of credits disclosure is easy to employ or if it should be deferred to phase 2.

Ernest Armijos (Pacific Life) said Pacific Life favors possibility 3 with the addition of a secondary guardrail designed to protect consumers. A feature of the secondary guardrail would be a guaranteed alternative cash value, which would limit the downside risk while allowing for potential growth. Possibility 3 proposes an allowance for a 45% annual return on charges up to 2.5%. Mr. Weber and Ms. Ahrens said 2.5% was chosen as a reasonable middle ground to use as a guardrail.

Mary Bahna-Nolan (Pacific Life) said Pacific Life opposes possibility 2 because it does not seem to comply with the requirements of the Life Insurance Illustrations Model Regulation (#582) or Actuarial Standard of Practice (ASOP) 24, Compliance with the NAIC Life Insurance Illustrations Model Regulation. She said the implementation of possibility 2 would require the illustration of the multiplier charges without allowing the illustration of the upside benefits. She also noted that possibility 2 may conflict with the Advertisements of Life Insurance and Annuities Model Regulation (#570), which requires life insurance advertising to be complete and clear. She said that since multiplier features were not modeled under possibility 2, companies would be prohibited from discussing these features, leading to incomplete information. Ms. Hemphill said possibility 2 models both the multiplier charges and an offsetting amount of associated credits; therefore, there would not be a prohibition on discussing the multiplier features. Mr. Leung questioned how possibility 2 would not comply with Model #582 and ASOP 24 if the current version of AG 49 is in compliance. Ms. Bahna-Nolan said that is a different issue related to the incorporation of features and benefits into the disciplined current scale.

Birny Birnbaum (Center for Economic Justice—CEJ) said possibility 2 is the best way to immediately address the current issues. He said the questions related to sequence of charges and disclosure can be addressed later.

Mr. Andersen asked the Task Force members to express their preference for revising AG 49 to reflect either possibility 2 or possibility 3. Alabama, Alaska, California, Connecticut, Illinois, Iowa, Kansas, Missouri, New Mexico, New York, Oklahoma,
Texas and Utah voted for possibility 2. Indiana, Minnesota, Nebraska, New Jersey, Ohio and Virginia voted for possibility 3. Mr. Boerner asked if anyone disagreed with directing the Subgroup to proceed with addressing the crediting rate for loans using the approach provided in the AG 49 edits that reflect possibility 2. No Task Force members objected. On behalf of the Subgroup, Mr. Andersen accepted the direction to revise AG 49 to reflect possibility 2 and submit the revised document to the Task Force for its consideration.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Actuarial Guideline XLIX

THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION TO POLICIES WITH INDEX-BASED INTEREST

Background

The Life Insurance Illustrations Model Regulation (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an external index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

1. Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
2. Limits the policy loan leverage shown in an illustration.
3. Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text

1. Effective Date

This Actuarial Guideline shall be effective as follows:

i. Sections 4 and 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after September 1, 2015.

ii. Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in-force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold.

iii. Sections 6 and 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:

i. The policy is subject to Model #582.

ii. The policy offers interest credits, multipliers, factors, bonuses, or other enhancements to policy values that are linked to an external index or indices.

3. Definitions

A. Alternate Scale: A scale of non-guaranteed elements currently being illustrated such that:

i. The credited rate for each Index Account does not exceed the lesser of the maximum credited rate for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does
not offer a Fixed Account with the illustrated policy, the credited rate for each Index Account shall not exceed the average of the maximum credited rate for the illustrated scale and the guaranteed credited rate for that account. However, the credited rate for each Index Account shall never be less than the guaranteed credited rate for that account.

ii. If the illustration includes a loan, the illustrated rate credited to the loan balance, including Index Credits and all other illustrated benefits and bonuses that impact the policy’s account value, shall not exceed the illustrated loan charge rate does not exceed the illustrated loan charge.

iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. Annual Net Investment Earnings Rate: Gross portfolio annual earnings rate, less provisions for investment expenses and default cost, of the general account assets (excluding hedges for Indexed Credits) allocated to support the policy.

B.C. Benchmark Index Account: An Index Account with the following features:

i. The interest calculation is based on the percent change in S&P 500® Index value only, over a one-year period using only the beginning and ending index values. (S&P 500® Index ticker: SPX)

ii. An annual cap is used in the interest calculation.

iii. The annual floor used in the interest calculation shall be 0%.

iv. The participation rate used in the interest calculation shall be 100%.

v. Interest is credited once per year.

vi. Account charges do not exceed the account charges for any corresponding Index Accounts within the policy in any policy year. If Index Accounts with different levels of account charges are offered with the illustrated policy, more than one Benchmark Index Account may be used in determining the maximum illustrated crediting rates for the policy’s Index Accounts, subject to the requirements of 5.D.. However, for each Index Account within the policy, only one Benchmark Index Account shall apply. Any rate calculated in 4 (B) shall not apply for an Index Account if the account charges for the applicable Benchmark Index Account exceed the account charges for that Index Account in any policy year. Account charges include all charges applicable to an Index Account, whether deducted from policy values or from premiums or other amounts transferred into such Index Account.

vii. Additional amounts credited are not less than the additional amounts credited for any corresponding Index Accounts within the policy in any policy year. Any rate calculated in 4 (B) shall not apply for an Index Account if the additional amounts credited for the applicable Benchmark Index Account are less than the additional amounts credited for that Index Account in any policy year. Additional amounts include all credits that increase policy values, including but not limited to experience refunds or bonuses.

viii. There are no limitations on the portion of account value allocated to the account.

C.D. Fixed Account: An account where the credited rate is not tied to an external index or indices.

E. Index Account: An account where the credited rate is tied to an external index or indices.

F. Indexed Credits: Any interest credit, multiplier, factor, bonus, or other enhancement to policy values that is linked to an external index or indices.

G. Supplemental Option Budget: The total amount spent to generate the Indexed Credits of the policy minus the Annual Net Investment Earnings Rate. This amount is expressed as a percent of the policy’s indexed account value.
4. Illustrated Scale

The credited rate for the illustrated scale for each Index Account shall be limited as follows:

A. Calculate the geometric average annual credited rate for each applicable Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.

i. If the insurer offers an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the applicable Benchmark Index Account in 4 (A).

ii. If the insurer does not offer an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of a Benchmark Index Account, and shall use that cap in 4 (A).

B. For each applicable Benchmark Index Account, the arithmetic mean of the geometric average annual credited rates calculated in 4 (A) shall be the maximum credited rate(s) for the illustrated scale.

C. For other Index Accounts using other equity, bond, and/or commodity indexes, and/or using other crediting methods, the illustration actuary shall use actuarial judgment to determine the maximum credited rate for the illustrated scale. The determination shall reflect the fundamental characteristics of the Index Account and the parameters shall have the appropriate relationship to the expected risk and return of the applicable Benchmark Index Account. In no event shall the credited rate for the illustrated scale exceed the applicable rate calculated in 4 (B).

D. At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

5. Disciplined Current Scale

The annual earned interest rate for underlying the disciplined current scale shall be limited as follows:

A. If an insurer engages in a hedging program for index-based interest Indexed Credits, the assumed annual earned interest rate underlying the disciplined current scale for the policy, inclusive of all hedge/derivative assets and cash flows that support Indexed Credits and all other investments that support the policy, shall not exceed i. + ii. + iii., where:

i. equals the Annual Net Investment Earnings Rate,

ii. equals 45% times the Annual Net Investment Earnings Rate, and

iii. equals the Supplemental Option Budget.

145% of the annual net investment earnings rate (gross portfolio earnings less provisions for investment expenses and default costs) of the general account assets (excluding hedges for index-based credits) allocated to support the policy.

Drafting note: i. is a proxy for the amount funding the 0% interest guarantee; ii. Allows a 45% return on the portion of the Option Budget up to the Annual Net Investment Earnings Rate; iii. Allows a return of the Supplemental Option Budget to offset the charges.
A-B. If an insurer does not engage in a hedging program for index-based interest Indexed Credits, the assumed annual earned interest rate underlying the disciplined current scale for the policy shall not exceed the annual net investment earnings rate of the general account assets allocated to support the policy.

B-C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all Indexed Credits and all other illustrated benefits and including illustrated bonuses.

D. If more than one Benchmark Index Account is used for an illustrated policy, each set of Index Accounts that correspond to each Benchmark Index Account, and all Indexed Credits that apply to an Indexed Account, must independently pass the self-support and lapse-support tests under Model #582, subject to the limitations in 5 (A), (B), and (C). All experience assumptions that do not directly relate to the Index Accounts and Indexed Credits as to expenses, mortality, investment earnings rate of the general account assets, lapses, and election of any Fixed Account shall equal the assumptions used in the testing for the entire policy.

E. The table below illustrates four examples of the calculation of the assumed annual earned interest rate underlying the disciplined current scale. Example 1 assumes the insurer engages in a hedging program and the Supplemental Option Budget is zero. Examples 2-4 assume the insurer’s Supplemental Option Budget is positive in increasing amounts.

<table>
<thead>
<tr>
<th></th>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
<th>Example 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Net Investment</td>
<td>4.5%</td>
<td>4.5%</td>
<td>4.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Earnings Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Option</td>
<td>0%</td>
<td>1.5%</td>
<td>2.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Budget (as % of Indexed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Account Value)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Annual Earned</td>
<td>6.53%</td>
<td>8.03%</td>
<td>9.03%</td>
<td>11.03%</td>
</tr>
<tr>
<td>Interest Rate underlying</td>
<td>1.45 * .045</td>
<td>1.45 * .045</td>
<td>1.45 * .045</td>
<td>1.45 * .045</td>
</tr>
<tr>
<td>the Disciplined Current</td>
<td>+ 0</td>
<td>+ .015</td>
<td>+ .025</td>
<td>+ .045</td>
</tr>
<tr>
<td>Scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Annual Earned</td>
<td>6.53%</td>
<td>6.53%</td>
<td>6.53%</td>
<td>6.53%</td>
</tr>
<tr>
<td>Interest Rate minus</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Option</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budget</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Policy Loans

If the illustration includes a loan, the illustrated rate credited to the loan balance, including Indexed Credits and all other illustrated benefits and bonuses that impact the policy’s account value, shall not exceed the sum of explicit illustrated loan charges and asset-based charges by more than 100 basis points.

6.7. Additional Standards

The basic illustration shall also include the following:

A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.

B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period.
Actuarial Guideline XLIX

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Background

The Life Insurance Illustrations Model Regulation (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an external index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

(1) Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.

(2) Limits the policy loan leverage shown in an illustration.

(3) Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text

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iii. Sections 6 and 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:

i. The policy is subject to Model #582.

ii. The policy offers interest credits, multipliers, factors, bonuses, or other enhancements to policy values that are linked to an external index or indices.

3. Definitions

A. Alternate Scale: A scale of non-guaranteed elements currently being illustrated such that:

i. The credited rate for each Index Account does not exceed the lesser of the maximum credited rate for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does
not offer a Fixed Account with the illustrated policy, the credited rate for each Index Account shall not exceed the average of the maximum credited rate for the illustrated scale and the guaranteed credited rate for that account. However, the credited rate for each Index Account shall never be less than the guaranteed credited rate for that account.

ii. If the illustration includes a loan, the illustrated rate credited to the loan balance, including Index Credits and all other illustrated benefits and bonuses that impact the policy’s account value, shall not exceed the illustrated loan charge rate does not exceed the illustrated loan charge.

iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. Annual Net Investment Earnings Rate: Gross portfolio annual earnings rate, less provisions for investment expenses and default cost, of the general account assets (excluding hedges for Indexed Credits) allocated to support the policy.

B.C. Benchmark Index Account: An Index Account with the following features:

i. The interest calculation is based on the percent change in S&P 500® Index value only, over a one-year period using only the beginning and ending index values. (S&P 500® Index ticker: SPX)

ii. An annual cap is used in the interest calculation.

iii. The annual floor used in the interest calculation shall be 0%.

iv. The participation rate used in the interest calculation shall be 100%.

v. Interest is credited once per year.

vi. Account charges do not exceed the account charges for any corresponding Index Accounts within the policy in any policy year. If Index Accounts with different levels of account charges are offered with the illustrated policy, more than one Benchmark Index Account may be used in determining the maximum illustrated crediting rates for the policy’s Index Accounts, subject to the requirements of 5.D. However, for each Index Account within the policy, only one Benchmark Index Account shall apply. Any rate calculated in 4 (B) shall not apply for an Index Account if the account charges for the applicable Benchmark Index Account exceed the account charges for that Index Account in any policy year. Account charges include all charges applicable to an Index Account, whether deducted from policy values or from premiums or other amounts transferred into such Index Account.

vii. Additional amounts credited are not less than the additional amounts credited for any corresponding Index Accounts within the policy in any policy year. Any rate calculated in 4 (B) shall not apply for an Index Account if the additional amounts credited for the applicable Benchmark Index Account are less than the additional amounts credited for that Index Account in any policy year. Additional amounts include all credits that increase policy values, including but not limited to experience refunds or bonuses.

viii. There are no limitations on the portion of account value allocated to the account.

C.D. Fixed Account: An account where the credited rate is not tied to an external index or indices.

E. Index Account: An account where the credited rate is tied to an external index or indices.

F. Indexed Credits: Any interest credit, multiplier, factor, bonus, or other enhancement to policy values that is linked to an external index or indices.

G. Supplemental Option Budget: The total amount spent to generate the Indexed Credits of the policy minus the Annual Net Investment Earnings Rate. This amount is expressed as a percent of the policy’s indexed account value.
4. Illustrated Scale

The credited rate for the illustrated scale for each Index Account shall be limited as follows:

A. Calculate the geometric average annual credited rate for each applicable Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.

   i. If the insurer offers an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the applicable Benchmark Index Account in 4 (A).

   ii. If the insurer does not offer an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of a Benchmark Index Account, and shall use that cap in 4 (A).

B. For each applicable Benchmark Index Account, the arithmetic mean of the geometric average annual credited rates calculated in 4 (A) shall be the maximum credited rate(s) for the illustrated scale.

C. For other Index Accounts using other equity, bond, and/or commodity indexes, and/or using other crediting methods, the illustration actuary shall use actuarial judgment to determine the maximum credited rate for the illustrated scale. The determination shall reflect the fundamental characteristics of the Index Account and the parameters shall have the appropriate relationship to the expected risk and return of the applicable Benchmark Index Account. In no event shall the credited rate for the illustrated scale exceed the applicable rate calculated in 4 (B).

D. At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

5. Disciplined Current Scale

The earned interest rate for the disciplined current scale shall be limited as follows:

A. If an insurer engages in a hedging program for index-based interest Indexed Credits, the assumed annual earned interest rate underlying the disciplined current scale for the policy, inclusive of all hedge/derivative assets and cash flows that support Indexed Credits and all other investments that support the policy, shall not exceed i. + ii. + iii., where:

   i. equals the Annual Net Investment Earnings Rate,

   ii. equals 45% times the Annual Net Investment Earnings Rate, and

   iii. equals 145% times the minimum of the Supplemental Option Budget and 2.5%.

145% of the annual net investment earnings rate (gross portfolio earnings less provisions for investment expenses and default costs) of the general account assets (excluding hedges for index-based credits) allocated to support the policy.

Drafting note: i. is a proxy for the amount funding the 0% interest guarantee; ii. Allows a 45% return on the portion of the Option Budget up to the Annual Net Investment Earnings Rate; iii. Allows for a 45% annual return on charges up to 2.5%.
If an insurer does not engage in a hedging program for index-based interest Indexed Credits, the assumed annual earned interest rate underlying the disciplined current scale for the policy shall not exceed the annual net investment earnings rate of the general account assets allocated to support the policy.

These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all Indexed Credits and all other illustrated benefits and including illustrated bonuses.

If more than one Benchmark Index Account is used for an illustrated policy, each set of Index Accounts that correspond to each Benchmark Index Account, and all Indexed Credits that apply to an Indexed Account, must independently pass the self-support and lapse-support tests under Model #582, subject to the limitations in 5 (A), (B), and (C). All experience assumptions that do not directly relate to the Index Accounts and Indexed Credits as to expenses, mortality, investment earnings rate of the general account assets, lapses, and election of any Fixed Account shall equal the assumptions used in the testing for the entire policy.

The table below illustrates four examples of the calculation of the assumed annual earned interest rate underlying the disciplined current scale. Example 1 assumes the insurer engages in a hedging program and the Supplemental Option Budget is zero. Examples 2-4 assume the insurer’s Supplemental Option Budget is positive in increasing amounts.

<table>
<thead>
<tr>
<th>Annual Net Investment Earnings Rate</th>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
<th>Example 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental Option Budget (as % of Indexed Account Value)</td>
<td>0%</td>
<td>2.5%</td>
<td>3.5%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Maximum Annual Earned Interest Rate underlying the Disciplined Current Scale</td>
<td>6.53% = 1.45 * .045 + 1.45 * min (.025, .025)</td>
<td>10.15% = 1.45 * .045 + 1.45 * min (.025, .025)</td>
<td>10.15% = 1.45 * .045 + 1.45 * min (.035, .025)</td>
<td>10.15% = 1.45 * .045 + 1.45 * min (.075, .025)</td>
</tr>
<tr>
<td>Maximum Annual Earned Interest Rate minus Supplemental Option Budget</td>
<td>6.53%</td>
<td>7.65%</td>
<td>6.65%</td>
<td>2.65%</td>
</tr>
</tbody>
</table>

Policy Loans

If the illustration includes a loan, the illustrated rate credited to the loan balance, including Index Credits and all other illustrated benefits and bonuses that impact the policy’s account value, shall not exceed the charge rates, including those from illustrated loan charges and other charges that impact the policy’s account value, by more than 100 basis points.

Additional Standards

The basic illustration shall also include the following:

A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.

B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period.
October 16, 2019

Mr. Mike Boerner, Chairperson, Life Actuarial (A) Task Force  
Mr. Fred Andersen, Chairperson, IUL Illustration (A) Subgroup  
National Association of Insurance Commissioners

Re: Illustration of Index Multipliers under AG 49

Mr. Boerner and Mr. Andersen,

In advance of the October 17 Life Actuarial Task Force call to discuss the illustration of index multipliers, Allianz would like to submit the following comments in support of a compromise approach and enhanced disclosures. Thank you for the opportunity to provide these comments.

**Innovative products provide value to consumers**

In this historically low interest rate environment, insurers are limited in the value they can provide through traditional insurance products, so insurers are developing innovative products that have the opportunity to provide more value to consumers. One example of a product innovation that provides value to consumers is the index multiplier.

Index multipliers offer policyholders more upside potential. In a traditional IUL product, the insurer has an option budget that is used to buy hedges that support index credits. When a multiplier is added, the option budget is increased by policy charges, which enable the insurer to purchase more units of the same hedges.

<table>
<thead>
<tr>
<th>Original option budget</th>
<th>4.0%</th>
<th>1.00 units of hedges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiplier charge</td>
<td>1.0%</td>
<td>0.25 units of hedges</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5.0%</td>
<td><strong>1.25 units of hedges</strong></td>
</tr>
</tbody>
</table>

Since the charges are used to purchase the same hedges that are used to support the base index credits, the options have the same level of risk premium. However, the additional policy charges result in a different risk profile for the policy as a whole.

**We support limits in the illustration of index multipliers**

Although index multipliers can provide value to consumers who want more upside potential, the additional policy charges increase the risk profile in the policy. Therefore, we support a limit to the amount that is shown in illustrations. We believe the proposed 2.5% limit to the illustrated option budget in excess of the annual net investment earned rate (NIER) reflects a reasonable balance between consumer value and consumer protection.

**Example of the 2.5% limit**

<table>
<thead>
<tr>
<th>NIER</th>
<th>Multiplier charge</th>
<th>Actual option budget</th>
<th>Maximum illustrated option budget</th>
<th>Maximum DCS illustrated rate</th>
<th>Net DCS illustrated rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0%</td>
<td>3.0%</td>
<td>7.0%</td>
<td>min (7.0, 4.0 + 2.5) = 6.5%</td>
<td>6.5 * 1.45 = 9.4%</td>
<td>9.4 – 3.0 = 6.4%</td>
</tr>
</tbody>
</table>

Allianz Life Insurance Company of North America, 5701 Golden Hills Drive, Minneapolis, MN 55416-1297. www.allianzlife.com

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In addition, we also support clarification that the 100 basis point limit on the illustrated loan credit is inclusive of multiplier credits and net of the loan charges and multiplier charges.

<table>
<thead>
<tr>
<th>Loan charge</th>
<th>Multiplier charge</th>
<th>Maximum illustrated loan credit (including multiplier credit)</th>
<th>Net illustrated loan credit (net of charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.0%</td>
<td>3.0%</td>
<td>5.0 + 3.0 + 1.0 = 9.0%</td>
<td>9.0 – 5.0 – 3.0 = 1.0%</td>
</tr>
</tbody>
</table>

**Allianz supports enhanced disclosure requirements within AG 49**

Allianz recognizes that value-adding product features such as index multipliers can increase product complexity, so we believe it is critical that illustrations are designed to educate consumers and empower them to make informed decisions. Therefore, we recommend two enhancements to the AG 49 disclosure requirements that would illuminate the risks associated with these index multiplier features as well as the risks associated with IUL products in general.

First, Allianz recommends adding a requirement in AG 49 that all credits and charges must be disclosed in the illustration using a year-by-year ledger. A year-by-year ledger showing all credits and charges would ensure that the consumer can clearly see the costs and benefits of the policy. Most carriers provide this type of ledger as an option to include in the illustration; we believe the ledgers should be mandatory because of the valuable information they provide.

Second, Allianz recommends adding a requirement in AG 49 for the illustration of a sequence of credits (i.e., non-level credited rates). Since 2015, we have included a demonstration of the impact of sequencing in our illustrations using a four year repeating pattern – 0%, x%, x%, x% – where the average of the four credits is equal to the illustrated rate.

As a result of the sequencing, the demonstration shows that either the maximum loan must decrease or the policy will lapse earlier than what was shown in the illustrated scale. As the risk of an option increases, the impact also increases.

**Example Demonstration**

<table>
<thead>
<tr>
<th>Illustrated scale</th>
<th>Option A: no index multiplier</th>
<th>Option B: index multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum annual loan</td>
<td>$14,654</td>
<td>$19,998</td>
</tr>
<tr>
<td>Sequenced scale</td>
<td>$14,261 (-2.7%)</td>
<td>$18,726 (-6.6%)</td>
</tr>
<tr>
<td>Lapse year with $14,654 annual loan</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Lapse year with $19,998 annual loan</td>
<td>50</td>
<td>42</td>
</tr>
</tbody>
</table>

This sequencing demonstration has strongly resonated with our distribution force because it highlights risks using the same average credit as the illustrated scale. Although these risks are also shown to some degree in the guaranteed scale and the alternate scale, these illustrations are less effective because they are perceived to be “unrealistic” or “too conservative.” One of the most frequent requests we receive from our distribution force is the ability to illustrate the impact of volatile credits on policy values.

It is important to note that a sequencing demonstration can be added to AG 49 without opening the model because a pattern can be constructed such that the values shown in the sequenced demonstration never exceed the values shown in the illustrated scale.

1 Because the pattern starts with 0%, the values shown in the sequenced demonstration never exceed the values shown in the illustrated scale; thus, the pattern complies with Model 582. We chose a four-year pattern because the S&P 500 has historically been negative approximately one out of every four years. We are open to other patterns where the average equals the illustrated rate.

2 Assumes a 45-year-old at issue with a $250,000 death benefit. Option B assumes a hypothetical 2.5% multiplier charge.
Conclusion

Product innovations such as index multipliers provide consumers the opportunity for value in today’s historically low interest rate environment. It is important to find a way to illustrate these benefits in a way that balances consumer value and consumer protection; without illustration of these benefits, consumer education will decrease. Thus, we support the compromise proposal of a 2.5% limit and the clarification of loan rules.

We also support enhanced disclosure requirements to highlight the risks associated with these index multiplier features as well as the risks associated with IUL products in general. The illustration of all charges and credits along with a demonstration of the impact of sequence of credits will provide consumers meaningful product education and enable them to make informed decisions.

Thank you for the opportunity to provide these comments.

Regards,

Austin Bichler, FSA, MAAA
Senior Director Actuary & Illustration Actuary
Allianz Life Insurance Company of North America
The Life Actuarial (A) Task Force met via conference call Oct. 3, 2019. The following Task Force members participated:

Kent Sullivan, Chair, represented by Mike Boerner (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Jacob Lauten (AK); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Ted Chang (CA); Andrew N. Mais represented by Wanchin Chou (CT); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Steve Kelley represented by Fred Andersen and John Robinson (MN); Marlene Caride represented by Seong-min Eom (NJ); Linda A. Lacewell represented by Bill Carmello (NY); Glen Muhleady represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Adopted the Joint Committee Recommendation for AG 38/VM-20 Mortality Improvement**

Mr. Boerner said the Individual Life Insurance Mortality Improvement Scale Recommendation—for Use with AG 38 and VM-20 is referenced in Section 9.C.3.g of VM-20, Requirements for Principle-Based Reserves for Life Products. He said VM-20 states that the mortality improvement factors are to be determined by the Society of Actuaries (SOA). He added that the *Valuation Manual* does not require nor provide for Task Force adoption of the mortality improvement factors.

Reggie Mazyck (NAIC) agreed and said the mortality improvement factors have not been subject to Task Force adoption in the past. Mr. Ostlund argued that the mortality improvement factors should be subject to Task Force adoption. Mr. Sartain said discussion of whether the mortality improvement factors should be approved by the Task Force is worthwhile, but requiring Task Force adoption of the proposed factors breaks the precedent. Mr. Chang noted that Task Force disapproval would not prevent the SOA from publishing the mortality improvement factors.

Brian Bayerle (American Council of Life Insurers—ACLI) discussed the ACLI comments (Attachment Two-A) on the proposed mortality improvement factors. He agreed that a future discussion of whether Task Force approval of the mortality improvement factors should be required is worthwhile. He suggested that an earlier release of the mortality improvement factors should also be considered. He said releasing the mortality improvement factors in October makes it challenging for companies to apply the factors to their year-end analysis.

Marianne Purushotham (American Academy of Actuaries [Academy] Life Experience Committee and the SOA Preferred Mortality Oversight Group Valuation Basic Table Team—Joint Committee) said the Joint Committee considered publishing the recommendation at the beginning of the year, but doing so would not allow for inclusion of the data from the most recent year. She said the SOA peer review process determines whether the calculation methodology, which was last changed in 2013, was applied correctly and looks at the history of changes and the materiality of proposed changes to determine if the proposed change should be applied.

Mr. Ostlund made a motion, seconded by Mr. Serbinowski, to adopt the Individual Life Insurance Mortality Improvement Scale Recommendation—for Use with AG 38 and VM-20 (see *NAIC Proceedings – Fall 2019, Life Actuarial (A) Task Force, Attachment Three-A*). Dan Schelp (NAIC) pointed out that the *Valuation Manual* does not require Task Force approval or adoption of the recommendation. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.
October 2, 2019

Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force

Re: Individual Life Insurance Mortality Improvement Scale Recommendation

Dear Mike:

The American Council of Life Insurers (ACLI) appreciates the opportunity to comment on the exposed Individual Life Insurance Mortality Improvement Scale Recommendation for Use with AG 38 and VM-20 on behalf of our member companies.

ACLI appreciates the diligent work of the SOA in the development of the updated mortality improvement scale. ACLI recognizes there has been mortality deterioration in certain segments of the general population; however, it is not clear that such deterioration has occurred in the insured population. Member companies are not reporting the level of deterioration in their blocks of business that have been recognized in the general population. However, a 7-day exposure period for this scale does not allow enough time for companies to reconcile the differences between their results and the SOA study. Furthermore, we don’t believe that the automatic table updates allowed by the Valuation Manual extend to the mortality improvement scale, as the tables that are automatically updated follow a documented methodology in the Valuation Manual and are not subject to discretionary judgement. That is clearly not the case for the mortality improvement factors.

In addition to the process concerns, ACLI is greatly concerned about the limited time for companies to implement and assess the impact to their reserve levels. While the impact is likely small for PBR, the impact on AG 38 could be quite significant. The current process of adopting changes to the mortality improvement scale during the Fall, with only three months to understand and implement the change, has been problematic for some time. This concern is magnified when the scale reflects a deterioration.

Our other concerns regarding the scalars are as follows:

Additional analysis is necessary

More work needs to be done to understand differences between the insured and population mortality data. To date, the mortality improvement scale has been developed using purely population mortality due to limitations in available insured data. However, Kansas and New York data calls have existed for several years expressly for the purpose of updating mortality tables. In fact, this data was contemplated in a recent SOA report on individual life mortality experience:

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1 ACLI is a Washington, D.C.-based trade association with approximately 290 member companies operating in the United States and abroad. ACLI advocates in state, federal, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers' products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing 95 percent of industry assets, 93 percent of life insurance premiums, and 98 percent of annuity considerations in the United States. Learn more at www.acli.com.
The mortality improvement scale is an interim mortality change, and this available data should be considered in determining if the impact of the deterioration is consistent with the insured population. ACLI understands that availability of Causes of death (CODs) within the Kansas and New York data calls are limited as they are not a required field. ACLI would suggest that LATF investigate the possibility to increase the availability of CODs in future submissions.

The most recent SOA research on population mortality provides some indication of the drivers of the deterioration. COD analysis indicates the primary drivers for the mortality deterioration are a slowdown in improvements in outcomes related to heart diseases and increases in death associated with opioids and suicide. Among these CODs, the magnitude of the impact associated with opioids and suicide on the insured population is not clear due to known demographic factors associated with these CODs. It would be extremely beneficial for analysis to be performed as more insured data emerges to broadly assess the impacts of the CODs to determine if these trends are as pronounced in the insured population.

Industry, the SOA, and regulators should take the time to further study and develop methods to reflect these differences, as appropriate.

**Methodology introduces volatility into the reserve framework**

We believe the methodology for updating the mortality improvement scale can introduce volatility into reserves, especially as a change to reflect insured mortality within the improvement factors is implemented. Even under the current methodology, we may see some volatility due to the need for judgment in the updating of the scale. The prior scale report recognized the trend of deterioration in the prior year, but it was not significant enough to justify changing the scale. Now that the trend has continued, the update results in a more significant impact, given the cumulative effect of the changes. While some volatility is inevitable, ACLI believes that there be a process to mitigate volatility with changing factors, such as a grade-in or smoothing of results. This would dampen some of the peaks and valleys of the volatility.

**Impact of the worsened scalars hurts smaller companies**

Both the AG 38 and VM-20 mortality methodologies recognize a company’s own experience in setting of the mortality assumption. Because the mortality improvement factors only impact the industry mortality tables, we are concerned that the update to the scalars penalizes companies with lower credibility. This creates some potential playing field concerns, particularly if the general population mortality continues to deteriorate, but the insured population does not.

**Potential harm to consumers**

ACLI is concerned about how the current methodology ultimately impacts consumers. If erroneous conclusions are drawn from population data, this may lead to harm to consumers vis a vis affordability of insurance.

ACLI would also like to comment on the work to develop product-neutral mortality improvement scales. It’s not clear this would be appropriate, given that life underwritten products have significant information on the insured populations, as opposed to annuity products. While there is inherently some overlap between these two populations, the disparity in availability data regarding underwriting suggests some valid reasons for separate scales.
In summary, ACLI believes it is appropriate to reflect deterioration if it is indicative of the mortality trends of the underwritten population. To avoid such late changes in the future, we encourage regulators to update the Valuation Manual to introduce a lag in implementation of the mortality improvement scale if it is exposed so late in the year, such as explicitly stating in the Valuation Manual that the mortality scale to be used is the named yearly report on the SOA website, as adopted by LATF.

We are optimistic we can work with LATF to develop a reasonable solution that appropriately reflects mortality trends while limiting potential hardship to companies.

We look forward to a discussion of these issues.

Sincerely,

[Signature]

cc Reggie Mazyck, NAIC
The Life Actuarial (A) Task Force met via conference call Sept. 26, 2019. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Jacob Lauten (AK); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce R. Ramge (NE); Marlene Caride represented by Seong-min Eom (NJ); Linda A. Lacewell represented by Bill Carmello (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Heard an Update on the YRT Reserve Credit Field Test**

Jason Kehrberg (American Academy of Actuaries—Academy) said the pre-survey for the Yearly Renewable Term (YRT) Reserve Credit field test was distributed to 187 companies. Thus far, 47 companies have responded, with five companies agreeing to participate, 13 companies saying they cannot participate due to resource limitations, and the remaining 29 companies declining to participate. The survey response period closes on Oct. 1. Mr. Kehrberg said the required level of effort for participants has been lessened. He said one-on-one discussions with the companies expressing resource limitations may be warranted to make them aware of the lightened requirements. He briefly reviewed the scaled back requirements for model information that participants will be asked to provide. He said the requirements are limited to information related to model preparation.

In response to questions submitted prior to the conference call, Mr. Kehrberg provided the following information:

- With input from industry, the consultant will consider whether YRT treaties with fully guaranteed premiums will need to be modeled.
- Amendment proposal form (APF) 2019-JR will not be field tested; APF 2019-39 will be the baseline for the field.
- The 2020 *Valuation Manual* will be the source of the modeling requirements.
- Future mortality improvement (FMI) sensitivities will not be included until focused modeling instructions are distributed in November.

2. **Exposed the Joint Committee Recommendation for AG 38/VM-20 Mortality Improvement**

Marianne Purushotham (Academy Life Experience Committee and the Society of Actuaries’ [SOA] Preferred Mortality Oversight Group Valuation Basic Table Team—Joint Committee) said the Individual Life Insurance Mortality Improvement Scale Recommendation—for use with AG 38 and VM-20 (Attachment Three-A) is reviewed annually for any recommended revisions for use with Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38) and VM-20, Requirements for Principle-Based Reserves for Life Products, of the *Valuation Manual*. She said the methodology for developing the recommendation includes a historical mortality component and a future mortality component, which are averaged to produce the recommended table. The methodology is consistent with the methodology used to develop the mortality improvement for the 2016 Valuation Basic Table (VBT) and the 2017 Commissioners’ Standard Ordinary (CSO) Table. To reduce volatility, the historical mortality component uses 10-year average annual historical mortality improvement levels implied from general population mortality data published by the U.S. Social Security Administration (SSA). The future mortality component uses the 20-year average annual mortality improvement levels based on the most recent SSA Trustees’ report intermediate assumption data. Ms. Purushotham said a decrease in the mortality improvement scale is recommended. She said the decrease is reflective of the mortality trends observed over the last few years. Given the decrease in mortality improvement, the Joint Committee wanted to inform and discuss with the Life Actuarial (A) Task Force. Prior to this year, the usual process was to have the recommended scale approval process limited to peer review.

Mr. Boerner agreed to expose the Individual Life Insurance Mortality Improvement Scale Recommendation—for Use with AG 38 and VM-20 for a seven-day public comment period ending Oct. 2.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Individual Life Insurance Mortality Improvement Scale Recommendation—for Use with AG 38 and VM-20
September 2019

This report outlines the 2019 individual life insurance mortality improvement recommendation.

**Background**

As part of the work done by the American Academy of Actuaries'1 Life Experience Committee and the Society of Actuaries'2 Preferred Mortality Oversight Group Valuation Basic Table Team ("Joint Committee") that developed the 2015 Valuation Basic Table (VBT), the Mortality Improvement subgroup was tasked with reviewing recent mortality improvement levels based on available data for the individual life insurance policyholder population.

As a result of this work, the subgroup presented a recommendation for the development of a set of improvement factors that differ by gender and attained age to be used in conjunction with the 2015 VBT. This recommended methodology was accepted and has been used for year-end 2013–2018 in conjunction with Actuarial Guideline (AG) 38 and Valuation Manual section 20 (VM-20). See Appendix A of this report for additional background on the development of the current methodology.

Since year-end 2014, a Mortality Improvements Life Working Group (MILWG) has been tasked with studying and annually recommending updates to the mortality improvement scales for use with AG 38 and VM-20 work (specific to the individual life insurance product lines).

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1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

2 The Society of Actuaries (SOA) is an educational, research and professional organization dedicated to serving the public, its members and its candidates. The SOA's mission is to advance actuarial knowledge and to enhance the ability of actuaries to provide expert advice and relevant solutions for financial, business and societal problems. The SOA's vision is for actuaries to be the leading professionals in the measurement and management of risk.
The Society of Actuaries (SOA) Mortality and Longevity Steering Committee is simultaneously working on a general framework for developing product-neutral mortality improvement scales, which will subsequently be used as a guide by the MILWG to revisit the current approach for creating these scales each year.

The recommended scales are intended to be applied to update (“improve”) valuation basic table mortality rates to the end of the current valuation year. As an example, for year-end 2019, the 2015 VBT table mortality would be improved from July 1, 2015, through Dec. 31, 2019 (4.5 years) using the current recommended scale outlined in this document.

**Example application:**

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</table>

**2019 Mortality Improvement Scale Methodology**

The raw, unsmoothed mortality improvement factors are equal to the average of a historical component and a future-looking component as described below:

- **Historical component:**
  
The historical component is represented by the 10-year average annual historical mortality improvement levels implied from general population mortality data published by the Social Security Administration (SSA). For each calendar year of data, the SSA results are published more than a year after the Centers for Disease Control and Prevention (CDC) results are available (so for example, for 2019 the published SSA historical data is only available through 2016 even though CDC data is available through 2017). In order to provide the subgroup with as much information as possible for this yearly update process, the SOA applies the SSA methodology to produce a preliminary set of SSA-consistent mortality rates for use in this calculation for attained ages 20 to 100. For the 2019 recommendation, the 2017 historical rates were estimated by the
SOA for ages 20 to 100. For ages under 20 and over 100, the SSA Alternative (Alt) 2 projected rates for 2017 were used as a proxy for actual historical rates.

Although a 5-year period more closely aligns with the period over which mortality rates are improved for the current purpose, a 10-year historical period was selected for use as it results in less volatility from year to year. The most recent 5-year averages (see Appendix B) were examined as part of the update process and have been considered in developing the final recommendation. Although these results indicate negative improvement for certain age groups (specifically 20-45) over the 5-year period, preliminary data for 2018 from the Vital Statistics Rapid Release Reports indicates potential improvements returning in 2018.

Future-looking component:
The future component is represented by the 20-year average annual mortality improvement levels (for 2019, this covers the period from 2017 to 2037), based on the most recent Social Security Administration Trustees’ report intermediate assumption (Alt 2). The SSA mortality projection is based on historical data and assumes ultimate average annual percentage reductions in future mortality rates by age and cause of death. These assumptions are used to estimate future central death rates by age, sex, and cause of death. From these estimated central death rates, probabilities of death by single year of age and sex are determined.

For AG 38/VM-20 purposes, the “future projected” component is relatively short (for 2019, historical data exists through 2017, so the “unknown” future component is 2 years). However, applying the 20-year period for averaging (rather than a shorter period) generally results in smoother patterns by age and calendar year. It also provides greater stability in year-over-year results as the longer period lessens the tendency to over-react to short-term fluctuations in historical experience. The determination of the future component will also be reviewed as part of the full methodology update to apply the recommended consistent framework from the SOA Mortality and Longevity Steering Committee work.

The average annual rates calculated as above are then smoothed using simple linear interpolation to produce a final scale by gender and age.

Historical data from the Human Mortality Database (HMD) was also considered in determining the 10-year historical averages, which provided a perspective from multiple sources in examining recent population mortality trends.

Recommendation

Based on a review of the improvement factors resulting from application of the methodology to include the 2019 data updates, it is recommended that the mortality improvement scale be revised for 2019 to reflect mortality deterioration trends that have emerged over the past several years in population mortality. The current methodology does not include an adjustment to reflect differences between the target insured population and the general population on which mortality data is based. From limited data from reinsurers and other sources, there is some indication that insured mortality is generally lower than general population mortality (possibly due to the generally higher socioeconomic status of those buying life insurance). However, there is not yet sufficient consistent, long-range insured data on which to
measure mortality improvement specific to the insured population. Several potential options to reflect adjustments in a future review of the current methodology are under consideration.

This revision will result in a reduction in mortality improvement levels from the 2018 scale of approximately 0.25 percentage points for males and 0.15 percentage points for females.

This decision is supported by an examination of the most recent 5-year historical averages, which show a smaller improvement in mortality than the earlier 5-year period. See Appendix B for historical averages by age and gender for these two historical 5-year periods.

The 2019 recommended improvement rates can be found in the accompanying spreadsheet.

**Applicability of Improvement Scale**

The above recommendation represents a view of reasonable mortality improvement factors for short- and medium-term projections and is intended to be applied solely for the purposes of updating the mortality assumption from the time of the valuation table publication to the beginning of the current valuation period.
APPENDIX A:

Considerations in developing mortality improvement factors for application with AG 38 and VM-20.

- Period of Experience Used—The desire for a methodology that weights the impact of recent historical rates of improvement with a longer-term assumption (i.e., SSA intermediate mortality projections) in determining projected improvement rates. This approach is (at a very high level) consistent with the current U.K. Continuous Mortality Investigation (“CMI”) projection models, as well as methods commonly used to develop other insured mortality projection scales. These methods basically project rates based on past experience, but trend toward a long-term assumed average annual improvement level.

- Insured Data—Aggregate insurance company data for the period 2002–2009 from the Society of Actuaries’ regular studies of individual life insurance mortality was initially examined. It was eventually decided that, given (1) the relatively short period over which historical insured experience is available and (2) the year-over-year volatility of results (likely in part the result of both industry-specific factors and changes in underlying mortality rates), general population data is a preferable source for determining both an improvement scale for use in VBT table development efforts and as annual AG 38/VM-20 scale recommendations, at least for the near term.

- General Population Data Source—The subgroup examined several sources of general population data, including data from the U.S. Vital Statistics, the Human Mortality Database (HMD), and the SSA. The SSA data was selected as the source for general population analysis for several reasons:
  - The data and reports are strongly vetted.
  - The SSA uses mortality statistics from the Centers for Medicare and Medicaid Services rather than the National Center for Health Statistics for ages 65 and older. A number of studies have questioned the validity of age reporting in the CDC National Statistics data.
  - Using the SSA data allows for consistency in applying the current methodology’s historical and future components (Trustees Report historical data is used as well as the projections of future estimated mortality).

- Additional Factors Considered (Gender, Attained Age, Smoker Status, Socioeconomic Status, Differences in Cause of Death for Insured vs. General Population)—In addition to data sources discussed above, the subgroup also researched and considered additional factors that could impact mortality improvement experience. The decision was made to regularly review the use of alternative or further adjustments to population mortality to eliminate potential basis risk at the same time any changes for consistent framework recommendations are incorporated.
APPENDIX B:


Males

Females

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Life Actuarial (A) Task Force
Conference Call
September 19, 2019

The Life Actuarial (A) Task Force met via conference call Sept. 19, 2019. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Mayumi Gabor (AK); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Rachel Hemphill and Perry Kupferman (CA); Andrew N. Mais represented by Wanchin Chou (CT); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramege represented by Derek Wallman (NE); Marlene Caride represented by Seong-min Eom (NJ); John G. Franchini represented by Mark Hendrick (NM); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. Adopted its 2020 Proposed Charges

The Task Force’s 2020 proposed charges remain consistent with its 2019 charges, except for the removal of the charge related to the implementation of the Variable Annuity Framework to recognize its completion.

Mr. Ostlund made a motion, seconded by Mr. Andersen, to adopt the Task Force’s 2020 proposed charges (Attachment Four-A). The motion passed unanimously.

2. Heard an Update on the YRT Reserve Credit Field Test

Jason Kehrberg (American Academy of Actuaries—Academy) discussed the draft of the General Modeling Instructions for Yearly Renewable Term (YRT) (Attachment Four-B). He said the draft is targeted toward non-reinsurer participants in the Academy’s YRT Reserve Credit field test. The instructions will be modified for participants that are reinsurers. Amendment proposals 2019-40, 2019-41 and 2019-42—as well as the interim solution, amendment 2019-39—will be appended to the draft for participant consideration. Mr. Kehrberg said the background information from the pre-survey will be included in Section A of the draft. He said Section C identifies the reinsurance treaty types and noted that only YRT reinsurance treaties are to be modeled. He said the design group is requesting results split by the five treaty types listed in the draft. He said to minimize the amount of work involved, the design group will attempt to collect only the treaty splits that are necessary to provide the Task Force with the data and analysis needed to make a good decision. Leonard Mangini (Academy) said the reserves are calculated at an aggregate level. Therefore, companies would combine multiple treaty types within the same VM-20 reserving category. Mr. Kehrberg said asking for splits will not allow the stochastic reserve offsets to be calculated correctly. He said the group is still considering whether the splits are necessary and would welcome feedback on the issue. He indicated that companies elected to participate in the study will receive a survey requesting information on product mix and treaty types. The information collected will be used to determine whether the splits are necessary. Mr. Kehrberg said the design group is considering whether to separate the information by product type within VM-20 reserving categories. He said the design group is recommending to separate business by term and universal life with secondary guarantees (ULSG) only. Field test participants will be asked to follow the requirements of the 2020 Valuation Manual and use year-end 2018 as the valuation date. Section K provides guidance on how to project cash flows and reserves.

Mr. Mangini discussed the output template (Attachment Four-C) to be used for documentation of the modeling results. He said the template represents a single treaty for one year of issues on a specific valuation date. He noted that this particular template is designed specifically for amendment proposal 2019-41.

Having no further business, the Life Actuarial (A) Task Force adjourned.
2020 PROPOSED CHARGES
LIFE ACTUARIAL (A) TASK FORCE

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

Ongoing Support of NAIC Programs, Products and Services

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

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

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

4. The IUL Illustration (A) Subgroup will:
   A. Consider enhancements to Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Indexed-Based Interest (AG 49). Provide recommendations for modifications to AG 49 to the Life Actuarial (A) Task Force.

5. The Longevity Risk (A/E) Subgroup, a joint subgroup of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group, will:
   A. Provide recommendations for recognizing longevity risk in statutory reserves and/or risk-based capital (RBC), as appropriate. Complete by the 2020 Spring National Meeting.

6. The VM-22 (A) Subgroup will:
   A. Recommend requirements as appropriate for non-variable (fixed) annuities in the accumulation and payout phases for consideration by the Life Actuarial (A) Task Force. A PBR methodology will be considered as appropriate.

NAIC Support Staff: Reggie Mazyck/Eric King

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General Modeling Instructions for **Non-Reinsurer** Participants in the PBR Yearly Renewable Term (YRT) Reinsurance Field Test

*(draft framework)*

**A. Background**

*(insert background from pre-survey)*

**B. Goals for the Field Test**

1. Compare Yearly Renewable Term (YRT) reinsurance reserve/credit differences by company, cedant/reinsurer perspective, product type, and treaty type for each Amendment Proposal Form (APF) and the one half of the one year mean reserve using the valuation mortality table (½ Cx) baseline.
2. Confidence in the reasonability of assumptions used and YRT premiums/claims projected.
3. Insight into the sources of deviation between ½ Cx and the reinsurance reserve/credit for each APF.
4. Better understand modeling complexities, intended/unintended outcomes, and differences due to company size/credibility/inforce and interpretation/implementation for each of the proposed APFs.
5. Insight into the impact of treaty types on cedant mortality margins, including the explicit credibility-linked margin, and the implicit margin from prohibiting future mortality improvement (FMI).

**C. YRT Reinsurance Treaty Types**

1. Model each of the company’s YRT reinsurance treaties.
2. Do not model non-YRT reinsurance treaties, e.g. coinsurance.
3. Classify each of the company’s YRT reinsurance treaties and produce results split by the five following treaty types:

<table>
<thead>
<tr>
<th>Type</th>
<th>Name</th>
<th>Initial guarantee period (GP) when rates can’t change</th>
<th>Restricted reinsurer ability to change rates after GP</th>
<th>Reinsurer pays experience refund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y1</td>
<td>1-Year Guarantee with Unrestricted Language</td>
<td>1 policy year or less</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Y2</td>
<td>1-Year Guarantee with Restricted Language</td>
<td>1 policy year or less</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Y3</td>
<td>[N]-Year Guarantee with Unrestricted Language</td>
<td>[N] policy years</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Y4</td>
<td>[N]-Year Guarantee with Restricted Language</td>
<td>[N] policy years</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Y5</td>
<td>1-Year Guarantee with Unrestricted Language and Experience Refund</td>
<td>1 policy year or less</td>
<td>No</td>
<td>Yes, [X%] * (YRT premium - YRT claims - Risk charge)</td>
</tr>
</tbody>
</table>

*Reinsurer shall provide prior written notice not less than [n] days prior to the effective date of any change in premium rates.*
• In no event shall the reinsurance premium rates exceed the guaranteed rates.

*Design Subgroup to consider adding additional categories described by responses in the pre-survey, including whether there should be an "Other" category.

D. Product Splits

<table>
<thead>
<tr>
<th>At a minimum, split by VM-20 reserving category</th>
<th>Ideally, further split by product type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term</td>
<td>[N]-year level term, ART, etc.</td>
</tr>
<tr>
<td>ULSG</td>
<td>ULSG, IULSG, VULSG, etc.</td>
</tr>
<tr>
<td>Other</td>
<td>WL, Accumulation-type UL, IUL, VUL, etc.</td>
</tr>
</tbody>
</table>

1. Separate out term field testing results by 10 year term, 20 year term, and 30 year term.

E. APFs for Calculating the Reserve Credit

<table>
<thead>
<tr>
<th>APF #</th>
<th>Short Name</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019-39</td>
<td>½ Cx baseline</td>
<td>Interim solution in 2020 VM.</td>
</tr>
<tr>
<td>2019-40</td>
<td>Up to actuarial judgement</td>
<td>Subject to clarified principles for modeling. 4 cedant sensitivities on counterparty action.</td>
</tr>
<tr>
<td>2019-41</td>
<td>Remove YRT claim margins</td>
<td>3 cedant sensitivities on mortality improvement.</td>
</tr>
<tr>
<td>2019-42</td>
<td>Add YRT premium margins</td>
<td>4 cedant sensitivities on mortality improvement.</td>
</tr>
</tbody>
</table>

1. See appendices for specific APF language and detail on instructions and sensitivities.

F. Valuation Manual

1. Follow the 2020 Valuation Manual unless directed otherwise in the APF-specific instructions.
2. Note any areas where the company’s field testing methodology is not in compliance.

G. Time Zero Valuation Date

12/31/18

H. Time Zero Inforce Population

1. Include policies issued during the last 12 months subject to the YRT treaty(ies) being tested.
2. Include plan codes that have been valued under PBR or are contemplated to be valued under PBR.
3. Use a mix of PBR pricing cells based on 12 months of issues if such an actual inforce population is not available.

I. Time Zero Yield Curve

<table>
<thead>
<tr>
<th>Maturity (years)</th>
<th>0.25</th>
<th>0.5</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>5</th>
<th>7</th>
<th>10</th>
<th>20</th>
<th>30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treasury Yield</td>
<td>2.45%</td>
<td>2.56%</td>
<td>2.63%</td>
<td>2.48%</td>
<td>2.46%</td>
<td>2.51%</td>
<td>2.59%</td>
<td>2.69%</td>
<td>2.87%</td>
<td>3.02%</td>
</tr>
</tbody>
</table>

(above is for 12/31/18)
J. Model Type
1. Use a model that can project reserves at future periods over the contract life for the modeled block.
2. If such a model is not available, consider basing on pricing model, business forecasting projection model, or cash flow testing model.

K. Inner Loop Projections
1. An inner loop projection projects cashflows forward from a valuation date, and those cashflows are only used to determine the deterministic reserve (DR) and stochastic reserve (SR) on that valuation date.
2. If possible, for each inner loop projection project cashflows until no liabilities remain.
3. Use VM-20 prescribed and prudent estimate assumptions.
4. A separate inner loop projection is required for each valuation date in the outer loop \((t = 0, 1, 2, ...)\).
   a. For each valuation date, use assumptions that comply with VM-20 and are consistent with the “state of the world” on that valuation date as defined by the outer loop at that point in time.
   b. Prudent estimate assumptions for each inner loop projection reflect increases in the credibility of company experience from one valuation date to the next.
   c. VM-20 scenarios for each inner loop projection are consistent with the outer loop yield curve on the valuation date.
   d. Current spreads for each inner loop projection are equal to spreads in the outer loop on the valuation date.
5. Optional sensitivity – FMI allowed for in the direct mortality experience
   a. While this sensitivity will not impact the YRT reinsurance premium modeling issue, there is interest in collecting some data on relaxing the prohibition of FMI in direct mortality experience. Time permitting, please calculate two sensitivities for the pre-reinsurance DR with FMI set to 0.5% and 1.0%, respectively.

L. Outer Loop Projections
1. Three outer loop projections
   a. Baseline of 0.5% FMI
   b. Sensitivities of 0% and 1% FMI
2. Outer loop experience assumptions
   a. Set equal to unmargined (i.e. anticipated) experience assumptions from the time zero inner loop projection.
   b. Assume 2% expense inflation in the outer loop.
3. Outer loop economic and reinvestment assumptions
   a. Assume the initial yield curve remains constant throughout the outer loop projection. This means the inner loop Stochastic Exclusion Ratio Test (SERT) 16 scenarios and stochastic reserve scenarios will be the same for time zero and every future valuation date.
   b. Use VM-20 prescribed current spreads and baseline defaults from the time zero inner loop projection. For the outer loop, keep spreads constant, i.e. do not grade to ultimate spreads as you do for the inner loop. For outer loop defaults, ignore the spread related factor and max net spread adjustment.
   c. Use the inforce portfolio mix from the time zero inner loop projection.
   d. Use the anticipated company experience reinvestment strategy from time zero.
4. Use separate inner loop projections to calculate reserves at time zero and each year-end in the outer loop projection.
   a. Can interpolate for month-end reserves in the outer loop projection as needed.

M. Numerical output template
1. Instructions – Instructions for the numerical output template are included in the template itself.
2. Comments – Please use the provided output template to capture all numerical input. Space is provided in the output template for comments. Comments in a Microsoft Word document will also be accepted, but please make comments on numerical output in the output template if possible.
3. (Note – A survey is being developed to capture additional non-numerical output. There are already some requests for non-numerical output in the APF-specific instructions.)

N. If cuts must be made due to resource constraints and/or modeling limitations
1. **Try these approximations and simplifications first:**
   a. **Outer Loop Projections** Project reserves at years 1-5 and every five years afterward (instead of annually)
   b. **Starting Assets** Scale starting assets within +/-10% (instead of 2% collar)
   c. **Product Types** Only provide field test results for the Term and ULSG reserving categories, with Term split by level term period and USLG split by UL/IUL/VUL
   d. **Stochastic Scenarios** Reduce the number of stochastic scenarios to 100 (or even 50)
   e. **Asset Portfolio** Use a simplified asset mix (e.g., ignore externally projected assets and reduce types of assets in portfolio)
   f. **Inner Loop Projection Period** For Term, limit each inner loop to a 40-year projection period (or less as deemed appropriate)
   g. **Expense Inflation** Use company-specific assumption expense inflation rate instead of 2% if needed (as long as both pre & post reinsurance are consistent)

2. **Try these if still experiencing resource constraints and/or modeling limitations:**
   a. **Outer Loop Projections** Project reserves at years 1, 5, 10, 20, 30
   b. **ULSG Product Types** Only provide field test results 20-year Term and ULSG (no IUL/VUL)
   c. **Pre-Reinsurance DR with FMI** Do not provide results
   d. **Stochastic Reserves** Only produce NPR and DR, but not SR
   e. **Outer Loop Improvement Scenarios** Only provide results for the baseline FMI scenario of 0.5%

3. **Only perform these if unable to complete field testing without them:**
   a. **Net Premium Reserve** Only produce DR and ½ Cx, not NPR
   b. **Outer Loop Projections** Only provide projected reserves at timing of expected reserve peak
   c. **Restrict Treaties** Only select key treaties that are more predominate on Term and USLG business
   d. **Forgo Nested Modeling** Forgo nested modeling by just projecting the inner loop and changing the valuation date (only recommended as a last resort)

* In the comments your company provides on field test modeling, please list and describe the shortcuts, approximations and/or simplifications used in your company’s modeling.
### American Academy of Actuaries

YRT Reinsurance Field Test

APF 2019-41 Output Reporting Template

All INPU values in $1 Units, spreadsheet will unite per $1,000 NAAR

---

#### Sub-Total Results for VM-20 Section 2.A.3 "Other Group"

**Type of Reinsurance used (See Instructions)**

- **YRT**

**Baseline One Year Issue Time Zero Un-Projected Reserves**

1.0% Future Mortality Improvement on Reinsurance Recoveries

---

#### Model Duration Cash Flows

<table>
<thead>
<tr>
<th>Time Zone Starting NAAR</th>
<th>0</th>
<th>1</th>
<th>2</th>
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<tr>
<td>Ceded NAAR in $1 Units - End of Period</td>
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<tr>
<td>Net of Reinsurance NAAR in $1 Units - End of Period</td>
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</table>

**Scaled Utilized Results**

- Direct Gross Premiums in $1 Units
- Direct Gross Claims in $1 Units
- YRT Premiums to Reinsurer in $1 Units
- Reinsurance Claims Recoveries in $1 Units

<table>
<thead>
<tr>
<th>Time Zone Starting NAAR</th>
<th>0</th>
<th>1</th>
<th>2</th>
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<tbody>
<tr>
<td>Direct Gross Premiums in $1 Units</td>
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<tr>
<td>Reinsurance Claims Recoveries in $1 Units</td>
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</table>

**Scaled "Loss ratio" by Duration**

<table>
<thead>
<tr>
<th>Time Zone Starting NAAR</th>
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<th>1</th>
<th>2</th>
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<tbody>
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<td>APV of Non-Guaranteed Reinsurance Claim Recoveries</td>
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<td>Non-Guaranteed Premium Loss Ratio for Treaty</td>
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<td>Guaranteed Premium Loss Ratio for Treaty</td>
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</tr>
</tbody>
</table>

#### Company Credibility Method

- **Company Credibility Level**
- **Prescribed Mortality Credibility Margin**
- **Duration of Start of Grading Period**
- **Duration End Grading to Industry Table**
- **Additional Mortality Margin (Explain Next Row)**
- **Explanation for Extra Margin**

<table>
<thead>
<tr>
<th>Time Zone Starting NAAR</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>Pre-Reinsurance Balance Sheet</td>
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<td>Post-Reinsurance Balance Sheet</td>
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<td>Utilized Reserve Credit &gt; Utilized 1/2 Cx 7</td>
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</table>

**SDP Latest Duration with 50 or More Expected Claims**

**Duration End Grading to Industry Table**

**APV of Non-Guaranteed Reinsurance Claim Recoveries**

**APV of Guaranteed YRT Reinsurance Premiums**

**Guaranteed Premium Loss Ratio for Treaty**

**Ceded "Loss ratio" by Duration**

<table>
<thead>
<tr>
<th>Time Zone Starting NAAR</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
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<tr>
<td>Implied Reserve Credit in $1 Units</td>
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<td>FALSE</td>
<td>FALSE</td>
<td>FALSE</td>
<td>FALSE</td>
</tr>
</tbody>
</table>

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Life Actuarial (A) Task Force Conference Call
September 12, 2019

The Life Actuarial (A) Task Force met via conference call Sept. 12, 2019. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Mayumi Gabor (AK); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Rachel Hemphill and Perry Kupferman (CA); Andrew N. Mais represented by Wanchin Chou (CT); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Bruce Sartain (IL); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Marlene Caride represented by Seong-min Eom (NJ); John G. Franchini represented by Mark Hendrick (NM); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. Adopted its Summer National Meeting Minutes

Mr. Ostlund made a motion, seconded by Mr. Weber, to adopt the Task Force’s Aug. 1–2 minutes (see NAIC Proceedings – Summer 2019, Life Actuarial (A) Task Force). The motion passed unanimously.

2. Adopted the 2020 GRET

Mr. Weber made a motion, seconded by Mr. Chou, to adopt the 2020 Generally Recognized Expense Tables (GRET) (Attachment Five-A). The motion passed unanimously.

2. Heard an Update on the YRT Reserve Credit Field Test

Jason Kehrberg (American Academy of Actuaries—Academy) said the Academy’s YRT Field Test Project Group is comprised of an oversight group and a design group. He presented PowerPoint slides (Attachment Five-B) showing the timeline, the field test pre-survey, yearly renewable term (YRT) treaty classification, risk transfer rules and proposed Task Force field test goals. He noted that amendment proposals 2019-40, 2019-41 and 2019-42 are to be assessed during the field test, with amendment proposal 2019-39 serving as a baseline. He emphasized that company information will be kept confidential. The timeline assumes the field test will be facilitated by a consultant. Mr. Kehrberg noted that the target date may not be met if the consultant is not hired prior to Sept. 30.

The results of the field test will inform the Task Force selection of a long-term solution for the methodology for the determination of the YRT reinsurance reserve credit. Mr. Kehrberg said the solution the Task Force chooses may require the Statutory Accounting Principles (E) Working Group to modify risk transfer rules. Mr. Boerner said the Working Group has been alerted that coordination with the Task Force to address risk transfer rules may be necessary.

Alice Fontaine (Fontaine Consulting) discussed the draft principles for YRT treaty/cash flow modeling (Attachment Five-C) to be used as a tool for comparing the amendment proposals assessed during the field test. She said the principles cover the environment surrounding the modeling of the reinsurance cash flows, provisions within the reinsurance treaty and consideration of the reinsurer’s potential reactions. Ms. Fontaine also discussed revisions to amendment proposal 2019-40 (Attachment Five-D). The document includes: 1) four counterparty scenarios under which the revised amendment proposal will be tested; and 2) tables for disclosing possible outcomes.

Mr. Robinson discussed amendment proposal 2019-JR (Attachment Five-E). He said the three basic hypotheses in the amendment proposal are: 1) the ceding company and the assuming company can have different perspectives on the future; 2) the reserve credit must bear a reasonable relation to the reserve set up by the reinsurer; and 3) the statement of statutory accounting principles (SSAP) should defer to the Valuation Manual as the single source of guidance on reserve credits.

Dave Neve (Global Atlantic) discussed amendment proposal 2019-41 (Attachment Five-F). He said the proposal calls for calculation of the reserve for 15 years under three mortality improvement scenarios to determine projected reinsurance claim settlements.

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Ms. Hemphill said amendment proposal 2019-42 (Attachment Five-G) requires the company to set its reinsurance premium margins at the same percentage as the margins for mortality. Both the explicit and the implicit margins are to be included in the assessment. Testing is to be completed using 5-year, 10-year, 15-year and 20-year scenarios of mortality improvement to approximate the implicit margin.

Having no further business, the Life Actuarial (A) Task Force adjourned.
As in previous years, the Society of Actuaries expresses its thanks to NAIC staff for their assistance and responsiveness in providing Annual Statement expense and unit data for the 2020 GRET analysis for use with individual life insurance sales illustrations. The analysis is based on expense and expense related information reported on companies' 2017 and 2018 Annual Statements. This project has been completed to assist the Life Actuarial Task Force (LATF) in its consideration of potential revisions to the GRET that could become effective for calendar year 2020. This memo describes the analysis and resultant findings.

NAIC staff provided Annual Statement data for life insurance companies for calendar years 2017 and 2018. This included data from 707 companies in 2017 and 722 companies in 2018. This increase breaks the trend of small decreases over the previous few years. Of the total companies, 326 were in both years and passed the outlier exclusion tests and were included as a base for the GRET factors (361 companies passed similar tests last year).

Approach Used

The methodology for calculating the recommended GRET factors based on this data is similar in broad outline to that followed the last several years. The methodology was last altered in 2015. The changes which were made at that time can be found in the recommendation letter sent on July 30, 2015. To calculate updated GRET factors, the average of the factors from the two most recent years (2017 and 2018 for those with data available for both years) of Annual Statement data was used. For each company an actual to expected ratio was calculated. Companies with ratios that fall outside predetermined parameters are excluded and this process is competed three times in order to stabilize the average rates. The boundaries of the exclusions are modified from time to time and there was a slight adjustment this year to increase the number of companies in the final study. Unit expense seed factors (the seeds for all distribution channel categories are the same), as given in Appendix B, were used to compute total expected expenses. Thus, these seed factors were used to implicitly allocate expenses between acquisition and maintenance expenses, as well as among the three acquisition expense factors (on a direct of ceded reinsurance basis).

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

1 https://www.soa.org/Files/Research/Projects/research-2016-gret-recommendation.pdf
years to increase the response rate to the surveys of companies that submit Annual Statements in order to reduce the number of companies in the “Other” category would be most welcomed.

Prior to 2014, when responding to the survey if a company indicated they used multiple channels to distribute their individual life sales, the percentage weights provided to us were applied to that company’s reported results in the tabulations of each of the distribution channel’s unit expense results. In 2015 this was changed so that all expenses for a company will go to the channel with the highest percentage weight. This approach was changed because: (1) as fewer channel types were used, it was expected that fewer companies would have multiple channels as currently defined and (2) an insufficient number of multiple distribution responses were provided in that year’s survey to result in a significantly different outcome. The intention is to continue surveying the companies in future years to enable enhancement of this multiple distribution channel information.

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

The Recommendation

Employing the above methodology results in the proposed 2020 GRET values shown in Table 1. To facilitate comparisons, the current 2019 GRET factors are shown in Table 2.

Further characteristics of the type of companies represented in each category are included in the last two columns in Table 1, including the average premium per policy issued and the average face amount ($000s) per policy issued.

**TABLE 1**

**PROPOSED 2020 GRET FACTORS, Based on Average of 2017/2018 Data**

<table>
<thead>
<tr>
<th>Description</th>
<th>Acquisition Per Policy</th>
<th>Acquisition Per Unit</th>
<th>Acquisition Per Premium</th>
<th>Maintenance Per Policy</th>
<th>Companies Included*</th>
<th>Average Premium Per Policy Issued During Year</th>
<th>Average Face Amt (000) Per Policy Issued During Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$168</td>
<td>$0.90</td>
<td>42%</td>
<td>$50</td>
<td>118</td>
<td>3,263</td>
<td>200</td>
</tr>
<tr>
<td>Career</td>
<td>214</td>
<td>1.20</td>
<td>54%</td>
<td>64</td>
<td>63</td>
<td>2,661</td>
<td>217</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>217</td>
<td>1.20</td>
<td>54%</td>
<td>65</td>
<td>20</td>
<td>2,489</td>
<td>213</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>125</td>
<td>0.70</td>
<td>32%</td>
<td>38</td>
<td>21</td>
<td>757</td>
<td>13</td>
</tr>
<tr>
<td>Other*</td>
<td>140</td>
<td>0.80</td>
<td>35%</td>
<td>42</td>
<td>104</td>
<td>876</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>326</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TABLE 2
CURRENT (2019) FACTORS, Based on Average of 2016/2017 Data

<table>
<thead>
<tr>
<th>Description</th>
<th>Acquisition Per Policy</th>
<th>Acquisition Per Unit</th>
<th>Acquisition Per Premium</th>
<th>Maintenance Per Policy</th>
<th>Companies Included*</th>
<th>Average Premium Per Policy Issued During Year</th>
<th>Average Face Amt (000) Per Policy Issued During Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$167</td>
<td>$0.90</td>
<td>42%</td>
<td>$50</td>
<td>130</td>
<td>3,496</td>
<td>194</td>
</tr>
<tr>
<td>Career</td>
<td>231</td>
<td>1.30</td>
<td>58%</td>
<td>69</td>
<td>69</td>
<td>2,287</td>
<td>203</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>221</td>
<td>1.20</td>
<td>55%</td>
<td>66</td>
<td>22</td>
<td>2,492</td>
<td>163</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>139</td>
<td>0.80</td>
<td>35%</td>
<td>42</td>
<td>21</td>
<td>702</td>
<td>20</td>
</tr>
<tr>
<td>Other*</td>
<td>136</td>
<td>0.70</td>
<td>34%</td>
<td>41</td>
<td>119</td>
<td>839</td>
<td>32</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>361</td>
<td></td>
</tr>
</tbody>
</table>

In previous recommendations, an effort was made to reduce volatility in the GRET factors from year-to-year by limiting the change in GRET factors between years to about ten percent of the prior value. The changes from the 2019 GRET were reviewed to ensure that a significant change was not made in this year’s GRET recommendation. Only the Niche Marketing distribution channel category experienced a change greater than ten percent so the factors for this line were capped at the ten percent level (the Acquisition per unit factor changed more than 10% because of rounding) from the corresponding 2019 GRET values. The change occurred due to the change in the composition of the companies in this category where there is a small number of companies included.

Usage of the GRET

Also asked in this year’s survey, responded to by companies’ Annual Statement correspondent, was a question regarding whether the 2018 GRET table was used by the company. Last year, 28% of the responders indicated their company used the GRET for sales illustration purposes, with similar percentage results by size of company; this contrasted with about 30% in the prior year. This year, 26% of responding companies indicated that they used the GRET in 2018 for sales illustration purposes, with similar results for each of the distribution channels with a significant number of responders. Based on the information received over the last several years, the variation in GRET usage appears to be in large part due to the relatively small sample size and different responders to the surveys.

We hope LATF finds this information helpful and sufficient for consideration of a potential update to the GRET. If you require further analysis or have questions, please contact Dale Hall at 847-273-8835.

Kindest personal regards,

Dale Hall, FSA, MAAA, CERA, CFA
Managing Director of Research
Society of Actuaries

Leon Langlitz, FSA, MAAA
Chair, SOA Committee on Life
Insurance Company Expenses

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Appendix A -- Distribution Channels

The following is a description of distribution channels used in the development of recommended 2020 GRET values:

1. Independent – Business written by a company that markets its insurance policies through an independent insurance agent or insurance broker not primarily affiliated with any one insurance company. These agencies or agents are not employed by the company and operate without an exclusive distribution contract with the company. These include most PPGA arrangements.

2. Career – Business written by a company that markets insurance and investment products through a sales force primarily affiliated with one insurance company. These companies recruit, finance, train, and often house financial professionals who are typically referred to as career agents or multi-line exclusive agents.

3. Direct Marketing – Business written by a company that markets its own insurance policies direct to the consumer through methods such as direct mail, print media, broadcast media, telemarketing, retail centers and kiosks, internet or other media. No direct field compensation is involved.

4. Niche Marketers – Business written by home service, pre-need, or final expense insurance companies as well as niche-market companies selling small face amount life products through a variety of distribution channels.

5. Other – Companies surveyed were only provided with the four options described above. Nonetheless since there were many companies for which we did not receive a response (or whose response in past years’ surveys confirmed an “other” categorization (see below), values for the “other” category are given in the tables in this memo. It was also included to indicate how many life insurance companies with no response (to this survey and prior surveys) and to indicate whether their exclusion has introduced a bias into the resulting values.

Appendix B – Unit Expense Seeds

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

The unit expense seeds used in the 2019 GRET and the 2020 GRET recommendation were based on the average of the 2006 through 2010 Annual SOA expense studies. These studies differentiated unit expenses by type of individual life insurance policy (term and permanent coverages). As neither the GRET nor the Annual Statement data provided differentiates between these two types of coverage, the unit expense seed was derived by judgment based this information. The following shows the averages derived from the Annual SOA studies and the seeds used in this study. Beginning with the 2019 Annual Statement submission this information may become more readily available.
### 2006-2010 (average) CLICE Studies:

<table>
<thead>
<tr>
<th>Term</th>
<th>Acquisition/Policy</th>
<th>Acquisition/Face Amount (000)</th>
<th>Acquisition/Premium</th>
<th>Maintenance/Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighted Average</td>
<td>$149</td>
<td>$0.62</td>
<td>38%</td>
<td>$58</td>
</tr>
<tr>
<td>Unweighted Average</td>
<td>$237</td>
<td>$0.80</td>
<td>57%</td>
<td>$76</td>
</tr>
<tr>
<td>Median</td>
<td>$196</td>
<td>$0.59</td>
<td>38%</td>
<td>$64</td>
</tr>
</tbody>
</table>

### Permanent

<table>
<thead>
<tr>
<th>Term</th>
<th>Acquisition/Policy</th>
<th>Acquisition/Face Amount (000)</th>
<th>Acquisition/Premium</th>
<th>Maintenance/Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighted Average</td>
<td>$167</td>
<td>$1.43</td>
<td>42%</td>
<td>$56</td>
</tr>
<tr>
<td>Unweighted Average</td>
<td>$303</td>
<td>$1.57</td>
<td>49%</td>
<td>$70</td>
</tr>
<tr>
<td>Median</td>
<td>$158</td>
<td>$1.30</td>
<td>41%</td>
<td>$67</td>
</tr>
</tbody>
</table>

### Current Unit Expense Seeds:

<table>
<thead>
<tr>
<th></th>
<th>Acquisition/Policy</th>
<th>Acquisition/Face Amount (000)</th>
<th>Acquisition/Premium</th>
<th>Maintenance/Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>All distribution channels</td>
<td>$200</td>
<td>$1.10</td>
<td>50%</td>
<td>$60</td>
</tr>
</tbody>
</table>
Pre-Survey

- Summary of questions asked
  - Willing to participate? If "No", due to resources, please describe.
  - If "Yes", okay to disclose company name?
  - Indicate types of YRT reinsurance treaties in use: Excess, Quota share, Quota share with attachment point, Other hybrid, Experience refund.
- Methodology for list of target companies (187 in total)
  - All companies that have implemented PBR as of 12/31/18
  - Additional companies expected to be subject to PBR in 2020 (based on premium volume), if they have YRT reinsurance ceded or assumed.
- Distribution targeted for Monday, September 9
  - Responses due by Monday, September 23
  - Confidential regulator/consultant follow up with selected "No/s"

YRT Treaty Classification

- Participants will clarify each modeled treaty as one of these 5 types.
  - Consultants will model one or more specimen treaties for each of these 5 types (from perspective of both ceding company and assuming reinsurer).
Risk Transfer Rules

- The long-term solution ultimately chosen by LATF could have implications requiring SAPWG to modify risk transfer rules.
  - APPM Appendix A-791 specifies the risk transfer rules a treaty must satisfy in order to qualify for reinsurance accounting, but exempts YRT treaties that do not provide surplus relief in the first year greater than the first year’s statutory COI.
  - SSAP 61R paragraph 19 states that YRT treaties (even if they meet the exemption criteria in A-791) must still comply with some of the risk transfer rules in A-791, including 2.b.
  - In order to qualify for reinsurance accounting, A-791 2.b states that the ceding insurer cannot be deprived of surplus at the reinsurer’s option, such as could occur by raising reinsurance premiums.

Proposed LATF Goals for Field Test

- Field test results that allow for:
  - Comparisons across companies given differences in interpretation, implementation, enforce and company size/credibility
  - Splits by product type, treaty type and APF tested
  - Confidence in the reasonableness of assumptions and YRT premiums/claims
  - Analysis of reserve amounts/geography on both sides of a treaty, w/ & w/o NPR
  - Analysis of impact of treaty types on ceding insurer mortality margin
    - Implicit margin due to prohibition of future mortality improvement
    - Explicitly prescribed, credibility-linked margin

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### Draft list of specific Principles for YRT treaty/cash flow modeling that have been proposed:

*Check boxes added to the right indicate which APF incorporates these draft Principles*

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>APF Options</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>There is already prescription with respect to recognizing or not recognizing future mortality improvement in the direct/gross model cash flows. To the extent pricing assumes some level of improvement will materialize, but is not allowed to be fully incorporated due to guidance in VM-20, PBR creates reserve strain that must be priced for. That reserve strain is created with respect to all life products and its existence should not vary between direct writers on fully retained risk and reinsurers on assumed risk.</td>
<td>☐ ½ Cx  ☑ APF 40  ☑ APF 41  ☑ APF 42  ☐ APF JR</td>
<td>Applies to APF 41 if future mortality improvement is included</td>
</tr>
<tr>
<td>2</td>
<td>The assumed actions are based on the prescribed industry moderately adverse mortality environment as if they are occurring industry wide for the applicable product.</td>
<td>☐ ½ Cx  ☑ APF 40  ☐ APF 41  ☑ APF 42  ☐ APF JR</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>In general, there is limited or no relevant company or industry experience currently available on which to base the anticipated experience assumption (as to company/reinsurer action) resulting from this adverse mortality environment.</td>
<td>☐ ½ Cx  ☑ APF 40  ☐ APF 41  ☑ APF 42  ☐ APF JR</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Ex ante, the company/reinsurer would not know if adverse experience is a random fluctuation or a trend. Counterparty actions should reflect expected assessment and implementation timeframes vs. immediate reactions to adverse mortality.</td>
<td>☐ ½ Cx  ☑ APF 40  ☐ APF 41  ☑ APF 42  ☐ APF JR</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>There is potential economic value to a guarantee or lack of guarantee, and the principle based reserve (PBR) valuation should reflect the value of such contract terms.</td>
<td>☐ ½ Cx  ☑ APF 40  ☑ APF 41  ☑ APF 42  ☐ APF JR</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Treaty provisions should support any assumed changes to current treaty rates, expenses and benefits. Similarly, any limits placed upon either party’s ability to exercise contractual options in the reinsurance treaty should be assessed.</td>
<td>☐ ½ Cx  ☑ APF 40  ☑ APF 41  ☑ APF 42  ☐ APF JR</td>
<td></td>
</tr>
</tbody>
</table>
7 Although YRT treaties permanently transfer mortality risk to the assuming company, the assuming company shall not be assumed to incur indefinite losses if treaty terms allow adjustment of the underlying economics.

Comment: Applies to 41 & 42 with regards to counterparty risk

8 Projected treaty profitability to the reinsurer (as part of both ceding company and reinsurer PBR calculations) with the profitability being assessed in terms of how the reinsurer would view it & react to it should be part of the model. Subject to provisions of the treaty(ies), it is reasonable to assume some increase in rates if the industry experiences adverse mortality. The combination of both the time frame of losses and the renewal level of rates should be considered in tandem, and without reflecting the recoupment of the prior losses. Modeled results should reflect an assessment of the a) likelihood of reinsurer changing rates; b) magnitude of any assumed rate change; and c) timing of any assumed rate change.

Comment: Applies to 42 with regards to Section 8.18.c, and reflection of best estimate actions in APF41

9 Counterparty risk: The longer the period that losses are projected for the reinsurer, the greater the counterparty risk and/or probability of recapture. The model should reflect margin (either implicit or explicit) such that the longer the projection period, and greater uncertainty, the margin has a larger impact on the positive reinsurer cash flows. (per VM-20, Section 9B.2 on margins)

10 There should be a “reasonable” relationship between the reported reserve credit vs. the reported assumed reserve

Comment: ½ Cx prescribes the same credit; APF JR establishes a comparison; APF 40, 41 and 42 may be viewed as providing this through use of consistent methodology for both ceding and assuming companies, but testing may demonstrate otherwise.

11 YRT rates between affiliated assuming and ceding companies must be the same;
|   | Corollary: Considerations for modeling counterparty actions should be the same for assuming and ceding companies | ☒ APF 42  
☐ APF JR |
|---|---------------------------------------------------------------|----------------|
| 12 | Reinsurance reserve credit is in compliance with APPM Risk transfer rules. | ☒ ½ Cx  
☐ APF 40  
☐ APF 41  
☐ APF 42  
☒ APF JR |
| Comment: Other APF do not have prescription that would definitively meet this requirement. |
| 13 | Approaches should be straightforward from a conceptual and auditability perspective. | ☒ ½ Cx  
☒ APF 40  
☒ APF 41  
☒ APF 42  
☐ APF JR |
Section 12 of SVL: Requirements of a Principle-Based Valuation

A. A Company must establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

1. Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For policies or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk.

2. Incorporate assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company’s overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

3. Incorporate assumptions that are derived in one of the following manners:
   (a) The assumption is prescribed in the valuation manual.
   (b) For assumptions that are not prescribed, the assumptions shall:
      (i) Be established utilizing the company’s available experience, to the extent it is relevant and statistically credible; or
      (ii) To the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience.

4. Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

B. A company using a principle-based valuation for one or more policies or contracts subject to this section as specified in the valuation manual shall:

   (1) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.
   (2) Provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.
   (3) Develop, and file with the commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

C. A principle-based valuation may include a prescribed formulaic reserve component.
Principles in APPM:

- Conservatism: Conservative valuation procedures provide protection to policyholders against adverse fluctuations in financial condition or operating results. Statutory accounting should be reasonably conservative over the span of economic cycles and in recognition of the primary responsibility to regulate for financial solvency.

- Recognition: The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests should not be recognized on the balance sheet by rather should be charged against surplus when acquired or when availability otherwise becomes questionable.

- Consistency: The regulators’ need for meaningful, comparable financial information to determine an insurer’s financial condition requires consistency in the development and application of statutory accounting principles.

Other Principles in VM:

“Overview of Reserve Concepts” in the Introduction Section of the VM”: (with emphasis added – may need refinement to reflect decisions on reinsurance modeling)

Reserve requirements prescribed in the Valuation Manual are intended to support a statutory objective of conservative valuation to provide protection to policyholders and promote solvency of companies against adverse fluctuations in financial condition or operating results pursuant to requirements of Model #820.

A principle-based valuation must only reflect risks that are:
1. Associated with the policies or contracts being valued, or their supporting assets.
2. Determined to be capable of materially affecting the reserve.

Risks not to be included in reserves are those of a general business nature, those that are not associated with the policies or contracts being valued, or those that are best viewed from the company perspective as opposed to the policy or contract perspective. These risks may involve the need for a liability separate from the reserve or may be provided for in capital and surplus.
APF 2019-40 Field Testing Instructions

Unique components to this APF are highlighted in Yellow

Testing of this APF Includes:

1. The company should perform a VM-20 reserve calculation, and if possible projection of future reserve results, using the 2020 Valuation Manual, except modified by APF 2019-40 under four counterparty action scenarios.

   a. Model current YRT rates for all projection years; Apply the APF only with regards to other counterparty actions such as default, recapture or other terminations.
   b. Model a prudent estimate of all counterparty actions; Apply the APF with no additional restrictions or guidance.
   c. Model prudent estimate of rate changes only after reaching the Loss ratio trigger. The Loss ratio is calculated by reviewing cumulative projected reinsurance cash flows from the assuming company perspective. When the Loss ratio exceeds 115% a rate change should be modeled;
   d. Model prudent estimate of rate changes only after reaching Consecutive Years of Loss trigger. The Losses are calculated by reviewing annual projected reinsurance cash flows from the assuming company perspective. When Losses are observed in 5 consecutive years, a rate change should be modeled;

   APF 40 Sections 8.C.8 through 12 require a review of the reinsurance treaty cashflows, and subsequent assumptions regarding counterparty actions.

2. The only difference between the pre-YRT-reinsurance and post-YRT-reinsurance results should be YRT reinsurance. This can be handled in either of two options: model no reinsurance or retrocessions for the pre-YRT-reinsurance results and only model YRT reinsurance or retrocessions for the post-YRT-reinsurance results or 2) model other types of reinsurance or retrocessions for both the pre-YRT-reinsurance and the post-YRT-reinsurance results.

3. When reviewing output for this APF, ensure to look at how results vary for the pre-reinsurance reserve for assuming companies with no modeled rate increases.

Testing of this APF should Produce Disclosures:

1. Provide reserve results per $1000 of NAAR. If possible, projected reserves should be provided on an annual basis for the company’s full projection horizon. These results should be provided separately for Term, ULSG, and Other, as applicable. That is, for each projection year, provide the following reserve results:
### Term (results per $1000)

<table>
<thead>
<tr>
<th>Counterparty</th>
<th>Pre-Reinsurance-Ceded</th>
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<tr>
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### ULSG (results per $1000)

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### Other (results per $1000)

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2. For each scenario result (a, b, c, d), disclose for the DR the individual annual reinsurance cash flows (e.g., reinsurance premiums paid, ceded benefits) for the time zero valuation projection.

3. For each scenario result (b, c and d), disclose whether YRT rates were modeled to change, by how much and/or how often as well as (in the case of scenario b) the trigger for such action. Disclose sensitivity test results and rationale for selecting modeled rate change assumptions.

4. For each scenario result (a, b, c, d), disclose whether, and if so in what time period, the company assumed recapture/contract termination would occur. Disclose sensitivity test results and rationale for selecting modeled assumption.

5. If any actions are modeled with respect to Sections 8.C.8, 14, 15 or 16 please disclose.

6. If there are features of the YRT reinsurance treaty or rates that you believe make the trigger outlined in scenario c or d unreasonable, please describe.

7. Disclose any material modeling simplifications and/or approximations applied.

See Modified APF 2019-40 Below:
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
YRT Field Test Design Group

Title of the Issue:
VM-20 Treatment for YRT Cash Flows in Modeled Reserves

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

January 1, 2019 NAIC Valuation Manual

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

See attached.

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

The current language of Section 8 has resulted in a wider variety of approaches in modeling YRT reinsurance cashflows than expected by regulators. More specific definition of principles is expected to narrow the range of practice but still allow companies to model the specific circumstances of their reinsurance agreements.

This proposal accomplishes this by expanding the general considerations section; removing the comparison to modeling of policy form NGE; and clarifying the need for establishing prudent estimate assumptions for company and counterparty actions that are at the conservative end of the plausible range of behavior.

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

NAIC Staff Comments:

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VM-20 Section 8: Reinsurance

A. General Considerations

1. In this section, reinsurance includes retrocession, and assuming company includes retrocessionaire.

Guidance Note: In determining reserves, one party to a reinsurance transaction may make use of reserve calculations of the other party. In this situation, if the company chooses assumptions that differ from those used by the other party, the company must either rerun the reserve calculation or be prepared to demonstrate that appropriate adjustments to the other party’s calculations have been made.

2. The company shall assume that the laws and regulations in place as of the valuation date regarding credit for reinsurance remain in effect throughout the projection period.

3. A company shall include a reinsurance agreement or amendment in calculating the minimum reserve if, under the terms of the AP&P Manual, the agreement or amendment qualifies for credit for reinsurance.

4. If a reinsurance agreement or amendment does not qualify for credit for reinsurance but treating the reinsurance agreement or amendment as if it did so qualify would result in a reduction to the company’s surplus, then the company shall increase the minimum reserve by the absolute value of such reductions in surplus.

Guidance Note: Section 8.A.3 provides that, in general, if a treaty does not meet the requirements for credit for reinsurance, it should not be allowed to reduce the reserve. Thus, it should not be allowed a reinsurance credit to the NPR, and its cash flows should not be included in the cash-flow models used to calculate the deterministic or stochastic reserve. Section 8.A.4 introduces the exception that if allowing a net premium credit and including the treaty cash flows in the cash-flow models would produce a more conservative result, then that more conservative result should prevail.

5. The company shall base its company and counterparty action assumptions relating to YRT reinsurance consistent with the moderately adverse environment as applicable to the valuation of all life policyholders.

Guidance Note: This consideration is intended to preclude assuming that other reinsured blocks have positive experience that would offset the statutory conservatism prescribed in the mortality assumption.

6. The company shall base its company and counterparty action assumptions relating to YRT reinsurance treaty changes reflecting that, in general, there is no relevant company or industry experience currently available upon which to base the anticipated experience assumption.

Guidance Note: Although some companies may have experience with adverse mortality on particular reinsured blocks, this would not be directly relevant to the scenario where industry mortality is adverse, as per the prescribed scenario. Assumptions and margins related to treaty provisions are therefore subject to Sections 9.A.6.c and 9.B.2 and the
7. Although YRT treaties permanently transfer mortality risk to the assuming company, the assuming company shall not be assumed to incur indefinite losses if treaty terms allow adjustment of the underlying economics.

8. The relationship between assuming companies and the company is between knowledgeable counterparties, and should be expected to result in negotiated contractual changes, subject to provisions of the treaty(ies), and after reflecting the output of modeled policyholder cashflows.

9. In addition, it should not be assumed that assuming reinsurers would take rate increase actions that are not a realistic reflection of the likely timing and magnitude of the rate actions that would unfold under the prescribed mortality scenario, based solely on the reinsurer’s foreknowledge that the prescribed mortality assumption does not allow mortality improvement beyond the valuation date.

B. Determination of a Credit to the NPR to Reflect Reinsurance Ceded

1. Determination of the credit to the NPR to reflect reinsurance shall be done in accordance with SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance in the AP&P Manual.

Guidance Note: The credit taken under a coinsurance arrangement shall be calculated using the same methodology and assumptions used in determining its NPR, but only for the percentage of the risk that was reinsured. If the reinsurance is on a YRT basis, the credit shall be calculated using the assumptions used in determining the NPR, but for the net amount at risk.

2. If a company cedes a portion of a policy under more than one reinsurance agreement, then the company shall calculate a credit separately for each such agreement. The credit for reinsurance ceded for the policy shall be the sum of the credits for all such agreements.

3. The credit for reinsurance ceded applied to a group of policies shall be the sum of the credit for reinsurance ceded for each of the policies of the group.

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

In calculations of the deterministic reserve or stochastic reserve pursuant to Section 4 and Section 5:

1. The company shall use anticipated experience assumptions and margins that are appropriate for each company pursuant to a reinsurance agreement. In such instance, the ceding and assuming companies are not required to use the same assumptions and margins for the reinsured policies unless they are affiliated.
2. To the extent that a single deterministic valuation assumption for risk factors associated with certain provisions of reinsurance agreements will not adequately capture the risk, the company shall do one of the following:

   a. Stochastically model the risk factors directly in the cash-flow model when calculating the stochastic reserve.

   b. Perform a separate stochastic analysis outside the cash-flow model to quantify the impact on reinsurance cash flows to and from the company. The company shall use the results of this analysis to adjust prudent estimate assumptions or to determine an amount to adjust the stochastic reserve to adequately make provision for the risks of the reinsurance features.

   **Guidance Note:** An example of reinsurance provisions where a single deterministic valuation assumption will not adequately capture the risk is stop-loss reinsurance.

3. The company shall determine cash flows for reinsurance ceded subject to the following:

   a. The company shall include the effect of projected cash flows received from or paid to assuming companies under the terms of ceded reinsurance agreements in the cash flows used in calculating the deterministic reserve in Section 4 and stochastic reserves in Section 5.

   b. If cash flows received from or paid to assuming companies under the terms of any reinsurance agreement are dependent upon cash flows received from or paid to assuming companies under other reinsurance agreements, the company shall first determine reinsurance cash flows for reinsurance agreements with no such dependency and then use the reinsurance cash flows from these independent agreements to determine reinsurance cash flows for the remaining dependent agreements.

   c. The company shall use *prudent estimate* assumptions to project cash flows to and from assuming companies that are consistent with other assumptions used by the company in calculating the deterministic or stochastic reserve for the reinsured policies and that reflect the terms of the reinsurance agreements.

4. The company shall determine cash flows for reinsurance assumed subject to the following:

   a. The company shall include the effect of cash flows projected to be received from and paid to ceding companies under the terms of assumed reinsurance agreements in the cash flows used in calculating the deterministic reserve in Section 4 and the stochastic reserve in Section 5.

   b. If cash flows received from or paid to ceding companies under the terms of any reinsurance agreement are dependent upon cash flows received from or paid to ceding companies under other reinsurance agreements, the company shall first determine reinsurance cash flows for reinsurance agreements with no such dependency and then use the reinsurance cash flows from these independent agreements to determine reinsurance cash flows for the remaining dependent agreements.
5. If a company assumes a policy under more than one reinsurance agreement, then the company may treat each agreement separately for the purposes of calculating the reserve.

6. An assuming company shall use assumptions to project cash flows to and from ceding companies that reflect the assuming company’s experience for the business segment to which the reinsured policies belong and reflect the terms of the reinsurance agreement.

7. The company shall assume that the counterparties to a reinsurance agreement are knowledgeable about the contingencies involved in the agreement and likely to exercise the terms of the agreement to their respective advantage, taking into account the context of the agreement in the entire economic relationship between the parties. In setting assumptions for the reinsurance cash flows, the company shall include, but not be limited to, the following:

   a. The usual and customary practices associated with such agreements.
   b. Past practices by the parties concerning the changing of terms, in an economic environment similar to that projected.
   c. Any limits placed upon either party’s ability to exercise contractual options in the reinsurance agreement.
   d. The ability of the direct-writing company to modify the terms of its policies in response to changes in reinsurance terms.
   e. Actions that might be taken by a party if the counterparty is in financial difficulty.

**Guidance note:** It should be assumed that if any treaty produces a pattern of projected losses to the counter party, that the risk of financial difficulty will increase commensurate with the magnitude of projected losses. The risk of default by the assuming company is addressed in item 15 below. The risk of default by the ceding company is addressed in item 16 below.

8. The company shall account for any actions that the ceding company and, if different, the direct-writing company have taken or are likely to take that could affect the expected cash flows of the reinsured business in determining **prudent estimate** assumptions for the modeled reserve. Note that these assumptions are in addition to, rather than in lieu of, assumptions as to the behavior of the underlying policyholders.

**Guidance Note:** Examples of NGE actions the direct-writing company could take include:
1) instituting internal replacement programs or special underwriting programs, both of which could change expected mortality rates; or 2) changing NGE in the reinsured policies, which could affect mortality, policyholder behavior, and possibly expense and investment assumptions. Examples of actions the ceding company could take include:
1) the exercise of contractual options in a reinsurance agreement to influence the setting of NGEs in the reinsured policies; or 2) the ability to participate in claim decisions.

9. The company shall account for any actions that the assuming company has taken or is likely to take that could affect the expected cash flows of the reinsured business **in determining**
prudent estimate assumptions. Appropriate assumptions for these elements may depend on the scenario being tested. The company shall take into account all likely consequences of the assuming company changing an element of the reinsurance agreement, including any potential impact on the probability of recapture by the ceding company.

**Guidance Note:** Examples of such actions include, but are not limited to, changes to the current scale of reinsurance premiums and changes to expense allowances.

10. In addition to exercising the terms of the agreement and implementing changes to an agreement, it is appropriate for the actuary to assume that knowledgeable counterparties may renegotiate terms of the agreement to the mutual benefit of both parties or to reflect risk sharing of adverse experience. To the extent that experience is limited in deriving the terms of a renegotiated agreement, or the timing of such renegotiation, the sensitivity tests required in Section 9.A.6.d are required to inform the selection of the assumption set at the conservative end of the plausible range.

11. The company shall take into account any ceding company option to recapture reinsured business. Appropriate assumptions may depend on the scenario being tested (analogous to interest-sensitive lapses).

**Guidance Note:** Cash flows associated with recapture include recapture fees or other termination settlements.

**Guidance Note:** To the extent that experience is limited in determining the timing of recapture, the sensitivity tests required in Section 9.A.6.d are required to inform the selection of the assumption set at the conservative end of the plausible range.

**Guidance Note:** The actions assumed by counterparties with respect to exercising treaty provisions need not all be modeled as some will be mutually exclusive. Exercise of treaty provisions shall be considered and discussed in the PBR actuarial Report.

12. The company shall take into account an assuming company’s right to terminate in-force reinsurance business. In the case in which the assuming company’s right to terminate is limited to cases of non-payment of amounts due by the ceding company or other specific, limited circumstances, the company may assume that the termination option would be expected to have insignificant value to either party and, therefore, may exclude recognition of this right to terminate in the cash-flow projections. However, if a reinsurance agreement contains other termination provisions with material impact, the company shall set appropriate assumptions for these provisions consistent with the particular scenario being tested.

**Guidance Note:** To the extent that experience is limited in determining the timing of contract termination, the sensitivity tests required in Section 9.A.6.d are required to inform the selection of the assumption set at the conservative end of the plausible range.
13. If, under the terms of the reinsurance agreement, some of the assets supporting the reserve are held by the counterparty or by another party, the company shall:
   a. Consider the following in order to determine whether to model such assets for purposes of projecting cash flows:
      i. The degree of linkage between the portfolio performance and the calculation of the reinsurance cash flows.
      ii. The sensitivity of the valuation result to the asset portfolio performance.
   b. If the company concludes that modeling is unnecessary, document the testing and logic leading to that conclusion.
   c. If the company determines that modeling is necessary, comply with the requirements in Section 7.E and Section 9.F, taking into account:
      i. The investment strategy of the company holding the assets, as codified in the reinsurance agreement or otherwise based on current documentation provided by that company.
      ii. Actions that may be taken by either party that would affect the net reinsurance cash flows (e.g., a conscious decision to alter the investment strategy within the guidelines).

Guidance Note: In some situations, it may not be necessary to model the assets held by the other party. An example would be modeling by an assuming company of a reinsurance agreement containing provisions, such as experience refund provisions, under which the cash flows and effective investment return to the assuming company are the same under all scenarios.

Guidance Note: Special considerations for modified coinsurance: Although the modified coinsurance (ModCo) reserve is called a reserve, it is substantively different from other reserves. It is a fixed liability from the ceding company to the assuming company in an exact amount, rather than an estimate of a future obligation. The ModCo reserve is analogous to a deposit. This concept is clearer in the economically identical situation of funds withheld. Therefore, the value of the modified coinsurance reserve generally will not have to be determined by modeling. However, the projected ModCo interest may have to be modeled. In many cases, the ModCo interest is determined by the investment earnings of an underlying asset portfolio, which, in some cases, will be a segregated asset portfolio or in others the ceding company’s general account. Some agreements may use a rate not tied to a specific portfolio.

14. If a ceding company has knowledge that an assuming company is financially impaired, the ceding company shall establish a margin for the risk of default by the assuming company. In the absence of knowledge that the assuming company is financially impaired, the ceding
company shall review the projected future profitability (after consideration of the assuming and ceding company actions modeled) of each group of reinsurance agreements by assuming company and establish a margin for the risk of default by the assuming company that is a function of the profitability of those agreements.

15. If an assuming company has knowledge that a ceding company is financially impaired, the assuming company shall establish a margin for the risk of default by the ceding company. Such margin may be reduced or eliminated if the assuming company has a right to terminate the reinsurance upon non-payment by the ceding company. In the absence of knowledge that a ceding company is financially impaired, the assuming company is not required to establish a margin for the risk of default by the ceding company.

16. In setting any margins required by Section 8.C.14 and Section 8.C.15 to reflect potential uncertainty regarding the receipt of cash flows from a counterparty, the company shall take into account the ratings, RBC ratio or other available information related to the probability of the risk of default by the counterparty, as well as any security or other factor limiting the impact on cash flows.

Additional Disclosures for VM-31 would likely be required, but are not included in this Draft APF.
In presenting the original APF 2018-58, NYL and NWM argued “we believe it is inappropriate to reflect reserve differences due to differing expectations of increases to future non-guaranteed premiums.”

Since that first presentation, there have been at least three different proposals concerning the proper way to model YRT premium increases in the DR and SR. Regulators were asked to choose the one that we felt is the “best”.

The approach taken then has the following weaknesses:
1. The guidance offered in all the proposals would only apply to the ceding company. This cannot resolve an issue of differing expectations, as described by NYL and NWM.

2. Contrary to the view tacitly underlying these discussions, the relationship between cedants and reinsurers is not one-to-one; rather, it is many-to-many: cedant may have more than one reinsurer on a block of business and the reinsurer can base its pricing decisions on the experience of multiple cedants.

3. By looking only at the DR and SR, we are not necessarily producing an outcome that is satisfactory when the final reserve credit is determined.

4. It is limited to YRT premiums. The problem of differing perspectives exists in other areas of reinsurance, such as COIs for UL (consider the perspective of an assuming company under coinsurance).

5. It goes against the grain of a principle-based approach, under which a company should have the freedom to select its approach, provided such approach is acceptable to its regulator. This must apply equally to cedants and reinsurers.

In my APF 2019-30, I proposed that concern over the DR and/or SR is misplaced, and that regulators should rather be concerned with the resulting reserve credit. Most recently, APF 2019-39, which was accepted by regulators in a close vote, limits the reserve credit to Cx/2 on an interim basis, pending a long-term solution.

The reserve credit is the difference between the pre-reinsurance reserve, which is the maximum of three reserves (NPR, DR and SR) and the post-reinsurance reserve, which is also a maximum of three reserves. As demonstrated by examples provided by Pat Allison, there is no rhyme or reason as to which of the three reserves will be the highest. Every year-end, a new issue year is added to the in-force, which changes its profile; so inferences from one year to the next are not possible. Therefore, a long-term solution based on consideration of each or any of the NPR, DR and SR will not be fruitful. On the other hand, regulators seem to be arriving at the conclusion that governing the reserve credit will produce a more satisfactory result.

It is debatable whether Cx/2 is an appropriate formula for the YRT Reinsurance NPR, in light of the multi-year nature of modern reinsurance treaties.

The primary purpose of this document is to propose a long-term solution, based on the principle that the reserve credit taken by cedant should bear a reasonable relationship to the reserve established by the assuming insurer. As discussed in my APF 2019-30, the proposed long-term solution is that the reserve credit taken by cedant shall not exceed the NPR established by the assuming company. I also propose a new formula for the NPR for YRT Reinsurance, based on existing guidance for the Term VM-20 Reserving Category.
In order to implement this guidance, there will need to be changes to both the Valuation Manual and the SSAP as follows:

1. Changes to SSAP:
   Revise
   (i) SSAP 61R, paragraph 37 (determination of YRT reserve credit); and
   (ii) SSAP 61R, paragraph 19, and the related Appendix A-791, so that the reserve credit for policies issued after on or after a specified date is determined in accordance with the provisions of the Valuation Manual. (I think (ii) is harder.)

2. Changes to Valuation Manual:
   Introduce in VM-20 Section 3 the calculation of the NPR for YRT Reinsurance based on the following guidance, applicable to cedant and reinsurer:

   Methodology: Follow the guidance in VM-20, Section 3.B.4, ignoring shock lapse provision.

   Assumptions:
   Interest: Follow VM-20, Section 3.C.2.b.
   Mortality: Follow the NPR guidance for the reinsured contract.
   Lapsation: Follow the NPR guidance for the reinsured contract.
   Net Amount At Risk: Follow the NPR guidance for the reinsured contract and the terms of the reinsurance treaty.

   Then, stipulate that the YRT reserve credit for a group of policies is capped at the sum of the corresponding YRT Reinsurance NPRs, as follows:

   a. Calculate the pre-reinsurance-ceded minimum reserve, here referred to as C.
   b. Calculate the post-reinsurance-ceded minimum reserve, here referred to as D.
   c. Calculate the NPR for the YRT reinsurance (Section 3.B.xx), as if it were a block of stand-alone policies each of which is mapped to a reinsured contract, here referred to as E.
   d. Determine an amount A, floored at 0, such that C – (D+A) ≤ E.
   e. Report the pre-reinsurance-ceded minimum reserve as C and the post-reinsurance-ceded minimum reserve as D+A.
APF 2019-41 Field Testing Instructions

**Unique components to this APF are highlighted in Yellow**

**Testing of this APF Includes:**

1. The company should perform a VM-20 reserve calculation, and if possible projection of future reserve results, using the 2020 Valuation Manual, except modified by APF 2019-41 under three mortality improvement scenarios: 0%, 0.5%, and 1% of future mortality improvement for 15 years.

2. When determining whether recapture would occur or whether changes to the current reinsurance premium scale are modeled or expected, the company should follow the principles developed in APF 2019-40.

3. The future mortality improvement assumptions of 0%, 0.5%, 1% for 15 years should only be applied for projected reinsurance claim settlements, not the actual pre-reinsurance death claims.

4. The only difference between the pre-YRT-reinsurance and post-YRT-reinsurance results should be YRT reinsurance. This can be handled in either of two options: model no reinsurance or retrocessions for the pre-YRT-reinsurance results and only model YRT reinsurance or retrocessions for the post-YRT-reinsurance results or 2) model other types of reinsurance or retrocessions for both the pre-YRT-reinsurance and the post-YRT-reinsurance results.

5. When reviewing output for this APF, ensure to look at how results vary for companies with low credibility. Base this using indicator for low credibility (below 80%) for testing APF 2019-42/17.

**Testing of this APF should Produce Disclosures:**

1. Provide reserve results per $1000 of NAAR. If possible, projected reserves should be provided on an annual basis for the company’s full projection horizon. These results should be provided separately for Term, ULG, and Other, as applicable. That is, for each projection year, provide the following reserve results:

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2. For each scenario result (0%, 0.5%, 1.0% improvement for 15 years), disclose for the DR the individual annual reinsurance cash flows (e.g., reinsurance premiums paid, ceded benefits) for the time zero valuation projection.

3. For each scenario result (0%, 0.5%, 1.0% improvement for 15 years), disclose whether, and if so in what time period, the company assumed recapture would occur.

4. Disclose any material modeling simplifications and/or approximations applied.

5. For each scenario result (0%, 0.5%, 1.0% for 15 years), disclose whether the improvement is higher or lower than that assumed by the company for the same block of business as part of CFT. In addition, disclose the “company’s best estimate of mortality improvement” (both the improvement level and length) if such wording were kept in APF 2019-41, as currently written below.

6. For both Term and ULSG, disclose the mix of business by Product Type (e.g., Term length), Issue Age, Gender, and Policy Year.

See Exposed APF 2019-41 Below:
APF 2019-41 REDLINE FOR FIELD TESTING:

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

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   Identification:
   David E. Neve, Vice President, Regulatory and Government Affairs, Global Atlantic Financial Group
   Title of the Issue:
   VM-20 Treatment for YRT Cash Flows in Modeled Reserves

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:
   VM-20 Section 8.C
   January 1, 2019 NAIC Valuation Manual

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

4. State the reason for the proposed amendment? (You may do this through an attachment.)
   Developing an appropriate margin for YRT reinsurance premiums has proven to be very difficult, given the margins in mortality assumptions that are used to determine YRT reinsurance claim settlements. Several proposals have been made that define the margin for reinsurance premiums to be somewhat consistent with the mortality margin that is used to determine YRT claim settlements. In effect, these proposals attempt to offset the two margins so that they largely cancel out. These proposals, while conceptually sound, are complex and difficult to implement.
   This proposal accomplishes the same goal of having offsetting margins, but does so using a straightforward and simple approach. It defines the margin for both reinsurance premiums and reinsurance claim settlements to be zero, so that the prudent estimate assumptions for YTR reinsurance premiums and YRT reinsurance claims are the company’s best estimate assumptions. Reinsurance premiums are projected using the premiums rates from the reinsurance treaties along with the company’s best estimate of future rate increases and recaptures. Projected reinsurance claim settlements are based on mortality rates that exclude the VM-20 prescribed margins, exclude the grading to an industry table, and include the company’s best estimate of mortality improvement.

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

NAIC Staff Comments:

<table>
<thead>
<tr>
<th>Dates: Received</th>
<th>Reviewed by Staff</th>
<th>Distributed</th>
<th>Considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/18/19</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: VM APF 2019-41
VM-20 Section 8.C

(The proposal below inserts a new Sec. 8.C.8 and renumbers the following sections accordingly)

7. The company shall assume that the counterparties to a reinsurance agreement are knowledgeable about the contingencies involved in the agreement and likely to exercise the terms of the agreement to their respective advantage, taking into account the context of the agreement in the entire economic relationship between the parties. In setting assumptions for the NGE in reinsurance cash flows, the company shall include, but not be limited to, the following:

a. The usual and customary practices associated with such agreements.

b. Past practices by the parties concerning the changing of terms, in an economic environment similar to that projected.

c. Any limits placed upon either party’s ability to exercise contractual options in the reinsurance agreement.

d. The ability of the direct-writing company to modify the terms of its policies in response to changes in reinsurance terms.

e. Actions that might be taken by a party if the counterparty is in financial difficulty.

8. The company shall use best estimate assumptions with no implicit or explicit margins, except margins pursuant to Section 8.C.16 through Section 8.C.18, as the prudent estimate assumptions for YRT reinsurance premiums paid and YRT reinsurance claim settlements received, using the following procedure:

a. Use the reinsurance rates and provisions from the relevant reinsurance agreement as the initial prudent estimate assumption for YRT reinsurance premiums paid, and project future reinsurance rate increases and recaptures using what the company actually expects will occur, based on treaty provisions, past reinsurance rate increase experience, and ongoing relationship with the reinsurer.

b. The mortality rates used to determine the prudent estimate assumptions for YRT reinsurance claim settlements shall equal the company’s anticipated experience assumptions adjusted to reflect the company’s best estimate of mortality improvement.

98. The company shall account for any actions that the ceding company and, if different, the direct-writing company have taken or are likely to take that could affect the expected cash flows of the reinsured business in determining assumptions for the modeled reserve.

[Renumber following sections accordingly]
APF 2019-42 Field Testing Instructions

Testing of this APF Includes:

1. The company should perform a VM-20 reserve calculation, and if possible projection of future reserve results, using the 2020 Valuation Manual, except modified by APF 2019-42 under four mortality improvement scenarios: 5, 10, 15, and 20 years of future mortality improvement.

2. For the purposes of the field testing reserve calculations, the company should not make any modification to the standard assumption based on Section 8.C.18.c. Instead, the impact of Section 8.C.18.c will be assessed through narrative response.

3. The only difference between the pre-YRT-reinsurance and post-YRT-reinsurance results should be YRT reinsurance. This can be handled in either of two options: model no reinsurance or retrocessions for the pre-YRT-reinsurance results and only model YRT reinsurance or retrocessions for the post-YRT-reinsurance results or 2) model other types of reinsurance or retrocessions for both the pre-YRT-reinsurance and the post-YRT-reinsurance results.

Testing of this APF should Produce Disclosures:

1. Direct Writers or Reinsurers assuming on a Coinsurance Basis: Provide reserve results per $1000 of NAAR. If possible, projected reserves should be provided on an annual basis for the company’s full projection horizon. These results should be provided separately for Term, ULSG, and Other, as applicable. The results should be provided pre-YRT-reinsurance and post-YRT-reinsurance. That is, for each projection year, provide the following reserve results:

<table>
<thead>
<tr>
<th>Term (results per $1000)</th>
<th>Pre-YRT-Reinsurance-Ceded</th>
<th>Post-YRT-Reinsurance-Ceded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NPR</td>
<td>DR</td>
</tr>
<tr>
<td>5 Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ULSG (results per $1000)</th>
<th>Pre-YRT-Reinsurance-Ceded</th>
<th>Post-YRT-Reinsurance-Ceded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NPR</td>
<td>DR</td>
</tr>
<tr>
<td>5 Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other (results per $1000)</th>
<th>Pre-YRT-Reinsurance-Ceded</th>
<th>Post-YRT-Reinsurance-Ceded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NPR</td>
<td>DR</td>
</tr>
<tr>
<td>5 Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Reinsurers Assuming on a YRT Basis Only: Provide reserve results per $1000 of NAAR. If possible, projected reserves should be provided on an annual basis for the company’s full projection horizon. That is, for each projection year, provide the following reserve results:

<table>
<thead>
<tr>
<th>Term – YRT Only (results per $1000)</th>
<th>Pre-YRT-Reinsurance-Ceded</th>
<th>Post-YRT-Reinsurance-Ceded</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPR</td>
<td>DR</td>
<td>SR</td>
</tr>
<tr>
<td>5 Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note that if a reinsurer assumes on both a coinsurance and YRT basis, they are requested to report their Term results separately for non-YRT and YRT, so that the modeling of business assumed on a YRT basis can be reviewed in isolation.

3. For each scenario result (5, 10, 15, and 20 years), disclose for the DR the individual annual reinsurance cash flows (e.g., reinsurance premiums paid/received, ceded benefits) for the time zero valuation projection.

4. Separately for each scenario (5, 10, 15, and 20 years), disclose whether, and if so in what time period, the company would assume recapture would occur if the company were to follow Section 8.C.18.c.

5. Separately for each scenario (5, 10, 15, and 20 years), if the company were to follow Section 8.C.18.c, disclose whether a different variation in the reinsurance premium assumption under VM-20 Section 8.C.18.c would be applied, and if so describe the variation and reasoning. Also disclose whether this treatment has been discussed with the domiciliary commissioner and their response to the treatment.

6. Disclose whether the minimum credibility (80%) and/or the minimum SDP (10 years) were applied due to being higher than the company’s calculated credibility and SDP under VM-20. If possible, results with and without these minimums should be provided, to ensure that they are functioning as intended, which was to avoid unfair and unrealistic high reinsurance premium margins on small companies or new blocks of business. If a full retesting is not possible, a qualitative assessment of the impact of these minimums is requested.

7. For each scenario result (5, 10, 15, and 20 years), disclose whether the length of time is longer or shorter than that assumed by the company for the same block of business as part of CFT.

8. Disclose whether the mortality improvement rates of Section 9.C.3.g are higher or lower annual rates overall than those assumed by the company for the same block of business as part of CFT. [For the purposes of this response, compare annual rates only – disregarding the length of time that mortality improvement is applied.]

9. Disclose any material modeling simplifications and/or approximations applied.

10. For both Term and ULSG, disclose the mix of business by Product Type (e.g., Term length), Issue Age, Gender, and Policy Year.

11. Are any policies in the Other category UL? For UL in the Other category, describe the mix of funding levels among low, medium, or high, where:
a. Low describes funding that is roughly designed to ensure term to age X or N-year term,
b. Medium describes funding that is roughly designed to mimic permanent insurance and endow at 100/unit at the valuation tables terminal (omega) age, and
c. High describes funding as dump-in products (whether single premium, MECs, etc., designed to maximize tax-sheltering and mature with much more than 1000/unit)
VM-20 Section 8.C.18 (New Section)

18. When projecting non-guaranteed future reinsurance features, the company shall use prudent estimate reinsurance premiums in projecting the reinsurance cash flows. The company shall project reinsurance cash flows pursuant to all provisions within a reinsurance agreement and shall determine the prudent estimate reinsurance premiums using the following procedure:

   a. Use the reinsurance rates and provisions from the relevant reinsurance agreement as the anticipated experience assumption for reinsurance, subject to any modifications in Section 8.C.18.c. No margin is required for years in which the reinsurance features are guaranteed. For years when reinsurance features are not guaranteed, Section 8.C.18.b below sets forth the prescribed reinsurance premium margin.

   **Guidance Note:** While the most commonly considered non-guaranteed reinsurance feature is future YRT premium rates, other non-guaranteed features are also to be considered, such as non-guaranteed expense allowances.

   b. Set the reinsurance premium margin equal to $\lambda$ times the reinsurance premium rate, where $\lambda = [(i) - (ii)]$ divided by (ii), in which (i) and (ii) are described below.

      i. “Baseline credibility” prudent estimate mortality, i.e., prudent estimate mortality following Section 9.C.1 through Section 9.C.6, but recalculated (1) with the margins determined under Section 9.C.5.b modified to reflect a credibility percentage equal to the greater of the one originally determined pursuant to Section 9.C.4 and 80% and (2) with grading modified to reflect a sufficient data period equal to the greater of the one originally determined pursuant to Section 9.C.6.b.ii and 10 years.

      i+ii. Company experience mortality as provided in Section 9.C.2, but recalculated including mortality improvement for [Separately test 5, 10, 15 and 20] years beyond the valuation date. Mortality improvement rates shall equal the mortality improvement rates of Section 9.C.3.g, whether or not the company chose to apply mortality improvement to the industry basic mortality table.
**Guidance Note:** Simplifications or approximations to estimate the effect of the “baseline credibility” prudent estimate mortality in Section 8.C.18.b.i are permissible if they comply with VM-20 Section 2.G.

For example, in situations where the sufficient data period originally determined pursuant to Section 9.C.6.b.ii was greater than or equal to 10 years, there is a simple approximation. Separately for the 2008 VBT limited underwriting, the 2015 VBT using Limited Fluctuation, and the 2015 VBT using Bühlmann, for a given credibility percentage, X%, the ratio of the margin with X% credibility to the margin with 80% credibility is fairly stable across all attained ages. Thus, the effect of the baseline credibility can be approximated by calculating $\lambda'$ by following Section 8.C.18.b using prudent estimate mortality rather than “baseline credibility” prudent estimate mortality and then obtaining $\lambda$ by multiplying $\lambda'$, by $\Theta/100$ in durations prior to when grading begins, by $(100 + \Theta)/200$ in the grading durations, and by 1.0 in durations after grading is complete, where $\Theta$ is:

<table>
<thead>
<tr>
<th>Credibility</th>
<th>Industry Table = 2015 VBT</th>
<th>Limited Fluctuation</th>
<th>Industry Table = 2008 VBT LU</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%–22%</td>
<td>50</td>
<td>33</td>
<td>39</td>
</tr>
<tr>
<td>23%–27%</td>
<td>51</td>
<td>37</td>
<td>39</td>
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<tr>
<td>28%–32%</td>
<td>53</td>
<td>40</td>
<td>39</td>
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<tr>
<td>33%–37%</td>
<td>55</td>
<td>44</td>
<td>39</td>
</tr>
<tr>
<td>38%–39%</td>
<td>57</td>
<td>48</td>
<td>39</td>
</tr>
<tr>
<td>40%–42%</td>
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<td>48</td>
<td>64</td>
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<tr>
<td>43%–47%</td>
<td>60</td>
<td>53</td>
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<tr>
<td>48%–52%</td>
<td>63</td>
<td>58</td>
<td>64</td>
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<tr>
<td>53%–57%</td>
<td>67</td>
<td>64</td>
<td>64</td>
</tr>
<tr>
<td>58%–59%</td>
<td>71</td>
<td>69</td>
<td>64</td>
</tr>
<tr>
<td>60%–62%</td>
<td>71</td>
<td>69</td>
<td>86</td>
</tr>
<tr>
<td>63%–67%</td>
<td>76</td>
<td>76</td>
<td>86</td>
</tr>
<tr>
<td>68%–72%</td>
<td>82</td>
<td>83</td>
<td>86</td>
</tr>
<tr>
<td>73%–77%</td>
<td>89</td>
<td>92</td>
<td>86</td>
</tr>
<tr>
<td>78%–79%</td>
<td>100</td>
<td>100</td>
<td>86</td>
</tr>
<tr>
<td>80%+</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

**Guidance Note:** In the case where applicable industry tables are used in lieu of company experience, Section 8.C.18.b.i would be the industry tables, but using company experience margins corresponding to the baseline 80% credibility and grading corresponding to a sufficient data period of 10, graded into that same industry table with industry margins. Similarly, Section 8.C.18.b.ii would be the industry tables, with future mortality improvement applied using the mortality improvement rates in Section 9.C.3.g.
c. Reinsurance premium prudent estimate assumptions may be modified if, in the company’s judgment, the prescribed reinsurance premium prudent estimate assumptions do not appropriately reflect the expected reinsurance premium experience under a moderately adverse scenario. In cases where the reinsurance premium prudent estimate assumptions are modified, the modifications must not result in reinsurance premium anticipated experience assumptions that are lower than those prescribed in Section 8.C.18.a or reinsurance premium margins that are lower than those prescribed in Section 8.C.18.b without prior approval by the domiciliary commissioner. Note that if the reinsurance agreement allows for the ceding company to recapture the ceded business if the reinsurer raises rates, the ceding company may model this explicitly or limit prudent estimate reinsurance premiums such that they do not exceed the prudent estimate mortality following Section 9.C.1 through Section 9.C.6, and this modification would not require commissioner approval.

**Guidance Note:** Examples of reasons to modify the reinsurance premium prudent estimate assumptions include, but are not limited to, counterparty default concerns, reinsurance contract language that contains particularly restrictive or permissive provisions regarding reinsurance rate increases, and potential recapture of the reinsured business.

**VM-31 Section 3.C.8.b**

b. **Assumptions** – Description of reinsurance assumptions used to determine the cash flows included in the model, **including the anticipated experience assumptions and margins for future reinsurance premiums reflecting non-guaranteed reinsurance features. For future reinsurance premiums, describe any adjustments made pursuant to VM-20 Section 8.C.18.c and provide the rationale for such adjustments.**
YRT Field Test Update

Timeline (workstreams/milestones) as of 11/20/2019

Jason Kehrberg, MAAA, FSA
Chairperson, YRT Field Test Project Oversight Group

**Workstreams**

**Milestones**

Note: More will be periodically transferred back with participants—call for details.

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Oliver Wyman was requested by the American Council of Life Insurers, the American Academy of Actuaries and the National Association of Insurance Commissioners to support an industry field test being conducted to aid the NAIC Life Actuarial (A) Task Force in the selection of a long-term solution for the treatment of non-guaranteed reinsurance under PBR.

Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein.

This report does not represent investment advice or provide an opinion regarding the fairness of any transaction to any and all parties. This report does not represent legal advice, which can only be provided by legal counsel and for which you should seek advice of counsel. The opinions expressed herein are valid only for the purpose stated herein and as of the date hereof.

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<td>Appendix D: Project team and governance</td>
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</tbody>
</table>
Executive summary
Long-term solution for modeling non-guaranteed reinsurance

BACKGROUND
A wide range of practice was observed from early adopters of FRS in regards to the modeling of non-guaranteed reinsurance and a formulaic solution was adopted as an interim basis for the 2020 Valuation Manual.

A field test is being performed to aid the NAIC Life Actuarial (A) Task Force ("LATF") in the selection of a longer-term solution that is more principles-based.

ANALYTICAL SUPPORT
Oliver Wyman was selected to support and supplement the industry field test. The scope of our support is summarized below and further outlined in the remaining slides of this section of the presentation.

1 - Analysis and insights
Using generic industry models, Oliver Wyman will perform analysis that will be provided in advance of field test results and provide additional insights beyond those provided by field test participants, informed by a survey on broader industry practices. As needed, analysis outside the scope of the field test may be performed.

2 - Field test support
Oliver Wyman will lead calls with field test participants and assist in the preparation and interpretation of results. Additionally, analysis will be performed to better understand the range of variation in participant results (e.g., company and reinsurance structure, field test interpretations, modeling simplifications and/or limitations).

The purpose of today’s presentation is to share details on the design of the analysis models as well as initial insights.

Initial analysis and insights
• Initial analysis and associated model design, with capabilities to analyze the impact field tested proposals across a range of product types, reinsurance structures and relevant reinsurance scenarios.
• Field test support will work closely with field test participants to ensure consistent understanding of field testing assumptions and provide additional analysis in light of any model simplifications or limitations (e.g., one-time assumptions).
• Reports summarizing results from industry field test, with additional analysis to further understand the range of interpretations for field tested proposals across a much larger participation base than the actual field test.

Deliverables for the stages of work shown on the prior slide are described on the next slide.

Field test support
• Field test participants will prepare the scenarios for the field test while Oliver Wyman performs deep analysis across a range of products and reinsurance scenarios to provide regulatory with representative potential solutions impacting on an apples-to-apples basis. Initial analysis will be shared with LATF at the Fall NAIC meeting (December 2019) and subsequent analysis shared at the Winter NAIC meeting (March 2020).

Deliverables for the stages of the field test depicted below

Timeline
Oliver Wyman will support the stages of the field test depicted below

Deliverables
Deliverables for the stages of work shown on the prior slide are described below.

Stage | Deliverables
--- | ---
Analysis and insights | • Initial analysis and associated model design, with capabilities to analyze the impact field tested proposals across a range of product types, reinsurance structures and relevant reinsurance scenarios.
• Field test support will work closely with field test participants to ensure consistent understanding of field testing assumptions and provide additional analysis in light of any model simplifications or limitations (e.g., one-time assumptions).
• Reports summarizing results from industry field test, with additional analysis to further understand the range of interpretations for field tested proposals across a much larger participation base than the actual field test.

Field test support | • Field test participants will prepare the scenarios for the field test while Oliver Wyman performs deep analysis across a range of products and reinsurance scenarios to provide regulatory with representative potential solutions impacting on an apples-to-apples basis. Initial analysis will be shared with LATF at the Fall NAIC meeting (December 2019) and subsequent analysis shared at the Winter NAIC meeting (March 2020).

Initial analysis and insights
Assumptions and modeling methodology underlying the results shown today are summarized below.

Component | Description
--- | ---
Model | • Liability assumptions are intended to reflect industry averages and are based on analysis from recent SOA experience studies.
• Future mortality improvements in 75% per year in all years.

Best estimate assumptions | • Mortality is improved to each valuation date to reflect historic mortality improvement.
• Future data period expected to be 25 years and increased by one year each future valuation date, subject to maximum years of sufficient data allowed for under VM-20 for the given level of credibility.

Prudent estimate assumptions | • Future data period expected to be 25 years and increased by one year each future valuation date, subject to maximum years of sufficient data allowed for under VM-20 for the given level of credibility.

Resource assumptions | • The DR (and if shown, SR) are re-valued annually for 10-years and every 5-years thereafter. Reserve balances are interpolated using policy level reserve calculations between re-valuation dates and smoothed to account for any “reserve blips” caused by the reinvestment frequency and resulting earned rates.

Analysis is intended to align with industry field test instructions and the products and assumptions are intended to be broadly representative of the industry.
Background

This section explores the relationship between mortality margin and the impact that reinsurance has on reserves under PBR.

1. Mortality and PBR prescribed margins
2. Impact of mortality margins
3. Projected reinsurance credit
4. Formulaic reserve credit

Results are presented for two sets of boundary reinsurer reactions under PBR mortality margins, and an analytical benchmark (10% mortality margin).

Mortality and PBR prescribed margin

Level of margin by VM-20 mortality assumption component is illustrated below:

- Male, 40 year old, preferred non smoker, 2019 valuation

Impact of mortality margins (1/2)

The impact of a 50% first dollar YRT reinsurance agreement with the current scale of rates equal to best estimate mortality is shown below:

- Rates are increased annually, on policy anniversary, by an amount equal to the difference between PBR mortality and the current scale of YRT rates.

The impact of reinsurance depends largely on the modeled reinsurer reaction.
Impact of mortality margins (2/2)

The impact of the 50% reinsurance agreement is re-evaluated below after updating the PBR mortality assumption to use a level 10% margin.

The impact of reinsurance depends largely on the modeled reinsurer reaction.

Impact on deterministic reserve
Impact on PBR reserve (max of NPR and DR)

Projected reinsurance credit

The reinsurance reserve credit (difference between pre- and post-reinsurance reserve) under the two sets of margins is shown below.

Key takeaways

1. Reinsurer reaction scenarios can produce reserve credits in excess of ½ Cx
   - ½ Cx represents the cost of reinsurance that corresponds to the period for which the reinsurance premium has been paid, but not yet earned by the reinsurer, with no provision for reinsurance beyond the paid to date.
   - Full reinsurer reaction scenario tested above for:
     - Reinsurer reaction that reflects differences between evolution of mortality margin and reinsurance premium payment dates.
     - Contractual provisions around the return of future unearned reinsurance premiums on death and lapse.
     - Other mechanical differences due to VM-20 requirements (e.g., differences in starting assets and the resulting earned rates).

2. It is important to look at long-term projections of reserves when evaluating the impact of reinsurance modeling approaches.
   - The level of margin in mortality as compared to best estimate changes at future valuation dates, due to unlocking of mortality improvement and extending the sufficient data period.
   - As the business ages, higher mortality and shorter projection horizons will change the impact of reinsurance on reserves at future valuation dates.
Overview
Proposed granularity for the analysis and modeling is outlined below.

<table>
<thead>
<tr>
<th>Reinsurance reaction</th>
<th>Sensitivity</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very high granularity of reinsurance reactions is tested as this is the primary driver of this area of where subjectivity can be found. Reinsurance reactions are tested across methodology analysis dimensions below</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Methodology analysis dimensions</th>
<th>Sensitivity</th>
<th>Proportion of the reinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>High</td>
<td>High/medium/low</td>
</tr>
<tr>
<td>Mortality</td>
<td>Medium</td>
<td>Low/medium/low</td>
</tr>
<tr>
<td>Reserves</td>
<td>Low</td>
<td>Low/medium/low</td>
</tr>
<tr>
<td>Products and population</td>
<td>Medium</td>
<td>Medium/low/low</td>
</tr>
<tr>
<td>Assets</td>
<td>Low</td>
<td>Low/medium/low</td>
</tr>
</tbody>
</table>

This section contains the results of sensitivities performed to confirm this level of granularity. See Appendix B for further details on the analysis design.

Impact analysis | High granularity
The following summarizes the impact reinsurance on PBR reserves for the sensitivities on model components with high granularity.

Impact on Deterministic Reserve

Impact on PBR reserve (loss of DR and NPR)

Both the properties of reinsurance and mortality have a significant impact on the reinsurance reserve credit.

Impact analysis | Low-medium granularity
The following summarizes the impact reinsurance on PBR reserves for the sensitivities on model components with low-medium granularity.

Impact on Deterministic Reserve

Impact on PBR reserve (loss of DR and NPR)

The product and yield curve sensitivities have a lower impact on the reinsurance reserve credit.

Reinsurer reaction scenarios
Proposed coverage is shown below. As needed, these results will be produced for the methodology analysis dimensions (e.g., product, company size, reinsurance attributes).

- N/A: Allow future mortality improvement in reserves
- N/A: Use reinsurance reserves (

- No change
- Increase by 100% of prescribed mortality margin
- Increase by 100% of prescribed mortality margin, including
- Increase by 105% of the difference between current scale and PBR mortality
- Increase by 100% of prescribed mortality margin, including
- Increase by 105% of the difference between current scale and PBR mortality
- Increase by 100% of prescribed mortality margin
- Increase by 100% of prescribed mortality margin
- Increase by 105% of the difference between current scale and PBR mortality
- Increase by 100% of prescribed mortality margin

These results will be produced primarily to assist with the analysis and interpretation of field test results.
Scope of field test
The scope of the industry field test is focused on the “field test modified” APFs discussed on the September 12th LATF call and summarized below.

### APF Description

<table>
<thead>
<tr>
<th>APF</th>
<th>Description</th>
<th>Field testing variations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019-40</td>
<td>Actuarial judgement with clarified modeling principles/guidance</td>
<td>• Prudent estimate of all counterparty actions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prudent estimate of rate changes only after reaching 115% reinsurer loss ratio</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Model prudent estimate of rate changes only after reaching 5 consecutive years of reinsurer losses</td>
</tr>
</tbody>
</table>

| 2019-41 | Reinsurance margin such that the difference between best estimate mortality and the current scale of YRT rates is maintained | • Best estimate mortality (used for the purposes of calculating reinsurance margin) contains future mortality improvement for 15 years at a rate of 5%, 3% and 1% per year |
|         |                                                                             | • Reinsurance rates by reinsurance premium margin, equal to the percentage difference between PBR and best estimate mortality |
|         |                                                                             | • Increase reinsurance rates by reinsurance premium margin, equal to the percentage difference between PBR and best estimate mortality |
|         |                                                                             | • Judgment modifications are allowed if these are consistent with what the market considers appropriate |

The field test submission calls for two baselines: the interim solution (½ Cx) and a scenario where no change from the current scale of YRT rates is assumed.

### Initial insights and analysis

The remainder of this section focuses on representative impacts for the field-tested APFs, as summarized in the table below. In addition the impact is provided for the two baselines described on the prior slide.

#### APF Field testing variations

- **2019-40**
  - Prudent estimate of all counterparty actions
  - Prudent estimate of rate changes only after reaching 115% reinsurer loss ratio
  - Model prudent estimate of rate changes only after reaching 5 consecutive years of reinsurer losses

- **2019-41**
  - Reinsurance margin such that the difference between best estimate mortality and the current scale of YRT rates is maintained
  - Best estimate mortality (for the purposes of calculating reinsurance margin) contains future mortality improvement for 15 years at a rate of 5%, 3% and 1% per year

- **2019-42**
  - Increase reinsurance rates by reinsurance premium margin, equal to the percentage difference between PBR and best estimate mortality
  - Judgment modifications are allowed if these are consistent with what the market considers appropriate

The purpose of these results is to foster dialogue around these APFs, the format results are presented in, and any desired follow-up analysis.

### Initial analysis

The remainder of this section focuses on representative impacts for the field-tested APFs, as summarized in the table below. In addition the impact is provided for the two baselines described on the prior slide.

#### APF Field testing variations

- **2019-40**
  - Prudent estimate of all counterparty actions
  - Prudent estimate of rate changes only after reaching 115% reinsurer loss ratio
  - Model prudent estimate of rate changes only after reaching 5 consecutive years of reinsurer losses

- **2019-41**
  - Reinsurance margin such that the difference between best estimate mortality and the current scale of YRT rates is maintained
  - Best estimate mortality (used for the purposes of calculating reinsurance margin) contains future mortality improvement for 15 years at a rate of 5%, 3% and 1% per year

- **2019-42**
  - Increase reinsurance rates by reinsurance premium margin, equal to the percentage difference between PBR and best estimate mortality
  - Judgment modifications are allowed if these are consistent with what the market considers appropriate

The purpose of these results is to foster dialogue around these APFs, the format results are presented in, and any desired follow-up analysis.

### Impact analysis

#### ½ Cx and no change to current scale of YRT rates

- **Reinsurance credit**
  - Reserve credit ($MM)
  - Reserve credit ($MM)
  - Reserve credit ($MM)
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  - Reserve credit ($MM)
Impact analysis | APF 2019-40
YRT rates are increased by 75% of the difference between the current scale and PBR mortality, until recapture in 2044

The reinsurer reaction (5% over mortality margin) produces a reserve credit in excess of ½ Cx (See Background section for explanation) until recapture in 2044.

Impact analysis | APF 2019-40
No change in YRT rates until 2024 followed by progressive increases to break even in 2044 and later

The reserve credit is higher than the prior slide because of a slower reinsurer action. The reserve credit persists beyond 2044 because recapture is not modeled.

Impact analysis | APFs 2019-41, 2019-42
Future mortality improvement included in the best estimate component of reinsurance margin for 15 years at a rate of 0.75% per year

The impact of APFs 2019-41 and 2019-42 are equal due to the selection of mortality improvement parameters and the method used to calculate the reinsurance margin.
Listed below are next steps for the analysis and field test:

<table>
<thead>
<tr>
<th>Next Step</th>
<th>Target Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>February 2020</td>
<td>Oliver Wyman to confirm and share results of industry field test for point-in-time reserves as well as additional consultant analysis at a LATF call in February</td>
</tr>
<tr>
<td>2</td>
<td>March 2020</td>
<td>Oliver Wyman to share APF specific results informed by industry range of practice survey at the March LATF meeting</td>
</tr>
<tr>
<td>3</td>
<td>April 2020</td>
<td>Oliver Wyman to work alongside companies to develop projected reserves and share results with LATF at an April call</td>
</tr>
<tr>
<td>4</td>
<td>May - June 2020</td>
<td>Academy working group will work with LATF to draft an amendment and expose for comment. Oliver Wyman will perform additional analysis as needed</td>
</tr>
</tbody>
</table>

Impact analysis | gross reserves (1 of 2)
Pre-reinsurance reserves are shown below for the sensitivities on model components with high granularity:

Impact analysis | gross reserves (2 of 2)
Pre-reinsurance reserves are shown below for the sensitivities on model components with low-medium granularity:
Impact analysis | net reserves (1 of 2)
Post-reinsurance reserves are shown below for the sensitivities on model components with high granularity.

Baseline Results from Section 1

Reserve ($MM)

<table>
<thead>
<tr>
<th>Year</th>
<th>0</th>
<th>250</th>
<th>500</th>
<th>750</th>
<th>1000</th>
<th>1250</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Impact analysis | net reserves (2 of 2)
Post-reinsurance reserves are shown below for the sensitivities on model components with low-medium granularity.

Baseline Results from Section 1

Reserve ($MM)

<table>
<thead>
<tr>
<th>Year</th>
<th>0</th>
<th>250</th>
<th>500</th>
<th>750</th>
<th>1000</th>
<th>1250</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Impact analysis | net reserves (3 of 2)
Post-reinsurance reserves are shown below for the sensitivities on model components with low-granularity.

Baseline Results from Section 1

Reserve ($MM)

<table>
<thead>
<tr>
<th>Year</th>
<th>0</th>
<th>250</th>
<th>500</th>
<th>750</th>
<th>1000</th>
<th>1250</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Impact analysis | net reserves (4 of 2)
Post-reinsurance reserves are shown below for the sensitivities on model components with no granularity.

Baseline Results from Section 1

Reserve ($MM)

<table>
<thead>
<tr>
<th>Year</th>
<th>0</th>
<th>250</th>
<th>500</th>
<th>750</th>
<th>1000</th>
<th>1250</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Methodology analysis dimensions
The proposed coverage for the analysis is summarized below.

<table>
<thead>
<tr>
<th>Component</th>
<th>Granularity</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reinsurance</td>
<td>Very high</td>
<td>- Amount of reinsurance (None, 10% and 50%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Attachment (first dollar and excess of retention)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Relationship between the current scale of YRT rates and best-estimate mortality (i.e., equal to, less than and greater than)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Default company experience and various customer reaction scenarios (See next section)</td>
</tr>
<tr>
<td>Mortality</td>
<td>High</td>
<td>- Different best-estimate mortality improvement rates (0%, 1%, 2%, 3%, 4% per year) and levels of credibility &amp; years of sufficient data</td>
</tr>
<tr>
<td>Reserves</td>
<td>Medium</td>
<td>- Projected reserves will be calculated based on the 2020 Valuation Manual and set to the Max(NPR, DR) with the SR enabled for select runs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Reserves will be re-valued annually</td>
</tr>
<tr>
<td>Products and population</td>
<td>Medium</td>
<td>- Mix of business by issue age, risk class, gender and band for Term (T10 and T20), ULSG (Shadow account, lifetime guarantee) and CAUL (5-year specified premium guarantee, general account only) products issued on June 30, 2019</td>
</tr>
<tr>
<td>Assets</td>
<td>Low</td>
<td>- Investments only, level yield curve</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 60/40 mix of AA assets with 10-year duration in both inner and outer loop (Note: Credit spread and defaults will vary by inner and outer loop)</td>
</tr>
</tbody>
</table>

Appendix B | Model design and assumptions
Liability assumptions (ULSG)
The assumptions used in the analysis are below, including assumed PBR margins

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Anticipated experience assumption</th>
<th>Prudent estimate assumption (e.g. margin)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>• 2015 VBT gender distinct, smoker distinct ANB</td>
<td>• Prescribed margins applied to company mortality</td>
</tr>
<tr>
<td></td>
<td>• Relative risk varies by risk class</td>
<td>• Industry table: 2015 VBT with prescribed margins and mortality improvement base</td>
</tr>
<tr>
<td></td>
<td>• A/E factors vary by high/low band</td>
<td>• Grading and margins assumes 100% LF credibility</td>
</tr>
<tr>
<td></td>
<td>• .75% annual future mortality improvement</td>
<td></td>
</tr>
<tr>
<td>Lapse</td>
<td>• 3% annual lapse rate</td>
<td>• 2% annual lapse rate</td>
</tr>
<tr>
<td>Expenses</td>
<td>• $60 per policy (annual)</td>
<td>• 100% margin on expenses</td>
</tr>
<tr>
<td></td>
<td>• 2.5% premium tax</td>
<td>• 2.5% inflation</td>
</tr>
<tr>
<td></td>
<td>• 2% inflation</td>
<td></td>
</tr>
</tbody>
</table>

Suite of modeling tools
Overview (1 of 2)

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>AXIS Dataset</td>
<td>- AXIS pricing and business model equipped with ALM and PBR functionality, representative policies from generic product types and the flexibility to run various reinsurance reactions and PBR revaluation scenarios</td>
</tr>
<tr>
<td></td>
<td>- DataLink functionality allowing for automated updates to product features and assumptions</td>
</tr>
<tr>
<td>Model documentation</td>
<td>- Self-contained documentation of model requirements, design, and testing</td>
</tr>
<tr>
<td>Detailed user guide</td>
<td>- Comprehensive guide choosing the model setup for product features, assumptions and Expenses</td>
</tr>
<tr>
<td></td>
<td>- Instructions on how to use the Testware and perform updates to the model</td>
</tr>
</tbody>
</table>

Suite of modeling tools
Overview (2 of 2)

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testware</td>
<td>- Comprehensive testing workbook which validates all calculations (scenario information, investment gains/losses and interpolated reserves taken as a given)</td>
</tr>
<tr>
<td></td>
<td>- Summarize, confirm, and provide meaningful metrics for the model office results</td>
</tr>
<tr>
<td>Analysis tool</td>
<td>- Graphs of reserve balances, distributable earnings, and the earned rate on general account assets</td>
</tr>
<tr>
<td></td>
<td>- Provides high-level check on outer and inner loop decrements and other implied values</td>
</tr>
<tr>
<td>Input builders</td>
<td>- User-friendly Excel tools in which assumptions and other required model values are translated from user-friendly “source information” into AXIS formatted tables</td>
</tr>
<tr>
<td></td>
<td>- These tools are embedded in the Dataset in order to enhance controls and governance</td>
</tr>
</tbody>
</table>
Documentation
Details the requirements, design, documentation, and testing of the model in a modular and expandable structure.

Documentation is centralized into a single, all-inclusive report to facilitate future maintenance. Appendices summarize future improvements and other key project deliverables.

User guide
Supplements the model documentation and provides additional detail on the AXIS model structure.

Testware
Replicates model calculations while supporting version management, increasing transparency, and augmenting documentation.

Analysis tool
Aggregates results under pre-PBR and PBR setups and provides financial metrics and implied rate analysis.
Project team and governance

The consultant analysis will be overseen by NAIC Staff, the Academy, and the ACLI, as depicted in the following chart.

Oliver Wyman team

<table>
<thead>
<tr>
<th>Contact Information</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chris Whitney, FSA, MAAA</td>
<td>Engagement manager</td>
</tr>
<tr>
<td>Dylan Strother, FSA, MAAA</td>
<td>Technical lead</td>
</tr>
<tr>
<td>Katie van Ryn, FSA, MAAA</td>
<td>AXIS model development</td>
</tr>
</tbody>
</table>

The report and the findings herein are subject to the reliance and limitations outlined at the beginning of this report. This report is considered a statement of actuarial opinion under the guidelines promulgated by the American Academy of Actuaries. Chris Whitney, Dylan Strother and Katie van Ryn of Oliver Wyman developed this report and meet the qualification requirements of the American Academy of Actuaries to render the opinion contained herein.
QUALIFICATIONS, ASSUMPTIONS AND LIMITING CONDITIONS

Oliver Wyman was requested by the American Council of Life Insurers, the American Academy of Actuaries and the National Association of Insurance Commissioners to support an industry field test being conducted to aid the NAIC Life Actuarial (A) Task Force in the selection of a long-term solution for the treatment of non-guaranteed reinsurance under PBR.

Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein.

This report does not represent investment advice or provide an opinion regarding the fairness of any transaction to any and all parties. This report does not represent legal advice, which can only be provided by legal counsel and for which you should seek advice of counsel. The opinions expressed herein are valid only for the purpose stated herein and as of the date hereof.

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Objective

- **AIRWG Pillars of Objective**
  1. **Adverse Selection Criteria**: Both risk in all-new, new-risk in moderately adverse conditions requires greater statutory
     reserve, and vice versa.
  2. **Consistency**: The statutory reserve accounts for all material risks covered in the Valuation Manual, product
     features, and potential management actions associated with the policies or contracts being valued.
  3. **Consistency across Products**: Statutory reserves between two contracts with similar features and risk are consistent
     given the same assumptions, regardless of product type.
  4. **Principles and Appropriateness**: Balance principles above with an approach that is practical, implementable, and
     able to be implemented.

(path forward)

Path Forward

- **Aug – Dec 2019**
  - Develop proposed fixed annuity PBR framework deck
  - Begin initial modeling sensitivities for general FI/annuity

- **Spring 2020**
  - AIRWG to present framework deck proposal to LATF

- **Fall 2020**
  - Seek LATF endorsement of PBR framework deck [as feedback addressed]
  - Valuation Manual language drafting efforts

- **Spring 2021**
  - Begin industry field testing using draft [specifics TBD]

- **Spring 2022**
  - Target adoption of fixed annuity PBM (potentially VM-22)
  - Target 1/1/2023 effective date (monitor as progress develops)
Topics for LATF Discussion

1) Net Assets and Reinvestment Risk – Primary driver for fixed annuity modeled reserves is general account investment income. Therefore, aligning with VA 20 with the following:
   - Company-specific spread/return for “x” years (e.g., 10 years) and grade to prescribed assumptions over time (e.g., 5-year period). Consider consistency with AII and certifications.
   - Company-specific reinvestment assumptions, including the Yn-Yn+Yn+1 certification from an investment officer?
2) Exclusion Test Methodology – Agree with exclusion test to ease implementation burden for fixed annuities with limited optionality or maximum risk? Thoughts on approach?
3) Scope – Any concerns with proposed product scope or potential retrospective application?

Preliminary Framework Methodology Elements

American Academy of Actuaries
Annuity, Reserves Work Group (AMWG)

1 – Product Scope

- Products In Scope:
  - Account Value Indexed Annuities
  - Deferred Annuities (SPDAs & PFDAs)
  - Multi-Year Guarantee Annuities (MYGAs)
  - Fixed Indexed Annuities (FIAs)
  - Market Value Adjustments (MVAs)
  - Two-Tiered Annuities
  - GLBs and Other Guarantees/Riders
  - Period Annuities
  - Single Premium Immediate Annuities (SPIAs)
  - Deferred Income Annuities (DIAs)
  - Pension Risk Transfer Annuities (PRT)
  - Structured Settlements

- Products Out-of-Scope:
  - Guaranteed Investment Contracts (GICs)
  - Funding Agreements
  - Mortality-Linked Securities
  - Longevity Reinsurance

- VA 21 or Fixed Annuity PBR (TBD)
  - Modified Guaranteed Annuities (MGA)
  - Structured Annuities
  - Hybrid Variable and Fixed Annuities

- Retrospective Application? (TBD)
  - Required in both private and non-business
2 – Hedging Requirements

Recommendation: Allow future hedging programs to be modeled if sufficiently to control whether CDHM or not. Use VM-21

Explanation: Use VM-21 where all hedging is limited or excluded.

Preliminary Fixed Annuity MB Methodology (consistent with VM-21 except hedge on indexed credits and CDHM)

a) No Hedges— Recommend all future hedging be reflected, regardless of whether CDHM or not.

b) Hedging Exclusions— Recommend all future hedging be reflected, regardless of whether CDHM or not.

c) Prorated Hedging— Recommend only 3/20 rates for SPIAs issued on/after 2018, and AG33/35 methodology (with interest rate

d) Exclusions— Recommend exclusion be reflected regardless of whether CDHM or not.

3 – Discount Rate and Starting Assets

Preliminary Fixed Annuity MB Methodology (consistent with VM-21)

4 – Exclusion Test Methodology


Preliminary Fixed Annuity MB Methodology (consistent with VM-21)

5 – Exclusion Test Methodology


Preliminary Fixed Annuity MB Methodology (consistent with VM-21)
5 – Preliminary Modeling Efforts

- Develop a reserve model for a prototype fixed Indexed annuity (IFA) product with a guaranteed living benefit (GLB) to project a preliminary non-variable annuity FIA
- Include sensitivity tests on various product features, probability level, economic conditions, reinvestment strategies, and liability assumptions
- Objectives are as follows:
  - Compare projected reserves for stochastic FIA reserves at 20% or less without and with GLB
  - Help test and refine ASAP recommendations for frameworks elements
  - Set potential threshold for percentage breakdown of stochastic reserve data test

6 – Topics for LATF Discussion

1) Net Assets and Investment Mix – Primary driver for S&L annuity modeled reserves is general account investments. Therefore, academy wants to explore refining from VA-19 with the following:
   - Company-specific IAIAC/LOA for “a” which (a) and (b) grade to prescribed assumptions over time (a & b) and year (2) consider consistency with VA-19 and VA-20
   - Company-specific reinvestment assumptions, including the VA-19/VA-20-1 certifications from an investment office?
2) Exclusion Test Methodology – Agree with Academy’s preference to use an exclusion test to ease implementation burden for fixed annuities with limited optionality or economic risk. Thoughts on discussed approach?
3) Supervision – Academy members expressed interest in researching retrospective application, including revisions issued prior to 2015. Between 2013 and 2018, effective dates, and prospectively, any concerns or considerations with retrospective adoption?

Appendix I: Product Descriptions

<table>
<thead>
<tr>
<th>Product Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deferred Income (DI)</td>
<td>Annuity with an account value established with a single premium amount that grows with a guaranteed interest rate during the accumulation phase and pays guaranteed income in the form of a lifetime annuity or a specified period of years.</td>
</tr>
<tr>
<td>Deferred Income (DI)</td>
<td>Annuity with an account value established with a single premium amount that allows for additional contributions for the period defined in the contract.</td>
</tr>
<tr>
<td>Fixed Income Annuity</td>
<td>Annuity with an account value that provides a predetermined and contractually guaranteed interest rate for a specified period of time, after which time it is typically an annual annuitization or a result of a multiple-year guaranteed period.</td>
</tr>
<tr>
<td>Multiple Year Guaranteed Annuity</td>
<td>Annuity with an account value that provides a predetermined and contractually guaranteed interest rate for a specified period of time, after which time it is typically an annual annuitization or a result of a multiple-year guaranteed period.</td>
</tr>
<tr>
<td>Adjustable Income Annuity</td>
<td>Annuity with an account value that provides a predetermined and contractually guaranteed interest rate for a specified period of time, after which time it is typically an annual annuitization or a result of a multiple-year guaranteed period.</td>
</tr>
<tr>
<td>Year-Term Annuity</td>
<td>Annuity with an account value that provides a predetermined and contractually guaranteed interest rate for a specified period of time, after which time it is typically an annual annuitization or a result of a multiple-year guaranteed period.</td>
</tr>
</tbody>
</table>

1) The descriptions contained in this table are not recommendations of definitions, and are intended for informational purposes only. They are not guidelines for use in any other context.
### Appendix I: Product Descriptions (cont’d)

<table>
<thead>
<tr>
<th>Product Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Premium Immediate Annuity</td>
<td>An annuity guaranteed with a single premium amount which guarantees a periodic payment for life of the annuitant or a term certain and payments begin within one year after the date of issue.</td>
</tr>
<tr>
<td>Deferred Income Annuity</td>
<td>An annuity which guarantees a periodic payment for the life of the annuitant or a term certain and payments begin one year after issue.</td>
</tr>
<tr>
<td>Pension Risk Transfer Diversification</td>
<td>An annuity typically group policy whereby insurance company issues participating retirement plan that guarantees periodic payments to retirement participants. The insurance company makes the death (general or specific) payment at death and mortality payments are based on life insurance.</td>
</tr>
<tr>
<td>Structured Settlements Transfer</td>
<td>An annuity wherein the policyowner transfers certain collection rights for court settlement to an insurance company, such as personal injury proceeds.</td>
</tr>
<tr>
<td>Transfer with Interest</td>
<td>An annuity issued by an insurance company that offers guaranteed periodic payments for a specified period of time, or until death, with interest credited to the account.</td>
</tr>
</tbody>
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W:\National Meetings\2019\Fall\TF\LA\National Meeting\1.4 Academy ARWG Update_Complete\ARWG LATF Update Fall 2019 (4 per page)
Standard Valuation Law
Interest Rate
Modernization Update

Chris Conrad, MAAA, FSA
Chairperson, SVL Interest Rate Modernization Work Group

Non-SPIA* Valuation Rates

- Must coordinate with the Annuity Reserves Work Group (ARWG)
  - Working plan is to develop valuation rates for products which pass under-development exclusion test
  - Current Plan: Refresh current valuation rates using similar methodology as was used to develop current rates
    - Generally, calculate the weighted average yield over the life of the business, taking into account the time value of money
    - Specifically, calculate the present value of benefits and expenses using portfolio book yields (including realized gains and losses)
      - Determine single rate that will produce the same present value as described above,
        - Consistent with VM-20 Deterministic Reserve

Non-SPIA Valuation Rates

- Open issues:
  - Examining three interest rate scenarios: level, rising, falling
  - How to use valuation rates produced from the three scenarios.
  - Whether to retain single locked-in valuation rate at issue or require future unlocking
  - Same scope as current regime: produce valuation rates for all non-SPIA annuities
  - So as to cover any annuities that pass the under-development exclusion test

Contemplated Changes to Current Framework

- New Reference Index: Treasuries + VM-20 Spreads
- Potential Differentiators:
  - Surrender Charge Period
  - Market Value Adjustment
  - Partial Free Withdrawals
  - Single Premium vs. Flexible Premium
  - Multi-Year Guarantee vs. Annuity Reset
- Work Continues on Multi-Year Guarantee and Annual Reset Annuities
- Proposed Effective Date: 1/1/23 (Consistent with ARWG)
  - May be part of field test
Questions?

- Chris Conrad, MAAA, FSA
  Chairperson, SVL Interest Rate Modernization Work Group
- Ben Slutsker, MAAA, FSA
  Vice Chairperson, SVL Interest Rate Modernization Work Group
- Ian Trepanier
  Life Policy Analyst
  American Academy of Actuaries
  Trepanier@actuary.org
Mortality Improvement Scale Methodology
AG38 and VM20

SOA Preferred Mortality Oversight Group ("Joint Committee") and Life Mortality Improvements Subgroup ("LMIS")

Purpose of the Individual Life MI Recommended Scale
- Used in conjunction with AG38 and VM20 reserve development
- Updated each year to account for an additional year of mortality improvement
- Applied to improve Valuation Basic Table mortality from the table date (e.g., 2015 for the 2015 VBT) to current valuation date

Current methodology for annual recommendations
- In use since year-end 2013 for AG38
- Approach is consistent with development process for the MI scale used in the 2015 VBT and 2017 Commissioners Standard Ordinary table development work

Agenda
- Purpose of Individual Life Mortality Improvement (MI) Recommended Scale
- Current methodology for annual recommendations
- Application of recommended scale
- Next steps
Current Methodology for annual recommendations

- Consistent • Use • Age • MI

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**Next Steps**

**Develop a consistent framework for producing MI scales**

- **Objective:** Develop a common tool, which would be made available to SOA members, to be used by practitioners from individual life, individual and group annuity, and pension/retirement (target: 2020)
  - Tool, currently in development, will use 2-dimensional approach
  - Similar to CM1 and RIPE MP table development, with some modifications
  - For life tables, intent is to use gender specific SSA data for the US population and SOA non-smoker and smoker experience with consideration to eventually allow users to input their own data
  - Will allow practitioner decisioning to convergence period
  - Requires significant testing from multiple practitioners across practice areas

---

**Suggested Next Steps**

- Revise prescribed methodology to remove any material actuarial judgement – Develop a threshold level of change to indicate update to the scale in any given year (timeline: for 2020 scale update)
  - Include a description of the methodology used each year to updated the life MI scale in the current valuation manual (timeline: TBD)
  - Scale updates would be made each year without required formal approval by LATF as long as no changes are made to the prescribed methodology (next change: expected only after recommended MI framework is released by SOA Mortality and Longevity Steering Committee)

---

**Contact Information**

Marianne Purushotham, FSA, MAAA  
Chairperson, Life MI Subgroup

Ian Trepanier  
Life Policy Analyst  
American Academy of Actuaries  
Trepanier@actuary.org
PBR Treatment for Individually Underwritten Group Insurance

Life Reserve Working Group

The VM, Section II.B and Section II.D state minimum reserve requirements for individual life contracts, thus excluding group life contracts.

- Section II.B* states the minimum reserve requirements for variable and nonvariable individual life contracts, with certain exceptions, are subject to PBR requirements and VM-20 and is silent on the treatment of individually underwritten group life insurance.
- Section II.D.1* provides for the PBR exemption in terms of premiums for ordinary life insurance, which, by definition, excludes group life contracts.

Discussion topic

- Certain group life certificates are solicited, acquired, managed, and have policy provisions consistent with individual ordinary life policies.
- These types of group life certificates should be subject to the same reserve requirements and other reporting within the Valuation Manual (VM) as other ordinary life insurance contracts of the same product type.

SSAP No. 50 Paragraph 33 defines group life characteristics*

- Insurance is on the lives of a group of persons under a single master contract;
- Customarily written on a yearly renewable term basis, though permanent products are sold;
- The terms are based on a master policy, which:
  - Usually precludes or disallows individual selection;
  - Is for the benefit of persons other than the policyholder;
  - Individual insured members are issued certificates of insurance rather than an insurance policy; and
- Contract is between the policyholder and the insurer—there is no contract of insurance between the policyholder and the members.

* Exposed to similar risk; (usually a work profession) who are related in some way such as belonging to a certain association.
Certain contracts issued under a master group contract or franchise contract reflect the characteristics of ordinary individual life contracts

- To qualify for issuance of a group insurance certificate, certain group contracts:
  - Require individual risk selection in order to qualify for issuance of the group insurance certificate; and
  - Do not require continued membership in the group in order to maintain coverage.
- These certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification as individual ordinary life insurance contracts.
- These certificates are managed in a similar manner to individual ordinary life insurance contracts.
- These individual certificates should follow the same reserve requirements as other individual life contracts of the same product type.

VM-51 scope excludes individually solicited group life

- VM-51 scope for individual ordinary life insurance and currently excludes separate lines of business such as:
  - SI/GI
  - Worksite
  - Individually solicited group life
  - Direct response
  - Final expense
  - Pre-need
  - Home service
  - Credit life
  - CDL/ BOLI/charity-owned life insurance (CHOLI).

LRWG recommends seven clarifying changes to the VM and one referral for change to the NAIC Blanks, PBR Supplemental Report

1. Change the minimum reserve requirements (Section II) to also apply to group life which, other than the difference between issuing a policy and issuing a certificate, have the same or mostly similar contract provisions, risk selection process, and underwriting as individual ordinary life contracts;
2. Add language to Reserve Requirements Section II, Subsection 1.D.5 and the corresponding footnote to include premiums from group life contracts which have individual certificates that were issued using individual risk selection processes (including in the footnote bring premiums associated with these types of group contracts into the PBR Exemption determination);
3. Add new paragraph, VM-20, Section 1.B, to clarify group life certificates issued using individual risk selection processes, including a definition for individual risk selection process, are subject to the requirements of VM-20;
4. Add guidance note after first sentence in VM-20, Section 2.A.1, to clarify applicability to group life insurance certificates that meet the individual risk selection process definition;
5. Modify VM-51 to no longer exempt individually solicited group life contracts which meet the requirements and definitions under items (1) and (2) above; and
6. Modify VM-51, Appendix 4, to no longer exempt individually solicited group life contracts which meet the requirements under items (1) and (2) above.
7. Refer to NAIC Blanks (E) Working Group, modifications to the VM-20 Reserves Supplement, Part 3 to report premiums for total Group Life and Group Life with an individual risk selection process as defined in VM-20 Section 1.B separately.
### Individual insured risk selection process for group life insurance certificates

**Proposed definition:**
- The risk selection process is based on characteristics of the insured(s) beyond sex, gender, age, and membership in a particular group.
- This may include, but is not limited to, completion of an application, questionnaire(s), or tele-interview (beyond acknowledgement of membership to the group master policyowner, sex, gender, and age), the use of non-medical information, medical or health history information, prescription history information, avocations, usage of tobacco, family history, or submission of fluids such as blood, Home Office Specimens (HOS), or oral fluid. The resulting risk classification is determined based on the characteristics of the individual insured(s) rather than the group, if any, of which it is a member (e.g., employer, affinity, etc.).

---

### Recommendation to include the premiums for group life subject to an individualized risk selection process in the PBR Exemption

<table>
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<tr>
<th>Yes</th>
<th>No</th>
<th>Further Analysis</th>
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<tr>
<td>Use US definition within subsection II(B) of the Revisions for the Life Risk Business (e.g., PBR), Section III</td>
<td>Yes</td>
<td>Yes</td>
</tr>
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</table>

**To avoid unintended consequences for non-life group insurance:**
- Recommendation for this definition within VM-20, Section II and not within VM-21.

---

### Recommend a three-year transition period

- **Recommend changes required for group certificates issued on or after 1/1/2024**
- **Need to allow companies with certificates meeting the definition of group certificates, which utilize an individual risk selection process, sufficient time to incorporate PBR**
  - Especially if previously met PBR exemption

---

### Appendix: VM, Section II. Reserve Requirements for Life Insurance Products

- **Section II.A:**
  - This subsection establishes reserve requirements for all contracts issued on and after the operative date of the Valuation Manual that are classified as life contracts as defined in SAP No. 31 (R) in the Life Manual, with the exception of annuity contracts, credit life, and collective contracts.
  - Reserves are based on life table mortality rates applicable to the insureds at the inception of the contract and are based on the mortality tables used for the life contracts as defined in SAP No. 31 (R) of the Valuation Manual.
  - The mortality tables used for the life contracts as defined in SAP No. 31 (R) of the Valuation Manual are as follows:
    - United States Male and Female Mortality Tables
    - United States Male and Female Mortality Tables
    - United States Male and Female Mortality Tables

- **Section II.B:**
  - This subsection establishes reserve requirements for variable and non-variable individual life contracts—excluding guaranteed issue life contracts, prepaid life contracts, industrial life contracts, and policies of companies exempt pursuant to the life PBR exemption in paragraph 16.1 (b) below for the purpose of being classified as life contracts under the definition of the transition period in paragraph 1A.2.1. For the purpose of being classified as life contracts, the reserve requirements of VM-20 are consistent with the principles-based valuation requirements for purposes of the Valuation Manual.

- **Nonforfeiture requirements for life contracts subject to VM-20:**
  - Nonforfeiture requirements for life contracts subject to VM-20 are consistent with the principles-based valuation requirements for purposes of the Valuation Manual.

- **Mortality tables:**
  - Mortality tables used for the life contracts as defined in SAP No. 31 (R) of the Valuation Manual are as follows:
    - United States Male and Female Mortality Tables
    - United States Male and Female Mortality Tables
    - United States Male and Female Mortality Tables

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Appendix: VM, Section II. Reserve Requirements for Life Insurance Products, continued

Section II.D

1. A company meeting the condition in D.2 below may file a statement of exemption for ordinary life insurance policies, except for policies in D.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. Such a statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that condition D.2 was met based on premiums from the prior calendar year annual statement. The statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

Footnote

1 Premiums reported as direct plus reinsurance assumed from an unaffiliated company for the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit II, Part I, Column 3. "Ordinary Life Insurance" excluding premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit I Part I, Column 3 as ordinary life insurance premium. Proceeds is as defined in VM-01.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

American Academy of Actuaries, Life Reserves Work Group

Addition of language to clarify the definition of individually underwritten life insurance and the applicability of Principle-Based Reserve (PBR) requirements for group insurance contracts with individual risk selection issued under insurance certificates.

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

January 1, 2020, version of the Valuation Manual used.

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

See Appendix.

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

Individual insurance certificates issued under a group contract which utilize an individual risk selection process, pricing, premium rate structures and product features are similar to individual life insurance policies. They are currently excluded from VM-20 because they are filed under a group contract, but they should be subject to VM-20 due to this similarity. See Appendix.

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

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Notes: APF 2019-33
Appendix

Issue

Certain contracts issued under a master group contract require individual risk selection in order to qualify for issuance of the group insurance certificate and do not require continued membership in the group in order to maintain coverage. The certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing and risk classification, and are managed in a similar manner as individual ordinary life insurance contracts. These individual certificates should follow the same reserve requirements as other individual life contracts of the same product type. Therefore, a change is needed within the Valuation Manual to bring these individual certificates into scope of VM-20.

Eight Seven changes are recommended:

1) Within the Reserve Requirements section (Section II), change the minimum reserve requirements to also apply to group life contracts which, other than the difference between issuing a policy and issuing a group certificate, have the same or mostly similar contract provisions, risk selection process and underwriting as individual ordinary life contracts;

2) Within the Reserve Requirements section (Section II), add a transition period for individual group certificates issued on or before 1/1/2024;

3) Add new paragraph, VM-20 Section 1.B (and reformat to make current paragraph Section 1.A) to clarify group life certificates issued using individual risk selection processes, including a definition for individual risk selection process, are subject to the requirements of VM-20;

4) Add guidance note after first sentence in VM-20 Section 2.A.1 that group life certificates that meet the definition for individual risk selection process use the same VM-20 Reserving Categories as defined in Section 2;

5) Modify VM-51 Section 2.B to no longer exempt individually solicited group life which meet the requirements and definitions under items (1) and (2) above; and

6) Modify VM-51, Appendix 4, Item 17 to no longer exempt individually solicited group life contracts which meet the requirements under items (1) and (2) above.

Referral to the NAIC Blanks (E) Working Group, to revise the PBR Supplemental Report VM-20 Reserves Supplement, Part 3 to report premiums, reserves, claims, etc. for total Group Life and Group Life with an individual risk selection process as defined in VM-20 Section 1.B separately.
VM Changes 1, 2 and 3 – II. Reserve Requirements

II. Reserve Requirements

This section provides the minimum reserve requirements by type of product, as set forth in the seven subsections below, as follows:

(1) Life Insurance Products
(2) Annuity Products
(3) Deposit-Type Contracts
(4) Health Insurance Products
(5) Credit Life and Disability Products
(6) Riders and Supplemental Benefits
(7) Claim Reserves

All reserve requirements provided by this section relate to business issued on or after the operative date of the Valuation Manual. All reserves must be developed in a manner consistent with the requirements and concepts stated in the Overview of Reserve Concepts in Section I of the Valuation Manual.

Guidance Note: The terms “policies” and “contracts” are used interchangeably.

Subsection 1: Life Insurance Products

A. This subsection establishes reserve requirements for all contracts issued on and after the operative date of the Valuation Manual that are classified as life contracts as defined in SSAP No. 50 in the AP&P Manual, with the exception of annuity contracts and credit life contracts. Minimum reserve requirements for annuity contracts and credit life contracts are provided below in subsection 2 and subsection 5, respectively.

B. Minimum reserve requirements for variable and nonvariable individual life contracts—excluding guaranteed issue life contracts, preneed life contracts, industrial life contracts, and policies of companies exempt pursuant to the life PBR exemption in paragraph D below—are provided by VM-20, Requirements for Principle-Based Reserves for Life Products, except for election of the transition period in paragraph C below. For this purpose, joint life policies are considered individual life.

1. Minimum reserve requirements for group life contracts in which the individual certificate holders were subjected to an individual risk selection process as described in VM-20 Section 1.B to obtain the insurance coverage are provided by VM-20, except for election of the transition period in paragraph C below.

1.2 Minimum reserve requirements of VM-20 are considered principle-based valuation requirements for purposes of the Valuation Manual.

3. Minimum reserve requirements for life contracts not subject to VM-20 are those pursuant to applicable requirements in VM-A and VM-C. For guaranteed issue life contracts issued after Dec. 31, 2018, mortality tables are defined in VM Appendix M – Mortality Tables (VM-M), and the same table shall be used for reserve requirements as is used for minimum nonforfeiture requirements as defined in VM-02, Minimum Nonforfeiture Mortality and Interest.
C. A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for:

1. Business described in Section B.1 above and issued on or after the operative date of the Valuation Manual and prior to 1/1/2024.

2. Business not described in Section B.1 otherwise subject to VM-20 requirements and issued during the first three years following the operative date of the Valuation Manual.

A company electing to establish reserves using the requirements of VM-A and VM-C may elect to use the 2017 Commissioners’ Standard Ordinary (CSO) Tables as the mortality standard following the conditions outlined in VM-20 Section 3. If a company during the three years elects to apply VM-20 to a block of such business, then a company must continue to apply the requirements of VM-20 for future issues of this business.

D. Life PBR Exemption

1. A company meeting the condition in D.2 below may file a statement of exemption for ordinary life insurance policies and group life contracts individually underwritten life insurance policies, except for policies in D.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. Such a statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that condition D.2 was met based on premiums from the prior calendar year annual statement. The statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

2. Condition for Exemption:
   a. The company has less than $300 million of ordinary life premiums, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums of less than $600 million.

3. Policies Excluded from the Life PBR Exemption:
   a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee that does not meet the VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

Footnote change

-Premiums are measured as direct plus reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance”. For exemptions after 1/1/2024, premiums should also include the premiums from group life insurance certificates that were subject to an individual risk selection process as defined in VM-20 Section 1.2 and included in the group life certificates subject to an individual risk selection process line of business reported in the prior calendar year life/health annual financial statement, VM-20 Reserves Supplement Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance”. Premiums should exclude premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed transaction and are

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reported in Exhibit 1 Part 1, Column 3 as ordinary life insurance premium. Preneed and guaranteed issue life insurance policy are as defined in VM-01.

**VM Change 4 – VM-20: Requirements for Principle-Based Reserves for Life Products**

**VM-20: Requirements for Principles-Based Reserves for Life Products**

**Section 1: Purpose**

A. These requirements establish the minimum reserve valuation standard for individual life insurance policies issued on or after the operative date of the *Valuation Manual* and subject to a principle-based valuation with an NPR floor under Model #820. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for policies of individual life insurance.

B. These requirements establish the minimum reserve valuation standard for group life insurance certificates in which an individual risk selection process is used to obtain group life insurance coverage, and which are issued on or after the operative date of the *Valuation Manual* and subject to a principle-based valuation with an NPR floor under Model #820. An individual risk selection process is based on characteristics of the insured(s) beyond sex, gender, age, and membership in a particular group. This may include, but is not limited to, completion of an application, questionnaire(s) or tele-interview (beyond acknowledgement of membership to the group master policyowner, sex, gender and age), the use of non-medical information, medical or health history information, prescription history information, avocations, usage of tobacco, family history, or submission of fluids such as blood, Home Office Specimens (HOS), or oral fluid. The resulting risk classification is determined based on the characteristics of the individual insured(s) rather than the group, if any, of which it is a member (e.g., employer, affinity, etc.).
VM Change 5 - VM-20: Requirements for Principle-Based Reserves for Life Products

Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

Guidance Note: Since Group Insurance subject to an individual risk selection process, as defined by Section 1.B, is subject to VM-20 requirements, Section 2.A shall apply—meaning that any such contracts will be included in one of the VM-20 Reserving Categories defined by Section 2.A.1, Section 2.A.2, and 2.A.3. All requirements in VM-31 which apply to a VM-20 Reserving Category shall apply to any group insurance subject to Individual Underwriting Selection that has been included in that VM-20 Reserving Category.

The company may elect to exclude one or more groups of policies from the stochastic reserve calculation and/or the deterministic reserve calculation. When excluding a group of policies from a reserve calculation, the company must document that the applicable exclusion test defined in Section 6 is passed for that group of policies. The minimum reserve for each VM-20 Reserving Category is defined by Section 2.A.1, Section 2.A.2 and Section 2.A.3, and the total minimum reserve equals the sum of the Section 2.A.1, Section 2.A.2 and Section 2.A.3 results below, defined as:
VM Change 6– VM-51: Experience Reporting Formats, Section 1.B.2

VM-51: Experience Reporting Formats

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Section 2: Statistical Plan for Mortality ...........................................
Appendix 1: Preferred Class Structure Questionnaire ......................
Appendix 2: Mortality Claims Questionnaire .................................
Appendix 3: Additional Plan Code Form ........................................
Appendix 4: Mortality Data Elements and Format ............................

Section 2: Statistical Plan for Mortality

A. Type of Experience Collected Under This Statistical Plan

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

B. Scope of Business Collected Under This Statistical Plan

The data for this statistical plan is the individual ordinary life line of business. Such business is to include direct written business issued in the U.S., and all values should be prior to any reinsurance ceded. Therefore, reinsurance assumed from a ceding company shall be excluded from data collection to avoid double-counting of experience submitted by an issuer and by its reinsurers; however, assumption reinsurance of an individual ordinary life line of business, where the assuming company is legally responsible for all benefits and claims paid, shall be included within the scope of this statistical plan. The ordinary life line of business does not include separate lines of business, such as SI/GI, worksite, individually solicited group life that did not use an individual risk selection process as defined in VM-20 Section 1.B, direct response, final expense, pre-need, home service, credit life and COLI/BOLI/charity-owned life insurance (CHOLI).

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

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

Additional exemptions may be granted by the Experience Reporting Agent where appropriate, following consultation with the domestic insurance regulator, based on achieving a target level of approximately 85% of industry experience for the type of experience data being collected under this statistical plan.
### VM Change 7 – VM-51: Experience Reporting Formats, Appendix 4: Mortality Data Elements and Format

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1–5</td>
<td>5</td>
<td>NAIC Company Code</td>
<td>Your NAIC Company Code</td>
</tr>
<tr>
<td>2</td>
<td>6–9</td>
<td>4</td>
<td>Observation Year</td>
<td>Enter Calendar Year of Observation</td>
</tr>
<tr>
<td>3</td>
<td>10–29</td>
<td>20</td>
<td>Policy Number</td>
<td>Enter Policy Number. For Policy Numbers with length less than 20, left justify the number, and blank fill the empty columns. Any other unique identifying number can be used instead of a Policy Number for privacy reasons.</td>
</tr>
<tr>
<td>4</td>
<td>30–32</td>
<td>3</td>
<td>Segment Number</td>
<td>If only one policy segment exists, enter segment number ‘1.’ For a single life policy, the base policy is to be put in the record with segment number ‘1.’ Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. For joint life policies, the base policy of the first life is to be put in a record with segment number ‘1,’ and the base policy of the second life is to be put in a separate record with segment number ‘2.’ Joint life policies with more than two lives are not to be submitted. Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. Policy segments with the same policy number are to be submitted for: a) Single life policies; b) Joint life policies; c) Term/paid up riders; or d) Additional amounts of insurance including purchase through dividend options.</td>
</tr>
<tr>
<td>5</td>
<td>33–34</td>
<td>2</td>
<td>State of Issue</td>
<td>Use standard, two-letter state abbreviation codes (e.g., NY for New York)</td>
</tr>
<tr>
<td>6</td>
<td>35</td>
<td>1</td>
<td>Gender</td>
<td>0 = Unknown or unable to subdivide 1 = Male 2 = Female 3 = Unisex – Unknown or unable to identify 4 = Unisex – Male 5 = Unisex – Female</td>
</tr>
<tr>
<td>7</td>
<td>36–43</td>
<td>8</td>
<td>Date of Birth</td>
<td>Enter the numeric date of birth in YYYYMMDD format</td>
</tr>
<tr>
<td>8</td>
<td>44</td>
<td>1</td>
<td>Age Basis</td>
<td>0 = Age Nearest Birthday 1 = Age Last Birthday 2 = Age Next birthday  <strong>Drafting Note:</strong> Professional actuarial organization will need to develop either age next birthday mortality tables or procedure to adapt existing mortality tables to age next birthday basis.</td>
</tr>
<tr>
<td>9</td>
<td>45–47</td>
<td>3</td>
<td>Issue Age</td>
<td>Enter the insurance Issue Age</td>
</tr>
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<td>ITEM</td>
<td>COLUMN</td>
<td>L.</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>------</td>
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<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>10</td>
<td>48-55</td>
<td>8</td>
<td>Issue Date</td>
<td>Enter the numeric calendar year in YYYYMDD format.</td>
</tr>
<tr>
<td>11</td>
<td>56</td>
<td>1</td>
<td>Smoker Status (at issue)</td>
<td>Smoker status should be submitted where reliable. 0 = Unknown 1 = No tobacco usage 2 = Nonsmoker 3 = Cigarette smoker 4 = Tobacco user</td>
</tr>
<tr>
<td>12</td>
<td>57</td>
<td>1</td>
<td>Preferred Class Structure Indicator</td>
<td>0 = If no reliable information on multiple preferred and standard classes is available or if the policy segment was issued substandard or if there were no multiple preferred and standard classes available for this policy segment or if preferred information is unknown. 1 = If this policy was issued in one of the available multiple preferred and standard classes for this policy segment. Note: If Preferred Class Structure Indicator is 0, or if preferred information is unknown, leave next four items blank.</td>
</tr>
<tr>
<td>13</td>
<td>58</td>
<td>1</td>
<td>Number of Classes in Nonsmoker Preferred Class Structure</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker or no tobacco usage policies that could have been issued as one of multiple preferred and standard classes, enter the number of nonsmoker preferred and standard classes available at time of issue.</td>
</tr>
<tr>
<td>14</td>
<td>59</td>
<td>1</td>
<td>Nonsmoker Preferred Class</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker policy segments that could have been issued as one of multiple preferred and standard classes: 1 = Best preferred class 2 = Next Best preferred class after 1 3 = Next Best preferred class after 2 4 = Next Best preferred class after 3 5 = Next Best preferred class after 4 6 = Next Best preferred class after 5 7 = Next Best preferred class after 6 8 = Next Best preferred class after 7 9 = Next Best preferred class after 8 Note: The policy segment with the highest nonsmoker Preferred Class number should have that number equal to the Number of Classes in Nonsmoker Preferred Class Structure.</td>
</tr>
</tbody>
</table>
If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank.

For smoker or tobacco user policies that could have been issued as one of multiple preferred and standard classes, enter the number of smoker preferred and standard classes available at time of issue.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>60</td>
<td>1</td>
<td>Number of Classes in Smoker Preferred Class Structure</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank. For smoker or tobacco user policies that could have been issued as one of multiple preferred and standard classes, enter the number of smoker preferred and standard classes available at time of issue.</td>
</tr>
<tr>
<td>16</td>
<td>61</td>
<td>1</td>
<td>Smoker Preferred Class</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank. For smoker policy segments that could have been issued as one of multiple preferred and standard classes: 1 = Best preferred class 2 = Next Best preferred class after 1 3 = Next Best preferred class after 2 4 = Next Best preferred class after 3 5 = Next Best preferred class after 4 6 = Next Best preferred class after 5 7 = Next Best preferred class after 6 8 = Next Best preferred class after 7 9 = Next Best preferred class after 8 Note: The policy segment with the highest Smoker Preferred Class number should have that number equal to the Number of Classes in Smoker Preferred Class Structure.</td>
</tr>
<tr>
<td>17</td>
<td>62–63</td>
<td>2</td>
<td>Type of Underwriting Requirements</td>
<td>If underwriting requirement of ordinary business is reliably known, use code other than “99.” Ordinary business does not include separate lines of business, such as simplified issue/guaranteed issue, worksite, individually solicited group life that did not use an individual risk selection process as defined in VM-20, Section 1.B, direct response, final expense, pre-need, home service and COLI/BOLI/CHOLI. 01 = Underwritten, but unknown whether fluid was collected 02 = Underwritten with no fluid collection 03 = Underwritten with fluid collected 06 = Term Conversion 07 = Group Conversion 09 = Not Underwritten 99 = For issues where underwriting requirement unknown or unable to subdivide</td>
</tr>
</tbody>
</table>
### Substandard Indicator

18 64 1 Substandard Indicator

- 0 = Policy segment is not substandard
- 1 = Policy segment is substandard
- 2 = Policy segment is uninsurable

**Note:**

- a. All policy segments that are substandard need to be identified as substandard or uninsurable.
- b. Submission of substandard policies is optional.
- c. If feasible, identify substandard policy segments where temporary flat extra has ceased as substandard.

### Plan Exclude from contribution: spouse and children under family policies or riders. If Form for Additional Plan Codes was submitted for this policy, enter unique three-digit plan number(s) that differ from the plan numbers below:

- 000 = If unable to distinguish among plan types listed below
- 100 = Joint life plan unable to distinguish among joint life plan types listed below

#### Permanent Plans:

- 010 = Traditional fixed premium fixed benefit
- 011 = Permanent life (traditional) with term
- 012 = Single premium whole life
- 013 = Econolife (permanent life with lower premiums in the early durations)
- 014 = Excess interest whole life
- 015 = First to die whole life plan (submit separate records for each life)
- 016 = Second to die whole life plan (submit separate records for each life)
- 017 = Joint whole life plan – unknown whether 015 or 016 (submit separate records for each life)
- 018 = Permanent products with non-level death benefits

#### Term Insurance Plans:

- 020 = Term (traditional level benefit and attained age premium)
- 021 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for five years)
- 211 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 10 years)
- 212 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 15 years)
- 213 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 20 years)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>214</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>215</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>022</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 10 years)</td>
</tr>
<tr>
<td>221</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 15 years)</td>
</tr>
<tr>
<td>222</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>223</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>224</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 30 years)</td>
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<tr>
<td>231</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 15 years)</td>
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<td>232</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 20 years)</td>
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<tr>
<td>233</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>024</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>241</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>242</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 25 years)</td>
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<tr>
<td>025</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>251</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>026</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>027</td>
<td>Term (level death benefit with guaranteed level premium period equal to anticipated level term period where the period is other than five, 10, 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>271</td>
<td>Term (level death benefit with guaranteed level premium period not equal to anticipated level term period, where the periods are other than five, 10, 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>028</td>
<td>Term (decreasing benefit)</td>
</tr>
</tbody>
</table>
040 = Select ultimate term (premium depends on issue age and duration)
041 = Return of Premium Term (level death benefit with guaranteed level premium for 15 years)
042 = Return of Premium Term (level death benefit with guaranteed level premium for 20 years)
043 = Return of Premium Term (level death benefit with guaranteed level premium for 25 years)
044 = Return of Premium Term (level death benefit with guaranteed level premium for 30 years)
045 = Return of Premium Term (level death benefit with guaranteed level premium for period other than 15, 20, 25 or 30 years)
046 = Economatic term
059 = Term plan, unable to classify
101 = First to die term plan (submit separate records for each life)
102 = Second to die term plan (submit separate records for each life)
103 = Joint term plan – unknown whether 101 or 102 (submit separate records for each life)

Universal Life Plans (Other than Variable), issued without a Secondary Guarantee:
061 = Single premium universal life
062 = Universal life (decreasing risk amount)
063 = Universal life (level risk amount)
064 = Universal life – unknown whether code 062 or 063
065 = First to die universal life plan (submit separate records for each life)
066 = Second to die universal life plan (submit separate records for each life)
067 = Joint life universal life plan – unknown whether code 065 or 066 (submit separate records for each life)
068 = Indexed universal life

Universal Life Plans (Other than Variable) with Secondary Guarantees:
071 = Single premium universal life with secondary guarantees
072 = Universal life with secondary guarantees (decreasing risk amount)
073 = Universal life with secondary guarantees (level risk amount)
074 = Universal life with secondary guarantees – unknown whether code 072 or 073
075 = First to die universal life plan with secondary guarantees (submit separate records for each life)
076 = Second to die universal life plan with secondary guarantees (submit separate records for each life)
077 = Joint life universal life plan with secondary guarantees unknown whether code 075 or 076 (submit separate records for each life)
078 = Indexed universal life with secondary guarantees

Variable Life Plans issued without a Secondary Guarantee:
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<th>Description</th>
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<td>Variable life</td>
</tr>
<tr>
<td>081</td>
<td>Variable universal life (decreasing risk amount)</td>
</tr>
<tr>
<td>082</td>
<td>Variable universal life (level risk amount)</td>
</tr>
<tr>
<td>083</td>
<td>Variable universal life – unknown whether code 081 or 082</td>
</tr>
<tr>
<td>084</td>
<td>First to die variable universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>085</td>
<td>Second to die variable universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>086</td>
<td>Joint life variable universal life plan – unknown whether 084 or 085 (submit separate records for each life)</td>
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</table>

### Variable Life Plans with Secondary Guarantees:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
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<td>090</td>
<td>Variable life with secondary guarantees</td>
</tr>
<tr>
<td>091</td>
<td>Variable universal life with secondary guarantees (decreasing risk amount)</td>
</tr>
<tr>
<td>092</td>
<td>Variable universal life with secondary guarantees (level risk amount)</td>
</tr>
<tr>
<td>093</td>
<td>Variable universal life with secondary guarantees – unknown whether code 091 or 092</td>
</tr>
<tr>
<td>094</td>
<td>First to die variable universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>095</td>
<td>Second to die variable universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>096</td>
<td>Joint life variable universal life plan with secondary guarantees – unknown whether code 094 or 095 (submit separate records for each life)</td>
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### Nonforfeiture:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>098</td>
<td>Extended term</td>
</tr>
<tr>
<td>099</td>
<td>Reduced paid-up</td>
</tr>
<tr>
<td>198</td>
<td>Extended term for joint life (submit separate records for each life)</td>
</tr>
<tr>
<td>199</td>
<td>Reduced paid-up for joint life (submit separate records for each life)</td>
</tr>
</tbody>
</table>
VM Change 8 – VM-20 Reserves Supplement, Part 3: Life PBR Exemption

Refer to NAIC Blanks (E) Working Group, request for modification to the supplemental report for the Life PBR Exemption, to show the premiums for the group life that utilized an individual risk selection process as these premiums are currently grouped together with other Group Insurance in Exhibit 1. As there are other instances where the ordinary life premiums are not included in the determination of the Life PBR Exemption (e.g., for guaranteed issue policies), it may be useful to request addition of the breakdown of premiums used to determine the exemption.

Possible insertion between questions 1 and 2 for disclosure of premiums used in the determination of eligibility for the Life PBR Exemption, split by ordinary life and group subject to an individual risk.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
American Academy of Actuaries’ Life Reserves Work Group.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:
   January 1, 2020, edition of the Valuation Manual with NAIC adoptions through August 6, 2019
   Locations with proposed changes: VM-20 and VM-31

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

4. State the reason for the proposed amendment? (You may do this through an attachment.)
   The Valuation Manual already requires that if there is additional risk arising from the conversion of term life insurance, whether group or individual, it must be reserved for. The purpose of this APF is to emphasize this requirement and to provide guidance on what must be included in the Life PBR Actuarial Report with respect to conversions.

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

NAIC Staff Comments:

<table>
<thead>
<tr>
<th>Dates:</th>
<th>Received</th>
<th>Reviewed by Staff</th>
<th>Distributed</th>
<th>Considered</th>
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<tbody>
<tr>
<td>11/12/19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: VM APF 2019-62
Add Guidance Note related to converted policies at the end of the section.

**Guidance Note:** The company must ensure that excess mortality associated with policies issued via conversion from term policies or from group life contracts is appropriately reflected in the anticipated experience mortality rates. This can be accomplished through the use of a separate segment for converted policies, through inclusion of conversion experience with the experience of a group of similar directly issued policies, by adjustment of anticipated experience rates for such group of similar directly issued policies, or through other methods.

---

3. **Policies** – A summary of the base policies within each VM-20 reserving category. Include information necessary to fully describe the company's distribution of business. For direct business, use PBR Actuarial Report Template A located on the NAIC website (https://www.naic.org/pbr_data.htm?tab_3) to provide descriptions of each base policy product type and underwriting process (including a description of the process, the time period in which it was used, and the level of any additional margin), with a breakdown of policy count and face amount by base policy product type and underwriting process. Also include the target market, primary distribution system, and key product features that affect risk, including conversion privileges.

---

**d. Assumption and Margin Development** – The following information for each risk factor: description of the methods used to determine anticipated experience assumptions and margins, including the sources of experience (e.g., company experience, industry experience, or other data); how changes in such experience are monitored; any adjustments made to increase mortality margins above the prescribed margin (such as to reflect increased uncertainty due to newer underwriting approaches; and any other considerations, such as conversion features helpful in or necessary to understanding the rationale behind the development of assumptions and margins, even if such considerations are not explicitly mentioned in the Valuation Manual.

**Commented [A1]:** Since the intent is to determine the range of company practices, it may be better not to give examples.

**Commented [A2]:** The conversion features have been moved away from the margins sentence because conversions should inform anticipated experience and the general requirement for uncertainty margins covers conversions. Not sure if we should just delete this.
We suggest placing after Adjustments for Mortality Improvement and before Mortality for Impaired Lives

x. Mortality for Converted Policies – Description of the treatment of mortality for policies issued under group or term conversion privileges including:

i. A description of the method(s) by which any excess conversion mortality was taken into account in the development of company experience mortality rates (e.g., through the use of separate mortality segments for policies issued upon conversion, through aggregation of claim experience, or through use of other methods), the rationale for the method(s) used, and any changes in the method(s) from those used in previous years.

ii. The source(s) of the data used in the method(s) employed.

VM-31 Section 3.D.4.x and y (new sections) [Life Report – Policyholder Behavior]

x. Term Conversions – Description of how the company reflects the impact of any term conversions privilege contained in the policy when setting reserves.

y. Lapse Rates for Converted Policies – Description of and rationale for lapse rates used for policies issued under any group or term conversion privilege.


a. Agreements – For those reinsurance agreements included in the calculation of the minimum reserve as per VM-20 Section 8.A, a description of each reinsurance agreement, including, but not limited to, the type of agreement, the counterparty, the risks reinsured, any provisions related to converted policies, the portion of business reinsured, identification of both affiliated and non-affiliated, as well as captive and non-captive, or similar relationships, and whether the agreement complies with the requirements of the credit for reinsurance under the terms of the AP&P Manual.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
Rachel Hemphill, Texas Department of Insurance
Mary Bahna-Nolan, Pacific Life

Title of the Issue:
VM-20 restriction on using different credibility methods for significantly different blocks of business

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

VM-20 Sections 9.C.5.a and 9.C.7.b.ii
January 1, 2020 NAIC Valuation Manual

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

See attached.

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

Currently, a company must select a single credibility methodology, Limited Fluctuation or Bühlmann, for all business that company has that is subject to VM-20 and requires credibility percentages. The Bühlmann methodology is technically allowed for Simplified Issue business within the Valuation Manual; however, at present, it is not practically possible since there are no industry factors available for Simplified Issue. Therefore, only the Limited Fluctuation method can currently be used for determining credibility for Simplified Issue business. The factors in VM-20 for the Bühlmann were developed to only be used in conjunction with the 2015 VBT. Thus, currently, a company with any Simplified Issue business subject to VM-20 that requires credibility calculations must use the Limited Fluctuation method for all of their business subject to VM-20 that requires credibility calculations, including the fully underwritten business. We do not see this as a reasonable restriction. VM-20 already requires that companies not change their credibility method once selected unless they receive commissioner approval for the change, and we believe that that constraint is sufficient to avoid any significant gaming of the credibility method selection.

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

NAIC Staff Comments:

<table>
<thead>
<tr>
<th>Dates:</th>
<th>Received</th>
<th>Reviewed by Staff</th>
<th>Distributed</th>
<th>Considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/6/19</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

Notes: APF 2019-60
**VM-20 Section 9.C.5.a**

5. Credibility of Company Experience

a. For valuations in which the industry basic mortality table is the 2008 VBT, determine an aggregate level of credibility over the entire exposure period using a methodology to determine the level of credibility that follows common actuarial practice as published in actuarial literature (for example, but not limited to, the Limited Fluctuation Method or Bühlmann Empirical Bayesian Method).

For valuations in which the industry basic mortality table is the 2015 VBT, determine an aggregate level of credibility following either the Limited Fluctuation Method by amount, such that the minimum probability is at least 95% with an error margin of no more than 5% or Bühlmann Empirical Bayesian Method by amount. Once chosen, the credibility method must be applied to all business subject to VM20 and requiring credibility percentages.

Not all blocks of a company’s business subject to VM-20 necessarily need to use the same credibility method. However, a company seeking to change the credibility methods for a given block of business must request and subsequently receive the approval of the insurance commissioner. The request must include the justification for the change and a demonstration of the rationale supporting the change.

**VM-20 Section 9.C.7.b.ii**

7. Process to Determine Prudent Estimate Assumptions

a. If applicable industry basic tables are used in lieu of company experience as the anticipated experience assumptions, or if the level of credibility of the data as provided in Section 9.C.5 is less than 20%, the prudent estimate assumptions for each mortality segment shall equal the respective mortality rates in the applicable industry basic tables as provided in Section 9.C.3, including any applicable improvement pursuant to Section 9.C.3.g, plus the prescribed margin as provided in Section 9.C.6.c, plus any applicable additional margin pursuant to Section 9.C.6.d.v and/or Section 9.C.6.d.vi.

b. If the company uses company experience mortality rates as the anticipated experience assumptions, the following process shall be used to develop prudent estimate assumptions:

i. Determine the values of A, B and C from the Grading Table below, based on the level of credibility of the data as provided in Section 9.C.5.

<table>
<thead>
<tr>
<th>Credibility of company data (as defined in Section 9.C.5 above) rounded to nearest %</th>
<th>A</th>
<th>B</th>
<th>C</th>
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<tbody>
<tr>
<td>20% - 30%</td>
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<td>2</td>
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<tr>
<td>31%–32%</td>
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<tr>
<td>35%–36%</td>
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<td>9</td>
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<td>14</td>
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</tr>
<tr>
<td>39%–40%</td>
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<td>10</td>
</tr>
<tr>
<td>41%–42%</td>
<td>16</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>43%–44%</td>
<td>17</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Percentage Range</td>
<td>Claims</td>
<td>Policy Duration</td>
<td>Notes</td>
</tr>
<tr>
<td>------------------</td>
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<tr>
<td>45%–46%</td>
<td>18</td>
<td>3</td>
<td>11</td>
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<td>16</td>
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<td>8</td>
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<td>81%</td>
<td>46</td>
<td>8</td>
<td>20</td>
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<td>82%</td>
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<td>83%</td>
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<tr>
<td>84%</td>
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<td>85%–87%</td>
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<tr>
<td>91%–93%</td>
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<td>10</td>
<td>24</td>
</tr>
<tr>
<td>94%–100%</td>
<td>50</td>
<td>10</td>
<td>25</td>
</tr>
</tbody>
</table>

ii. Determine the value of D, which represents the last policy duration that has a substantial volume of claims, using the chosen data source(s) as specified in Section 9.C.2.b. D is defined as the last policy duration at which there are 50 or more claims (not the first policy duration in which there are fewer than 50 claims), not counting riders. This may be determined at either the mortality segment level or at a more aggregate level if the mortality for the individual mortality segments was determined using an aggregate level of mortality experience pursuant to Section 9.C.2.d.
**Guidance Note:** The same level of aggregation is used in Section 9.C.2.d for determining company experience mortality rates, Section 9.C.5.b for determining credibility, and Section 9.C.7.b.ii for determining the value of D. Thus, when determining the value of D, all claims being aggregated will have used the same credibility method in Section 9.C.5.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
Rachel Hemphill, Texas Department of Insurance

Title of the Issue:
The Life PBR Exemption restriction is intended to apply to ULSG with material secondary guarantees regardless of whether the secondary guarantee is an embedded guarantee or is a separate rider.

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

VM Section II, Subsection 1.D.3

January 1, 2020 NAIC Valuation Manual

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

See attached.

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

ULSG policies with material secondary guarantees are intended to be excluded from the Life PBR Exemption, regardless of whether the secondary guarantee is embedded in the base policy or is a separate rider. The VM does say that non-ULSG base policies with secondary guarantee riders follow the reserving requirements for ULSG policies in Section II, Subsection 6.C: “ULSG and other secondary guarantee riders shall be valued with the base policy and follow the reserve requirements for ULSG policies under VM-20, VM-A and/or VM-C, as applicable.” It should be made clear that following the reserve requirements for ULSG includes exclusion from the Life PBR Exemption, when the secondary guarantee is material.

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

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<td></td>
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<td></td>
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</tbody>
</table>

Notes: APF 2019-61
VM Section II, Subsection 1.D.3

3. Policies Excluded from the Life PBR Exemption:
a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee, or policies – other than ULSG – that contain a rider with a secondary guarantee, in which the secondary guarantee that does not meet the VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”
<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Variable Annuity Guaranteed Living Benefit</td>
<td>Examine the utilization of guaranteed living benefit options on variable annuity policies under a Joint SOA/LIMRA project and release Tableau visualizations with the observations from the study.</td>
<td>Complete. On SOA web site. 2</td>
</tr>
<tr>
<td>Utilization Study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019 Life Mortality Improvement</td>
<td>Develop AG 38 mortality improvement assumptions for year end 2019.</td>
<td>Complete. On SOA web site. 3</td>
</tr>
<tr>
<td>2013-2015 Fixed Index Annuity Experience Study</td>
<td>Examine lapse and the utilization of guaranteed living withdrawal benefit options on fixed index annuity policies under a Joint SOA/LIMRA project and release Tableau visualizations with the observations from the study.</td>
<td>Complete. On SOA web site. 4</td>
</tr>
<tr>
<td>GRET for 2020</td>
<td>Develop a recommendation for Generally Recognized Expense Table (GRET) for 2020 purposes.</td>
<td>Complete. On SOA web site. 5</td>
</tr>
<tr>
<td>Experience Study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009-2015 Individual Life Large Amount Study</td>
<td>Study mortality experience for large life insurance amounts and release a report with the findings.</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>2005-2017 Structured Settlement Mortality Study</td>
<td>Examine the mortality experience from 2005-17 in structured settlements arising from personal injury claims and release a report with the findings and a database with the experience data.</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Experience Studies Methods, Variance, and Credibility</td>
<td>Describe variance and credibility calculations for experience studies in a report that can be used as an educational reference.</td>
<td>1/31/2020</td>
</tr>
<tr>
<td>US Population Mortality Observations: Updated with 2018 Experience</td>
<td>Explore observations from the full release of the 2018 U.S. population mortality data and release a report and Tableau visualizations with the findings.</td>
<td>1/31/2020</td>
</tr>
<tr>
<td>Mortality Improvement Survey</td>
<td>Complete a survey to learn how companies are reacting to the slowdown in the level of mortality improvement within the general population.</td>
<td>1/31/2020</td>
</tr>
<tr>
<td>Emerging Issues in Underwriting Survey</td>
<td>Complete a survey to give insight into emerging issues in underwriting and their impact on processes and practices.</td>
<td>2/28/2020</td>
</tr>
<tr>
<td>2011-2015 Deferred Annuity Mortality Study</td>
<td>Examine the mortality experience from 2011-2015 in deferred annuity contracts and release a report with the findings and a database with the experience data.</td>
<td>3/31/2020</td>
</tr>
<tr>
<td>2017 Variable Annuity Guaranteed Living Benefit</td>
<td>Examine the utilization of guaranteed living benefit options on variable annuity policies under a Joint SOA/LIMRA project and release Tableau visualizations with the observations from the study.</td>
<td>3/31/2020</td>
</tr>
<tr>
<td>Utilization Study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009-2015 Individual Life Experience Committee Lapse</td>
<td>Study mortality and lapse experience in the database of 2009-2015 individual life experience data and release a report with the findings.</td>
<td>3/31/2020</td>
</tr>
<tr>
<td>and Mortality Study</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3 https://www.soa.org/resources/experience-studies/2019/mortality-improvement/
5 https://www.soa.org/resources/research-reports/2019/2020-gret-recommendations/
## SOA LIFE PRACTICE RESEARCH IN PROGRESS - December 2019

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<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
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</thead>
<tbody>
<tr>
<td>Economic Impact of Opioid Abuse</td>
<td>Estimate associated economic and financial cost of opioid crisis in U.S.</td>
<td>Complete. On SOA web site.¹</td>
</tr>
<tr>
<td>Simplified Methodologies</td>
<td>Investigate simplifications, approximations, and modeling efficiency techniques allowed under VM-20 for determining reserves.</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Life Insurance Accelerated Underwriting Survey-Phase 2: Full Report</td>
<td>Examine life insurance accelerated underwriting programs and practices.</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Modelling and Forecasting Cause-of-Death Mortality</td>
<td>Develop mortality projection models and produce cause of death mortality forecasts.</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Negative Interest Rates</td>
<td>Examine the potential impact of a sustained negative interest rate environment on the insurance industry.</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Public Perception of Longevity and its Drivers</td>
<td>Examine the public perceptions of longevity.</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Reinsurance Treaty Recapture</td>
<td>Compile an inventory of life reinsurance recapture treaty provisions and terms across industry.</td>
<td>1/31/2020</td>
</tr>
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Proposed GI Life Valuation (A) Subgroup

Proposed Charge for 2020:

Provide recommendations regarding valuation requirements for Guaranteed Issue Life business including any appropriate mortality table(s) for valuation as well as nonforfeiture. Initial recommendations are to be provided to LATF by the 2020 Summer National Meeting.

Establishment of this subgroup is consistent with the following LATF charges:

1.A. - keep reserve requirements current
1.B.1 - work with the Academy of Actuaries and the Society of Actuaries to create, update and revise mortality tables that are necessary for valuation purposes
1.B.6 – provide recommendations for changes necessary for reserving and nonforfeiture standards and interact with other NAIC groups to comment on their work and assist in addressing actuarial matters

Preliminary Agenda for early 2020 Subgroup open meetings and calls

1. Recap GI Life valuation concerns and explain issues with maintaining the current interim solution which includes reverting to the 2001 CSO table.
   a. A GI Life specific mortality table was created and adopted to ensure that an assumed higher mortality rate compared to underwritten business was being appropriately reflected in GI Life reserves.
   b. The newly adopted table created a deficiency reserve issue that had not been identified when the table was established. Instead it was discovered as companies prepared for implementation of the new table. There may have been some issues with the low number of companies participating in the SOA study and an attempt to cover mortality for X% of those companies while the experience of the companies was wide in range.
   c. The 2001 CSO table may not appropriately reflect the slope of mortality for GI Life and could result in reserves developing into a deficient position over time. Discuss potential issues with maintaining the current interim solution of going back to the 2001 CSO table.

2. Consider the short term solution and problems that could arise from deficient reserves for some or all companies if the mortality is understated by the 2001 CSO table.
   a. Can VAWG, or another NAIC group, under LATF charge 1.B.6 be asked to determine the exposure to reserve inadequacies under the interim solution, standalone AAT for GI Life blocks, etc?
   b. Should the short-term solution be modified?

3. The Subgroup may need more time to formulate a long-term solution, but could design one by Summer National Meeting 2020. A long-term solution may contemplate the following:
   a. Establishment of a better table or a decision to utilize more than one table as well as company specific experience in establishing valuation mortality for a company. How does this work with nonforfeiture and the taxability of life insurance benefits?
   b. Establishment of a method that can be used to combine more than one table or combine tables with company experience such that the appropriate valuation mortality is used by each company.
   c. Data collection requirements under the VM that will allow updates to the set of tables used in the new valuation and nonforfeiture process for GI Life.
GI Life Valuation (A) Subgroup

This subgroup is needed to provide recommendations to improve valuation requirements for guaranteed issue (GI) life insurance. Recent attempts by LATF to improve valuation requirements were lacking sufficient data to produce a mortality valuation table tailored for the types of guaranteed issue business in the marketplace. The subgroup will focus on possible alternative methods in the short term in addition to a possible longer term effort for the data needed to develop an improved valuation table.

The recommended charge for this subgroup is as follows:

2020 Charge:

Provide recommendations regarding valuation requirements for Guaranteed Issue Life business including any appropriate mortality table(s) for valuation as well as nonforfeiture. Initial recommendations are to be provided to LATF by the 2020 Summer National Meeting.
Principle-Based Reserves (PBR) Resources From the Life Practice Council of the American Academy of Actuaries

Donna Claire, MAAA, FSA, CERA
Chairperson, PBR Governance Work Group

---

PBR Page on Academy Website

- Go to actuary.org and click on Principle-based Reserving (navigation bar on right or bottom)

OR

- www.actuary.org/content/pbr-practice

Page includes a PBR Toolkit

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Academy PBR Toolkit

<table>
<thead>
<tr>
<th>ACADEMY PBR TOOLKIT</th>
<th>NAIC RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBR Checklist</td>
<td>• Valuation Manual 2019–2020 Comparison</td>
</tr>
<tr>
<td></td>
<td>• Valuation Manual, published January 2020</td>
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<tr>
<td></td>
<td>• Valuation Manual Versions and Amendments</td>
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<tr>
<td></td>
<td>• SVL Model Law</td>
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<tr>
<td></td>
<td>• VM-20 / VM-22 Tables</td>
</tr>
<tr>
<td></td>
<td>• NAIC Impact Study of VM-20 on PBR for Life Insurance</td>
</tr>
<tr>
<td></td>
<td>• Life Actuarial (A) Task Force of the NAIC</td>
</tr>
<tr>
<td></td>
<td>• 2017 PBR Review Report</td>
</tr>
</tbody>
</table>

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Academy PBR Toolkit (cont.)

PBR-RELEVANT ASOPS

- ASOP No. 52: Principle-Based Reserves for Life Products under the NAIC Valuation Manual
- More ASOPs

PBR QUALIFICATION STANDARDS

Qualification Standards Response on PBR

What are the minimum requirements an actuary should consider to be qualified to render opinions related to PBR under the U.S. Qualification Standards? This question and answer came from the Academy’s Committee on Qualifications, which developed a list of frequently asked questions for actuaries.
Seminars/Webinars

- Academy is having a 2½-day seminar here in Austin December 9–11; first ever to also include variable annuities
- Will have another if demand warrants it
- Also conducting webinars: e.g., plan on webinars on VM-21 changes for variable annuities

Practice Note on PBR Projections

- Contains questions and answers related to projecting future principle-based reserve and capital calculations
- Focuses on VM-20, but also applicable to other frameworks

Four-Page “PBR Checklist”

- The PBR Checklist Task Force is has prepared a short reference of important characteristics to consider for PBR valuations
- Can act as a reminder to actuaries as to all the tasks as well as letting senior management know the extent of issues that need to be considered
- Released in October 2019

PBR Analysis Template

- Academy group under Pat Allison is developing ways to display PBR (and other) data:
  - Examples: waterfalls, trend analysis graphs
  - Advantages: one picture is worth a 1,000 words
- Goal is to have this done the middle of next year
**Update to VM-20 Practice Note**

- Work on updates to VM-20 practice note to reflect changes effective in the 2020 Valuation Manual is in process
- Target release for this update is December 2019

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**Questions/Suggestions**

- Anything else the Academy can do to help you with PBR?
Update on the Request for Proposal for the Economic Scenario Generator (ESG)

Pat Allison, MAAA, FSA
12/5/2019

RFP for a New ESG

- An RFP is being developed to select a vendor to provide a new ESG to be prescribed for life and annuity reserves and capital (VM-20, VM-21, C-3 Phase I, and C-3 Phase II)
- The group drafting the RFP includes regulators, NAIC staff, the Academy, the ACLI, and industry subject-matter experts.
- The targeted completion date for the RFP is Q1 2020
- The new ESG is expected to be implemented no earlier than 2022
Cessation of the London Interbank Offered Rate (LIBOR)

Pat Allison, MAAA, FSA
12/5/2019

Agenda

- LIBOR Background
- Transition to Secured Overnight Financing Rate (SOFR)
  - Alternative Reference Rates Committee
  - Reasons for Selection of SOFR
- Risks
- Actions Needed
- Useful Links

LIBOR Background

- LIBOR is a global benchmark interest rate calculated daily representing the cost of short-term unsecured borrowing by banks
- LIBOR is used to set interest rates on about $200 trillion of assets, including corporate bonds, home mortgages, business loans, and derivatives contracts.
- The UK’s Financial Conduct Authority is responsible for regulating LIBOR and has indicated that publication of LIBOR is not guaranteed beyond 2021.
- LIBOR has become less suitable as a benchmark because:
  - Banks have substantially reduced this type of borrowing
  - Banks typically must submit rates based on judgment instead of actual transactions, and many are reluctant to continue doing so

Transition to SOFR: Alternative Reference Rates Committee

- The Alternative Reference Rates Committee (AARC) was formed in 2014 by the Federal Reserve Board and the NY Fed
- AARC was formed in response to recommendations and objectives from the Financial Stability Board and the Financial Stability Oversight Council to address risks related to USD LIBOR
- In 2017, the AARC identified the Secured Overnight Financing Rate (SOFR) as the rate that represents best practice for use in certain new USD derivatives and other financial contracts
Transition to SOFR: Alternative Reference Rates Committee

- AARC members include:
  - Banks
  - Asset managers
  - Industry trade associations
  - Insurers

- The AARC has 10 working groups to help ensure a successful transition from USD LIBOR to SOFR, e.g.:
  - Outreach/Communications Working Group
  - Regulatory Issues Working Group
  - Accounting/Tax Working Group

- In April 2018, the NY Fed began publishing SOFR daily

Reasons for Selection of SOFR

The AARC selected SOFR for the following reasons:

- As an overnight secured rate, SOFR better reflects the way financial institutions fund themselves today.
- SOFR is fully based on actual transactions and does not rely on judgment.
- SOFR references multiple segments of the US Treasury repurchase agreement market. The transactions underlying SOFR regularly exceed $800 billion in daily volumes.
- SOFR’s underlying market is resilient and robust.
- SOFR is a true “risk-free” rate suitable as a reflection of interest rates overall.
- SOFR is produced by the public sector using a transparent methodology.

Risks

- Many contracts linked to LIBOR continue past 2021, when LIBOR may no longer be available.
- Industry readiness – A significant effort may be needed to prepare for the transition.
- Many contracts contain fallback provisions describing what happens if LIBOR is not produced.
  - Many were written to address temporary unavailability of LIBOR. There may be unintended consequences (e.g. floating rate products become fixed, interest rates for a borrower increase substantially).
  - Amending old fallback language may be difficult.

Actions Needed

- Insurance companies will need to take inventory of existing products and processes that use LIBOR, which may include:
  - Investments (e.g. floating rate debt, where the interest rate is reset periodically based on LIBOR; derivatives linked to LIBOR)
  - Contracts with policyholders (e.g. annuities with credited rates linked to LIBOR)
  - Reinsurance treaties
  - IT feeds
- Take action where required to move toward SOFR or another rate
- Study tax, accounting, and actuarial impacts
**Actions Needed**

Make *Valuation Manual* and other updates as needed:

  
  Interest rate swap spreads over Treasuries shall be prescribed by the NAIC for use throughout the cash flow model wherever appropriate for transactions and operations including, but not limited to, purchase, sale, settlement, cash flows of derivative positions and reset of floating rate investments. A current and long-term swap spread curve shall be prescribed for year one and years four and after, respectively, with yearly grading in between. The three-month and six-month points on the swap spread curves represent the corresponding London Interbank Offered Rate (LIBOR) spreads over Treasuries.

- Accounting Practices & Procedures Manual – various citations where LIBOR is mentioned

- Others?

---

**Useful Links: Sources used for this presentation**

- ARRC website
  
  [http://www.newyorkfed.org/arrc](http://www.newyorkfed.org/arrc)

- Government Finance Officers Association - Guide for Municipal Issuers
  

- Oliver Wyman Report – LIBOR Fallbacks in Focus: A Lesson in Unintended Consequences
  

- NAIC – Capital Markets Bureau *Market Buzz*: The Rise in LIBOR
  
  [https://www.naic.org/capital_markets_archive/buzz_180522.pdf](https://www.naic.org/capital_markets_archive/buzz_180522.pdf)

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**Questions?**
Update on Life Insurance Mortality Experience Reporting for 2020

Pat Allison, MAAA, FSA
12/5/2019

Agenda
- Data collection timeline
- Recap of company selection process
- Communication with companies and regulators
- NAIC Preparation
  - Resources for companies
  - Data checks
  - Legal agreements
  - Security
- Reports to be produced
- FAQs

Data Collection Timeline

- Q4, 2019: Companies may begin 1) requesting exemptions or communicating exclusions, and 2) testing data submissions using the Regulatory Data Collection (RDC) tool
- Q2, 2020: Call for companies to submit data for 2018 observation year using 2020 Valuation Manual requirements
- 9/30/2020: Deadline for companies to submit data using the RDC tool
- 12/31/2020: Deadline for companies to make corrections
- 5/31/2021: Deadline for NAIC to submit aggregate experience data to SOA

Company Selection Process

Scope: VM-51 Section 2.B
- Individual ordinary life line of business, excluding SI/GI, worksite, individually solicited group life, direct response, final expense, pre-need, home service, credit life, COI, BOLI, CHOLI
- Direct written business, prior to reinsurance ceded (exception: assumption reinsurance is in scope)

Selection Criteria: VM-51 Section 2.C
- Achieve target level of approximately 85% of industry experience
- Individual companies or groups of affiliated companies with less than $50 million of direct individual life premium are exempt
Company Selection Process

Additional criteria used:

- Focus on groups of affiliated companies and individual companies that are large enough to be subject to PBR in 2020, to enable regulators to receive reports and monitor experience
- Achieve a reasonable distribution of large and small companies across states of domicile

Results:

- 176 companies selected, across 31 states of domicile
- 69 of these companies are new to this process (the other 107 have participated in the KS or NY data calls)

Communication with Companies

- Sent notifications to 176 companies selected for data collection
  - Requested that each of the selected companies identify primary and secondary contacts to receive future communications regarding data collection
  - Requested notification to the NAIC as soon as possible if the company plans to request an exemption for any reason
- Sent notifications to the remaining 513 companies to let them know they were not selected for data collection

Communication with Regulators: Exclusions and Exclusions

Exclusions

- Business out of scope
- A group may elect to exclude data for an affiliate with < $10 million premium
  - No regulator decision needed

Exemptions

VM-51 Section 2.C: "Additional exemptions may be granted by the Experience Reporting Agent where appropriate, following consultation with the domestic insurance regulator, based on achieving a target level of approximately 85% of industry experience for the type of experience data being collected under this statistical plan."
- NAIC will consult with domestic regulator prior to granting or disallowing exemptions

Company Selection Status

<table>
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<th>Number</th>
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<tbody>
<tr>
<td>176 Companies initially selected</td>
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<tr>
<td>-10 Group affiliate companies that elected exclusion due to small premium amount</td>
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</tr>
<tr>
<td>-4 Companies that identified all business as out of scope</td>
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</tr>
<tr>
<td>162 Companies selected at this point</td>
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</tr>
<tr>
<td>-12 Companies claiming out of scope but more info is needed from the company to confirm</td>
<td></td>
</tr>
<tr>
<td>-2 Companies requesting an exemption - pending regulator approval</td>
<td></td>
</tr>
<tr>
<td>148 Companies selected if all pending exclusions / exemptions are approved</td>
<td></td>
</tr>
</tbody>
</table>
NAIC Preparation: Resources for Companies

https://www.naic.org/pbr_data.htm
VM-50 / VM-51 EXPERIENCE REPORTING
Company Training on Mortality Experience Data Reporting
Company Training on Mortality Experience Data Reporting Powerpoint
Mortality Statistical Plan Company Selection Memo
RDC File Submission Instructions (PDF)
Contact experience_reporting@naic.org with questions.

Submission Beta testing – Companies have the ability to test their submissions using RDC and make adjustments prior to the 2020 data call

More to come: FAQs, Control files, RDC form and format checks

NAIC Preparation: Data Checks

Control Files
• Control totals – VM-50 Section 4.B.2 requires each data submission to be balanced against a set of control totals provided by the company.
• Data reconciliation – VM-50 Section 4.B.3 requires companies to provide a reconciliation between submitted experience data and its statistical and financial data, along with an explanation of differences.

Reasonability Checks
• RDC form and format screening (Ready)
• Actuarial data review (In development)

NAIC Preparation: Legal Agreements

• The NAIC will be entering into agreements with a small number of states
• The agreements between these states and the NAIC will cover data collection and confidentiality, and will consider state procurement requirements in the data collection process
• “Click-through agreements” are nearly final

NAIC Preparation: Security

• Internal and External Data Security Audits
  – Annually, the NAIC will undertake a Service Organization Control (SOC) 2 external data security audit and internally assess their data security practices through a Standardized Information Gathering (SIG) questionnaire.
  – The 2019 reports have been completed for both the SOC 2 external data security audit and the internal SIG process
• Policies and procedures are in place to ensure confidentiality, including defined RDC user roles, secure logins, and data encryption
**Reports**

- VM-51 Section 2.F requires the NAIC to provide an experience data report of aggregated experience to the SOA for development of industry and valuation mortality tables. A report has been programmed to match SOA specifications.

- After data is collected, reports will be provided to state insurance departments
  - VM-50 Section 5.E requires the NAIC to provide a list of companies whose data is included, and a list of those whose data was excluded because it fell outside the tolerances set for missing or invalid data, or for any other reason.

**FAQs**

**Will there be a cost for the 2020 Mortality Experience Data Call?**

No. The NAIC will not be charging companies a fee for the 2020 data collection.

**Will New York and/or Kansas continue with their own data calls? Will MIB continue to be involved in data collection?**

KS – No
NY – Yes

States may implement their own data calls and choose another Experience Reporting Agent (e.g. MIB).

- VM-50 Section 6.B.3.b: “Use of the Experience Reporting Agent by the contracting state insurance departments does not preclude those state insurance departments or any other state insurance departments from contracting independently with another Experience Reporting Agent for similar data required under this Valuation Manual or other data purposes.”

**FAQs**

**My company is the direct writer for a block of business in scope, but the business is covered by a 100% coinsurance arrangement and is now administered by the assuming company. The policies were not legally novated. Does my company need to submit mortality experience data for this business?**

Yes. This is not assumption reinsurance. Unless the policies were legally novated, the original direct writer of the life insurance will be required to submit the mortality experience data.
Mortality Aggregation Examples

NAIC National Meeting
Summer 2019

Rachel Hemphill, MAAA, FSA, FCAS
Pat Allison, MAAA, FSA

Key Concepts for Mortality Aggregation

- Mortality segments subject to the same or similar underwriting processes may be aggregated to calculate credibility
- Using separate mortality segment experience to set each corresponding assumption and then simply grouping the segments together to calculate credibility is not mortality aggregation under VM-20
- The aggregate experience must inform the mortality segment assumptions; two approaches are allowed under VM-20

Agenda

- Key Concepts and Applicable VM-20 Language
- Examples and Comparison of Approaches
- Next Steps

Applicable VM-20 Language

VM-20 Section 9.C.2.d

vi. If the company uses the aggregate company experience for a group of mortality segments when determining the company experience mortality rates for each of the individual mortality segments in the group, the company shall either:

a. Use techniques to further subdivide the aggregate experience into the various mortality segments (e.g., start with aggregate non-smoker then use the conservation of total deaths principle, normalization or other approach to divide the aggregate mortality into super preferred, preferred and residual standard non-smoker class assumptions), or

b. Use techniques to adjust the experience of each mortality segment in the group to reflect the aggregate company experience for the group (e.g. by credibility weighting the individual mortality segment experience with the aggregate company experience for the group).
Mortality Aggregation Examples

Disclaimer:

The examples presented are for illustrative purposes to demonstrate acceptable approaches. They are not intended to cover all complexities that may arise in practice. Additional variations and other methods may be appropriate. These examples are intended to illustrate general principles, not to be an exhaustive presentation of acceptable methods.

Approach: “Bottom Up”

Level of Aggregation: All Segments

Identify Segments for Aggregation

<table>
<thead>
<tr>
<th>(1) Groups of Policies</th>
<th>(2) Segment Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Segment 1</td>
<td>MNS Ultra Preferred</td>
</tr>
<tr>
<td>Segment 2</td>
<td>MNS Super Preferred</td>
</tr>
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<td>Segment 3</td>
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</tr>
<tr>
<td>Segment 4</td>
<td>MNS Standard</td>
</tr>
<tr>
<td>Segment 5</td>
<td>MSM Preferred</td>
</tr>
<tr>
<td>Segment 6</td>
<td>MSM Standard</td>
</tr>
<tr>
<td>Segment 7</td>
<td>FNS Ultra Preferred</td>
</tr>
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<td>Segment 8</td>
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<tr>
<td>Segment 9</td>
<td>FNS Preferred</td>
</tr>
<tr>
<td>Segment 10</td>
<td>FNS Standard</td>
</tr>
<tr>
<td>Segment 11</td>
<td>FSM Preferred</td>
</tr>
<tr>
<td>Segment 12</td>
<td>FSM Standard</td>
</tr>
<tr>
<td>Aggregate</td>
<td>All Segments Combined</td>
</tr>
</tbody>
</table>

Calculate Expected Claims and A/E Ratios

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<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Segment 1</td>
<td>MNS RR 70</td>
<td>64</td>
<td>50</td>
<td>78.1%</td>
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<tr>
<td>Segment 2</td>
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</tr>
<tr>
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Calculate Credibility and Credibility-Weighted (CW) A/E

\[
\text{Groups of Policies} \quad \text{Credibility} \times \frac{A/E}{\text{Complement}} \times \frac{A/E}{\text{Aggregate}} = \text{CW A/E}
\]

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<td>62%</td>
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<td>+</td>
<td>22%</td>
<td>*80.9%</td>
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<td>89%</td>
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<td>= 81.0%</td>
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</table>

Perform Calculations to Maintain Conservation of Deaths

\[
\text{Groups of Policies} \quad \text{Expected Claim Amounts} \quad \text{Actual Claim Amounts} \quad \text{CW A/E} \quad \text{Normalized Claim Amounts}
\]

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<thead>
<tr>
<th>Segment</th>
<th>Expected Claim Amounts</th>
<th>Actual Claim Amounts</th>
<th>CW A/E</th>
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<td>51</td>
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Aggregate | 5904 | 4775 | 4766 | 4775 | Normalization Ratio (NR) = 4775 / 4766: 1.001905

Set the Assumption for Company Experience Mortality Rates

\[
\text{Groups of Policies} \quad \text{Mortality Tables} \quad \text{Normalized CW A/E} \quad \text{Company Experience Mortality Rates}
\]

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<th>Segment</th>
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<th>Normalized CW A/E</th>
<th>Company Experience Mortality Rates</th>
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<td>MNS RR 70</td>
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<td>80.6% of 2015 VBT MNS RR 70 ALB</td>
</tr>
<tr>
<td>2</td>
<td>MNS RR 80</td>
<td>85.1%</td>
<td>85.1% of 2015 VBT MNS RR 80 ALB</td>
</tr>
<tr>
<td>3</td>
<td>MNS RR 90</td>
<td>79.1%</td>
<td>79.1% of 2015 VBT MNS RR 90 ALB</td>
</tr>
<tr>
<td>4</td>
<td>MNS RR 110</td>
<td>81.2%</td>
<td>81.2% of 2015 VBT MNS RR 110 ALB</td>
</tr>
<tr>
<td>5</td>
<td>MSM RR 75</td>
<td>75.4%</td>
<td>75.4% of 2015 VBT MSM RR 75 ALB</td>
</tr>
<tr>
<td>6</td>
<td>MSM RR 125</td>
<td>84.2%</td>
<td>84.2% of 2015 VBT MSM RR 125 ALB</td>
</tr>
<tr>
<td>7</td>
<td>FNS RR 70</td>
<td>80.9%</td>
<td>80.9% of 2015 VBT FNS RR 70 ALB</td>
</tr>
<tr>
<td>8</td>
<td>FNS RR 80</td>
<td>83.6%</td>
<td>83.6% of 2015 VBT FNS RR 80 ALB</td>
</tr>
<tr>
<td>9</td>
<td>FNS RR 90</td>
<td>79.6%</td>
<td>79.6% of 2015 VBT FNS RR 90 ALB</td>
</tr>
<tr>
<td>10</td>
<td>FNS RR 110</td>
<td>82.3%</td>
<td>82.3% of 2015 VBT FNS RR 110 ALB</td>
</tr>
<tr>
<td>11</td>
<td>FSM RR 75</td>
<td>75.6%</td>
<td>75.6% of 2015 VBT FSM RR 75 ALB</td>
</tr>
<tr>
<td>12</td>
<td>FSM RR 125</td>
<td>86.0%</td>
<td>86.0% of 2015 VBT FSM RR 125 ALB</td>
</tr>
</tbody>
</table>

Applicable VM-20 Language

VM-20 Section 9.C.2.d

vi. If the company uses the aggregate company experience for a group of mortality segments when determining the company experience mortality rates for each of the individual mortality segments in the group, the company shall either:

a. Use techniques to further subdivide the aggregate experience into the various mortality segments (e.g., start with aggregate non-smoker then use the conservation of total deaths principle, normalization or other approach to divide the aggregate mortality into super preferred, preferred and residual standard non-smoker class assumptions), or

b. Use techniques to adjust the experience of each mortality segment in the group to reflect the aggregate company experience for the group (e.g. by credibility weighting the individual mortality segment experience with the aggregate company experience for the group).
Mortality Aggregation Example

Approach: “Top Down”

2 Levels of Aggregation: Smoker Segments, Non-Smoker Segments

Identify Segments for Aggregation

<table>
<thead>
<tr>
<th>(1) Groups of Policies</th>
<th>(2) Segment Description</th>
<th>(3) Mortality Tables: 2015 VBT ALB</th>
<th>(4) Aggregate Level</th>
<th>(5) Aggregate A/E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Segment 1 MNS RR 70</td>
<td>Non-Smoker</td>
<td>97.1%</td>
<td>97.1% of 2015 VBT MNS RR 70 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 2 MNS RR 80</td>
<td>Non-Smoker</td>
<td>97.1%</td>
<td>97.1% of 2015 VBT MNS RR 80 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 3 MNS RR 90</td>
<td>Non-Smoker</td>
<td>97.1%</td>
<td>97.1% of 2015 VBT MNS RR 90 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 4 MNS RR 110</td>
<td>Non-Smoker</td>
<td>97.1%</td>
<td>97.1% of 2015 VBT MNS RR 110 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 5 MSM RR 100</td>
<td>Smoker</td>
<td>102.6%</td>
<td>102.6% of 2015 VBT MSM RR 100 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 6 MSM RR 125</td>
<td>Smoker</td>
<td>102.6%</td>
<td>102.6% of 2015 VBT MSM RR 125 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 7 FNS RR 70</td>
<td>Non-Smoker</td>
<td>97.1%</td>
<td>97.1% of 2015 VBT FNS RR 70 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 8 FNS RR 80</td>
<td>Non-Smoker</td>
<td>97.1%</td>
<td>97.1% of 2015 VBT FNS RR 80 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 9 FNS RR 90</td>
<td>Non-Smoker</td>
<td>97.1%</td>
<td>97.1% of 2015 VBT FNS RR 90 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 10 FNS RR 110</td>
<td>Non-Smoker</td>
<td>97.1%</td>
<td>97.1% of 2015 VBT FNS RR 110 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 11 FSM RR 100</td>
<td>Smoker</td>
<td>102.6%</td>
<td>102.6% of 2015 VBT FSM RR 100 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 12 FSM RR 150</td>
<td>Smoker</td>
<td>102.6%</td>
<td>102.6% of 2015 VBT FSM RR 150 ALB</td>
<td></td>
</tr>
</tbody>
</table>

Calculate Relativity Structure (here based on RR Tool output)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Segment 1 MNS RR 70</td>
<td></td>
<td>200</td>
<td>187</td>
<td>93.5%</td>
</tr>
<tr>
<td>Segment 2 MNS RR 80</td>
<td></td>
<td>484</td>
<td>495</td>
<td>102.3%</td>
</tr>
<tr>
<td>Segment 3 MNS RR 90</td>
<td></td>
<td>533</td>
<td>520</td>
<td>97.6%</td>
</tr>
<tr>
<td>Segment 4 MNS RR 110</td>
<td></td>
<td>582</td>
<td>563</td>
<td>96.7%</td>
</tr>
<tr>
<td>Segment 5 MSM RR 100</td>
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<td>525</td>
<td>545</td>
<td>103.8%</td>
</tr>
<tr>
<td>Segment 6 MSM RR 125</td>
<td></td>
<td>833</td>
<td>850</td>
<td>102.0%</td>
</tr>
<tr>
<td>Segment 7 FNS RR 70</td>
<td></td>
<td>175</td>
<td>182</td>
<td>104.0%</td>
</tr>
<tr>
<td>Segment 8 FNS RR 80</td>
<td></td>
<td>335</td>
<td>320</td>
<td>95.5%</td>
</tr>
<tr>
<td>Segment 9 FNS RR 90</td>
<td></td>
<td>425</td>
<td>384</td>
<td>90.4%</td>
</tr>
<tr>
<td>Segment 10 FNS RR 110</td>
<td></td>
<td>542</td>
<td>531</td>
<td>98.0%</td>
</tr>
<tr>
<td>Segment 11 FSM RR 100</td>
<td></td>
<td>490</td>
<td>500</td>
<td>102.0%</td>
</tr>
<tr>
<td>Segment 12 FSM RR 150</td>
<td></td>
<td>725</td>
<td>745</td>
<td>102.8%</td>
</tr>
</tbody>
</table>

Aggregate NS 3276 3182 97.1% 100% Aggregate Non-Smoker Credibility: 100%
Aggregate SM 2573 2640 102.6% 85% Aggregate Smoker Credibility: 85%

Set the Assumption for the Company Experience Mortality Rates

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Segment 1 MNS RR 70</td>
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<td>97.1% of 2015 VBT MNS RR 70 ALB</td>
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<tr>
<td>Segment 2 MNS RR 80</td>
<td>Non-Smoker</td>
<td>97.1%</td>
<td>97.1% of 2015 VBT MNS RR 80 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 3 MNS RR 90</td>
<td>Non-Smoker</td>
<td>97.1%</td>
<td>97.1% of 2015 VBT MNS RR 90 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 4 MNS RR 110</td>
<td>Non-Smoker</td>
<td>97.1%</td>
<td>97.1% of 2015 VBT MNS RR 110 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 5 MSM RR 100</td>
<td>Smoker</td>
<td>102.6%</td>
<td>102.6% of 2015 VBT MSM RR 100 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 6 MSM RR 125</td>
<td>Smoker</td>
<td>102.6%</td>
<td>102.6% of 2015 VBT MSM RR 125 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 7 FNS RR 70</td>
<td>Non-Smoker</td>
<td>97.1%</td>
<td>97.1% of 2015 VBT FNS RR 70 ALB</td>
<td></td>
</tr>
<tr>
<td>Segment 8 FNS RR 80</td>
<td>Non-Smoker</td>
<td>97.1%</td>
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</tr>
<tr>
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<td>Non-Smoker</td>
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<td></td>
</tr>
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<td>Non-Smoker</td>
<td>97.1%</td>
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<td></td>
</tr>
<tr>
<td>Segment 11 FSM RR 100</td>
<td>Smoker</td>
<td>102.6%</td>
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<td></td>
</tr>
<tr>
<td>Segment 12 FSM RR 150</td>
<td>Smoker</td>
<td>102.6%</td>
<td>102.6% of 2015 VBT FSM RR 150 ALB</td>
<td></td>
</tr>
</tbody>
</table>
### Comparison of Approaches

<table>
<thead>
<tr>
<th>Methodology</th>
<th>&quot;Top Down&quot; Example</th>
<th>&quot;Bottom Up&quot; Example</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Uses relativities to subdivide the aggregate experience into mortality segments.</td>
<td>Uses credibility weighting to adjust the experience of each mortality segment to reflect the aggregate experience.</td>
</tr>
<tr>
<td>Source of experience data</td>
<td>Uses a company experience study A/E for the aggregate class(es), along with predefined expected relativities between mortality segments determined from a reliable and applicable external source.</td>
<td>Uses company experience study A/E and credibility results for all individual mortality segments and for the aggregate class.</td>
</tr>
</tbody>
</table>

### Updates based on new experience studies

- The aggregate class A/E ratios(s) and aggregate credibility must be updated based on each new company experience study. The relativities would not change unless the external source (e.g., RR Tool, reinsurer) indicates that relationships between segments have changed or the external source data is no longer representative of the company experience.

- The aggregate class and individual mortality segment credibilities and A/E ratios must be updated based on each new company experience study.

### Conservation of deaths

Conservation of deaths is maintained using the normalization process, such that the total amount of expected claims is not less than the aggregate.

### Prudent estimate assumptions

Anticipated experience assumptions are likely to be different by approach, but prescribed margins would be the same if the same level of aggregation is used to determine credibility.

### Other examples have been developed.

See Excel spreadsheet.
Next Steps

Consider exposing examples for public comment

Review comments and revise accordingly

Post examples to the Industry Tab on the NAIC website
IIPRC Report to LATF December 6, 2019

Management Committee & Commission Meeting: Monday, December 9, 3:00 to 4:30

- The full agenda is available on the compact website
- Management Committee and Commission will consider approval/adoption of the following Uniform Standards
  - Group Policyholder Application
  - Group Annuity Certificate for Employer Groups
  - Group Guaranteed Interest Contracts for Non-Variable Annuities for Employer Groups
- Consider approval of Proposed Strategic Plan, 2020 Annual Budget, and 2020 Schedule of Fees
- Hear reports of the Audit Committee, Product Standards Committee, and Rulemaking Committee
- Form Compact Member Committees
- Form Management Committee
- Appointments to the Industry Advisory Committee
- Election of 2019/2020 Officers

Uniform Standards Development—See IIPRC website: insurancecompact.org

- PSC has finalized its work on group annuity Uniform Standards. The Commission adopted the Single Premium Group Fixed Annuity Contract Standards (used for pension risk transfer) and they will be effective for filing January 14th. As noted above, The Commission will consider the remaining group annuity Uniform Standards for adoption during Monday’s Management Committee and Commission meeting.
- PSC continues to address the priority list for filling in gaps in existing individual life and annuity uniform standards. This includes a referral to the Actuarial Working Group to consider developing standards for index-linked variable annuity products. The AWG requested more information about these products and SEC registration requirements from industry trades and is continuing its discussions on developing new standards for these products.
- The PSC will be recommending amendments to the Additional Standards for Waiver of Premium and Additional Standards for Waiver of Monthly Deduction to the Management Committee on Monday to add qualifying events triggers other than the current total disability. They will also recommend a new standard for Waiver of Surrender Charge Benefit for life insurance, similar to the standard on the annuity side.
- Reminder: You can follow the progress of both the PSC and the AWG by reviewing the Call Summaries that are posted under the Committee links on the About the Compact section of the Compact’s website and the Docket (Uniform Standards Under Construction) and participating in the Public Calls that are posted on our events calendar.

Product Operations

- To Be Provided Later
- With respect to 2017 CSO filings, the large increase in the number of life filings the compact has received this year can in part be explained by the change to 2017 CSO. From BOY 2019 through June 2019 we received over 450 life filings compared to 295 filings for the same period last year. We’re receiving more complete filings instead of revisions/amendments and more UL and VUL in 2019.
• The Compact implemented a pilot program to allow companies to pay additional fees to receive an expedited review of their filing. The program has been extended to the end of the year.

**LTC Annual Rate Certification and Triennial Memos**

• The Compact completed the review of the certifications/memos that were due May 1 of this year.
• The Compact has prepared a public report summarizing the review, common compliance issues, and outstanding issues.
• The report will be released at the Commission meeting Monday and will be available on the Compact website.
• The public report will be sent to Commissioners along with a confidential addendum with a summary of the LTC products filed for use in their state.

**Other Activities**

• Monitoring IUL Illustration Subgroup conference calls as well as the LTC Executive Task Force work stream calls
• Webinars
  o The Compact recently completed a series of webinars for regulators.
  o The Compact plans to offer a webinar for regulatory actuaries in the spring of 2020.
  o The Compact plans to offer a webinar for LTC company actuaries on the LTC annual certification requires in the spring of 2020

**Additional Resources**

• Added a full-time actuary, Naomi Kloeppersmith, in July and a new full-time form reviewer, Yada Horace, in August.

**What types of product information regarding Compact filings and review would be helpful for LATF to receive, if any?**
IUL Illustration (A) Subgroup
Conference Call
November 14, 2019

The IUL Illustration (A) Subgroup of the Life Actuarial (A) Task Force met via conference call Nov. 14, 2019. The following Subgroup members participated: Fred Andersen, Chair (MN); Ted Chang (CA); Andrew Greenhalgh (CT); Vincent Tsang (IL); Rhonda Ahrens (NE); Bill Carmello (NY); Peter Weber (OH); Mike Boerner and John Carter (TX); and Craig Chupp (VA). Also participating was: Rachel Hemphill (TX).

1. Discussed Comments on the IUL Illustration Questions Exposed on Nov. 1

Mr. Andersen said nine comment letters were received in response to the Nov. 1 exposure. He suggested discussing the issues question by question instead of sequentially discussing each commenter’s letter. On the question related to the effective date of the proposed changes, he recommended that the changes be effective the later of five months after adoption by the Life Actuarial (A) Task Force or three months after adoption by the Executive (EX) Committee and Plenary. There was no opposition to the recommendation.

a. Question 2

The second question exposed was related to the application of the recommended changes to in-force illustrations. Mr. Andersen discussed his summary of feedback received from commenters (Attachment Twenty-Five-A). He noted that commenters supported positions for and against application of the changes to in-force illustrations. A few Subgroup members expressed desires to find a compromise solution. One member advocated strongly for application of the changes to in-force illustrations.

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comment letter (Attachment Twenty-Five-B) did not specifically address this question.

Birny Birnbaum (Center for Economic Justice—CEJ) said the CEJ comment letter (Attachment Twenty-Five-C) points to the applicability of Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49) to in-force policies. He said the issue was discussed and settled years ago. He said the application is not retroactive because it applies only to new illustrations.

Mr. Andersen asked Mr. Birnbaum to address a commenter’s question related to a consumer purchased multiplier option, the value of which has increased with the market but would no longer be illustratable under the proposed changes to AG 49. Mr. Birnbaum responded that the company should explain that the illustration can no longer illustrate the multiplier, but the consumer is still able to see the historical performance of the multiplier.

Chris Kite (Financial Independence Group) said, while in-force illustrations are used in policy replacement comparisons, the original intent was to demonstrate how policies work. Sheryl J. Moore (Moore Market Intelligence) concurred that in-force illustrations help manage the consumers expectations of their policy’s performance.

Tom Doruska (Global Atlantic) said the Global Atlantic comment letter (Attachment Twenty-Five-D) encourages the Subgroup to apply the proposed changes on a going forward basis.

Scott Harrison (Harrison Law Office) said the two comment letters written (Attachment Twenty-Five-E and Attachment Twenty-Five-F) on behalf of Lincoln Financial Group, Pacific Life, Sammons Financial Group, and John Hancock Insurance (collectively, the “IUL Coalition”) support the grandfathering of in-force illustrations from the proposed changes to AG 49.

Gary A. Sanders (National Association of Insurance and Financial Advisors—NAIFA) said the NAIFA comment letter (Attachment Twenty-Five-G) states its opposition to application of the proposed changes to in-force illustrations.

Ata Azarshahi (National Life) said the National Life comment letter (Attachment Twenty-Five-H) recommends not applying the proposed changes to in-force policies, as doing so may cause consumer confusion.
Gayle Donato (Nationwide) said the Nationwide comment letter (Attachment Twenty-Five-I) suggests that, if the changes are applied to in-force policies, a one-year phase-in would allow time for customer and producer education.

Ernest Armijos (Pacific Life) said the Pacific Life comments (Attachment Twenty-Five-J) support prospective application of the proposed changes to AG 49.

Seth Detert (Securian Life) said the Securian Life comments (Attachment Twenty-Five-K) support the application of the proposed changes to policies regardless of when they are sold.

Mr. Boerner said further clarification of the treatment of hedges for indexed-based credits may be necessary. He recommended deferring the vote until the Fall National Meeting to allow time for additional information to be provided.

b. Question 3

The third question in the exposure requested comments on the Task Force decision to not allow multiplier products to illustrate more favorably or no worse than non-multiplier products.

The Nationwide comment letter proposes two methods of addressing the issue. Ms. Donato said changes are needed to Section 4 and Section 5 of AG 49 to implement the Task Force decision. She noted the Section 4 changes can be addressed later. The changes to Section 5 are to ensure that it is not more or less difficult for a product with a multiplier to pass disciplined current scale (DCS) testing. Method One uses investment returns net of investment expenses when determining the maximum net investment return for DCS testing. Method Two inputs gross investment returns and reflects investment expenses, including hedge costs, as negative cashflow. Ms. Donato said the Nationwide recommendation is to revise Section 5, noting that it provides a net limit on the annual earned rate, and exclude the supplemental option budget from Section 5.A.iii.

Mr. Andersen asked if a sentence could be added to further define the use of the term “net.” Ms. Donato said clarity will be added.

Mr. Chupp said he is concerned that there is double-counting in Section 4 based on how the multiplier is determined.

Laura Hanson (Allianz Life) suggested moving the “145 percent rule” to Section 4 and taking a principled approach in Section 5 as a way to avoid the double-counting. She noted that there are different approaches to DCS testing, which makes a formulaic approach to addressing the issue difficult.

Mr. Andersen said he prefers making revisions under the current structure of AG 49 and addressing other issues at a later date.

Donna Megregian (Reinsurance Group of America—RGA) agreed with the Subgroup direction, but she suggested the addition of a guidance note to address the double-counting issue.

As discussion continued, a number of concerns about Section 4.E were raised.

Having no further business, the IUL Illustration (A) Subgroup adjourned.
### Summary of early November 2019 IUL illustration comments

1. Should the effective date for new policies be the later of 5 months after LATF adoption or 3 months after NAIC Executive/Plenary adoption?

   - **ACLI:** Yes - if revisions are substantively consistent with those in 11/1 version
   - **CEJ:** Should be 11-12 weeks (just less than 3 months) after NAIC Exec/Plenary adoption; No record of past effective dates are needed
   - **GlobalAtl:** Yes - acceptable if the approved version is materially consistent with the 11/1 version
   - **IUL Coalit.:** Yes - acceptable if the NAIC-adopted version is materially consistent with LATF-adopted version
   - **NAIFA:** Response not provided
   - **Nat’l Life:** Yes - acceptable if the approved version is materially consistent with the 11/1 version
   - **N’Wide:** Yes - if revisions are substantively consistent with those in 11/1 version
   - **Pac Life:** Response not provided (comments reflected in IUL Coalition letter)
   - **Securian:** Yes - expects Exec / Plenary version to match LATF version

2. Should the revised guidelines be in place for inforce illustrations for policies sold before the effective date for new policies?

   - **ACLI:** Response not provided
   - **CEJ:** Yes - decided by NAIC in 2016 that AG 49 changes would apply to inforce policies
   - **GlobalAtl:** Yes - assuming sufficient time is provided; fulfills a goal of uniform practice & prevents confusion when comparing policies
   - **IUL Coalit.:** No - consumer benefit is not clear & compelling and inforce illustration serves different purpose than illustration at time of sale
   - **NAIFA:** No - Retroactively applying revisions made to NAIC models to inforce business/products is likely to confuse consumers and adversely impact the consumer/producer relationship
   - **Nat’l Life:** No - it could cause undue consumer confusion and disruption
   - **N’Wide:** If revisions are put in place for inforce policies, apply to inforce one year after the effective date of the revised AG 49 to new policies; this would allow time for customer & producer education
   - **Pac Life:** No - consumer confusion and loss of confidence will result if feature purchased is not illustrated
   - **Securian:** Yes - otherwise unrealistic expectations will be reinforced

3a. Does the approach of having the disciplined current scale earned rate including or excluding the Supplemental Option Budget lead to the result of the multiplier product illustrating about the same as a non-multiplier product?

   - **ACLI:** Since charges for a multiplier reduce policy values, both the crediting of interest and the funding of option credits need to consider not only the rate but also the balance against which that rate is applied
   - **CEJ:** Yes - decided by NAIC in 2016 that AG 49 changes would apply to inforce policies
   - **GlobalAtl:** Pay attention to Sections 3 through 6; to attain the desired result, the return of the Supplemental Option Budget, not its inclusion or exclusion, is required
   - **IUL Coalit.:** Response not provided
   - **NAIFA:** Response not provided
   - **Nat’l Life:** The cost of the hedge should be offset with the hedge payoff
   - **N’Wide:** Depends on how a company reflects hedge cash flows in DCS testing; Add "net" to 5A wording; update Section 4 & 6B, also;
   - **Pac Life:** Response not provided
   - **Securian:** Recent revisions do reasonable job; If Supplemental Option Budget included, need to define what constitutes cash flows from DCS testing standpoint

3b. If neither of the approaches mentioned in 3a leads to this result, is there an alternative approach that leads to this result such as providing explicit guidance in Section 4?

   - **ACLI:** Contained in 3A response
   - **CEJ:** Contained in 3A response
   - **GlobalAtl:** Need to align 4E and 4A/4B; 6B creates unintended consequences
   - **IUL Coalit.:** Response not provided
   - **NAIFA:** Response not provided
   - **Nat’l Life:** In the absence of an explicit charge, the funding for the multiplier could come from the company’s net earned rate and may result in different total index credits.
   - **N’Wide:** Investment returns are net of investment expenses; or Investment expenses are treated separately as expenses
   - **Pac Life:** Response not provided
   - **Securian:** Alternate: Introduce new definitions; Add language to 4C, agrees with 4E
November 12, 2019

Mr. Fred Andersen
Chair, NAIC IUL Illustration (A) Subgroup

Re: Indexed Universal Life (IUL) Illustration Subgroup Questions

Dear Mr. Andersen:

The American Council of Life Insurers (ACLI)\(^1\) appreciates the opportunity to submit the following responses to several of the questions posed by the IUL Illustration Subgroup on its November 1\(^{st}\) call.

**Question 1:** Should the effective date for new policies be the later of 5 months after LATF adoption or 3 months after NAIC Executive/Plenary adoption?

**ACLI Response to 1:** If the revisions to Actuarial Guideline 49 are substantially consistent with the version circulated on the November 1\(^{st}\) call, ACLI would be supportive of the 5 month/3 month recommendation. If modifications are made to the exposure, that timeframe may not be appropriate depending on the extent and significance of those changes.

**Question 3a:** Does the approach of having the disciplined current scale earned rate including or excluding the Supplemental Option Budget lead to the result of the multiplier product illustrating about the same as a non-multiplier product?

**Question 3b:** If neither of the approaches mentioned in 3a leads to this result, is there an alternative approach that leads to this result such as providing explicit guidance in Section 4?

**ACLI Response to 3a/3b:** The language in the current exposure appears to create a discrepancy in the requirements, and as such it’s unclear if this approach meets the desired regulatory outcome. Section 3.C.vi. provides for more than one benchmark account when a product has different levels of account charges. The language in Sections 4.a and 4.b provide for a separate illustrated rate for each benchmark account. The account charges that generated separate benchmark accounts seem to meet the definition of a Supplemental Option Budget. Applying the language in Section 4.e, however, seems to produce a different answer than that derived within 4.a and 4.b.

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\(^1\) The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. 90 million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. Learn more at [www.acli.com](http://www.acli.com).
Regarding deciding if a product with a multiplier should be illustrated the same as a product without a multiplier, there are two issues at work: one being how the interest is being credited, and how the option crediting is funded. Since charges for a multiplier reduce policy values, both the crediting of interest and the funding of option credits need to consider not only the rate but also the balance against which that rate is applied. To have consistent results between a product with a multiplier and one without, different rates would need to be applied due to differences in the account values.

As regulators contemplate clarification of the drafted language, we would note that care needs to be taken to where the option budget is added in the text to avoid unfairly advantaging or disadvantaging multiplier products through potentially doubling counting of credits or charges.

We look forward to a discussion of these questions on a future Subgroup call. Thank you.

Sincerely,

[Banffeli]

cc Reggie Mazyck, NAIC
Comments for the Center for Economic Justice

To the Indexed Universal Life Subgroup of the NAIC Life Actuarial Task Force

Proposed Revisions to AG 49

November 12, 2019

In response to questions posed by the subgroup and the exposed draft revisions to AG 49, CEJ submits the following comments to the IUL subgroup. The following questions were exposed for comment:

1. Should the effective date for new policies be the later of 5 months after LATF adoption or 3 months after NAIC Executive/Plenary adoption?

2. Should the revised guidelines be in place for inforce illustrations for policies sold before the effective date for new policies?

3a. Does the approach of having the disciplined current scale earned rate including or excluding the Supplemental Option Budget lead to the result of the multiplier product illustrating about the same as a non-multiplier product?

3b. If neither of the approaches mentioned in 3a leads to this result, is there an alternative approach that leads to this result such as providing explicit guidance in Section 4?

Application to In-force policies – Question 2

It is unclear why the question of application of AG 49 to new illustrations for in-force policies is being presented as an issue for discussion. LATF, the A Committee and the NAIC Executive Committee and Plenary decided in 2016 that AG 49 would apply to in-force policies. There is no evidence that any of rationale for this decision was misplaced or needs to be revisited.

A lengthy debate regarding application of AG 49 to in-force policies occurred throughout 2016 and the NAIC settled the debate with a decision in 2016 to adopt the revisions to AG 49 that included:
i. Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in-force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold.

LATF recommended this change to the Life Insurance and Annuities (A) Committee with a proposed effective date of July 1. The A Committee revised the effective date to March 1, 2017 when adopting the provision on December 11, 2019. The Executive Committee and Plenary adopted the revision to AG 49 from the A Committee on December 13, 2016.

The arguments in favor of application of AG 49 to new illustrations for in-force policies include: 1

- Consistent application of the consumer protection of AG 49 for all consumer receiving an illustration on or after the effective date;
- Realistic illustrated interest rates for consumers receiving an updated illustration for a policy issued before the effective date;
- Ease of compliance for insurers and regulatory oversight by regulators compared to; a system of multiple interest rate regimes depending upon the date of policy issuance;
- Reduced expenses for insurers from elimination of multiple systems of interest rate calculations.

The arguments against application of AG 49 to new illustrations for in-force policies were that consumers would be confused when a new illustration used a different crediting rate than an older illustration and that application to in-force policies was retroactive application of AG49.

Regarding “consumer confusion,” no evidence was ever presented to support this claim and examination of the argument proved it was without merit. First, crediting rates for updated illustrations can already vary from crediting rates for prior illustrations based on changes in the calculation prescribed in Section 4 of AG 49. Second, failure to apply AG 49 – or the most current version of AG 49 – to new illustrations for in-force policies will cause disparate treatment of consumers, including:

- Two consumers purchasing the same product a day before and a day after the effective date of the revisions would receive different illustration crediting rates;
- Two consumers receiving updated illustrations of the same product would receive different illustration crediting rates if one purchased the product before the effective date and one purchased the product after the effective date.
- Consumers purchasing an IUL product before the effective date do not receive the same consumer protections as consumers who purchased the product after the effective date.

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1 AXA letter of July 31, 2016; AAA letter of August 1, 2016, CEJ letters of July 31, 2016 and August 19, 2016. CEJ’s comment letters are attached.
Similarly, the argument that application of AG49 to new illustrations for in-force policies was a “retroactive” change to IUL policies was without merit. Application to new illustrations for in-force policies did not and will not require any insurer to revise or replace any illustration provided before the effective date. Rather, the proposed change applies to all illustrations provided on or after the effective date and, consequently, will not impact previously-issued illustrations or any features of the IUL contract.

Effective Date – Question 1

The effective date should be the first day of the month 11 to 12 weeks after adoption by the NAIC Executive Committee and Plenary.

In 2016, LATF adopted revisions to AG 49, including application to in-force policies, on November 17. The A Committee and Exec/Plenary adopted the revisions with a March 1, 2017 effective date on December 11 and December 13, 2016, respectively. The March 1, 2017 effective date was 78 days after adoption by Exec/Plenary.

An effective date for the proposed revisions to AG 49 no greater than 11 to 12 weeks following adoption by Exec/Plenary is reasonable. First, industry has shown itself capable of implementing changes to AG 49 within an 11 to 12 week time frame. The NAIC determined – and there is no evidence to contradict – that insurers could both revise illustration software and prepare any necessary information for existing customers within that time frame. Second, changes to illustration parameters in illustration software are routine and do not require lengthier lead times. Insurers and their intermediaries and vendors tweak parameters in illustration software when crediting rates change – due to a change in the cap or a change in the illustrated scale crediting rate calculation – and when new products are introduced.

The Effective Date section should be simplified to simply state “This version of the Actuarial Guideline is effective [date].” The current effective date section contains 3 subsections with three different effective dates to reflect a phased-in approach for AG 49. All those dates have passed and there is no longer a need for an updated AG 49 to retain these provisions. Just as the new versions of the Valuation Manual do not include effective dates for all provisions, so are multiple past effective dates in AG 49 unnecessary. If an insurer or regulator wishes to see the AG 49 provisions in effect prior to the effective date of the proposed revisions to AG 49, they can refer to that earlier version of AG 49.

What Revisions Are Needed to Ensure a Non-Multiplier Product Illustrates Like a Multiplier Product, All Other Things Equal – Question 3

There are structural problems with the Life Insurance Illustrations Model Regulation and with AG 49 such that there is no technical solution to problems in AG 49 caused by insurers’ use of multipliers and bonuses to game the current provisions of AG 49. The goal should be to revise AG 49 to stop current abuses and ask the A Committee to review illustrations more broadly to fix structural problems, such as permitting back-testing of indexes as the basis for projecting future performance.
CEJ suggests the following approach to ensure non-multiplier products illustrate the same as a multiplier product, all other things equal. The concept is to include a specific prohibition against including any interest-crediting enhancements beyond the cap and 0% floor in the development of the Benchmark Index Account. In addition to the specific prohibition, the proposal deletes most of current vi and vii to eliminate the gaming that would otherwise occur with multiple accounts used in the illustration.

We understand our proposal will limit illustration of some of the features of some IUL products. However, the subgroup has already acknowledged this with the decision to require products with bonuses and multipliers to illustrate the same as products without, all other things equal. The deletion of vi and vii is consistent with this concept and necessary to avoid the gaming of AG49 that would occur if these sections remain.

We reiterate that the framework of the illustration regulation and AG49 cannot eliminate the problems with and potential for misleading life insurance illustrations. The revisions to AG49 should be seen as the first step to protecting consumers followed quickly by a thorough review of illustrations generally to develop a meaningful approach to empowering consumers to understand the key aspects of increasingly complex life insurance products.

B. Benchmark Index Account: An Index Account with the following features:

i. The interest calculation is based on the percent change in S&P 500® Index value only, over a one-year period using only the beginning and ending index values. (S&P 500® Index ticker: SPX)

ii. An annual cap is used in the interest calculation.

iii. The annual floor used in the interest calculation shall be 0%.

iv. The participation rate used in the interest calculation shall be 100%.

v. Interest is credited once per year.

vi. No charges or benefits from interest crediting enhancements are permitted. While an illustration may vary based on the cap and floor and non-hedging costs, no variation in the illustration is permitted for differences in asset charges, multipliers, bonuses or other interest-crediting enhancement benefits or costs.

vii. Account charges, other than any charges for interest crediting enhancements, are the highest of any do not exceed the account charges for any corresponding Index Accounts within the policy in any policy year. If Index Accounts with different levels of account charges are offered with the illustrated policy, more than one Benchmark Index Account may be used in determining the maximum illustrated crediting rates for the policy’s Index Accounts, subject to the requirements of 5.D. However, for each Index Account within the policy, only one Benchmark Index Account shall apply. Any rate calculated in 4 (B) shall not apply for an Index Account if the account charges for the applicable
Benchmark Index Account exceed the account charges for that Index Account in any policy year. Account charges include all charges applicable to an Index Account, whether deducted from policy values or from premiums or other amounts transferred into such Index Account.

vii. Additional amounts credited are not less than the additional amounts credited for any corresponding Index Accounts within the policy in any policy year. Any rate calculated in 4 (B) shall not apply for an Index Account if the additional amounts credited for the applicable Benchmark Index Account are less than the additional amounts credited for that Index Account in any policy year. Additional amounts include all credits that increase policy values, including but not limited to experience refunds or bonuses.

viii. There are no limitations on the portion of account value allocated to the account...
Comments of the Center for Economic Justice
to the
NAIC Life Insurance and Annuities (A) Committee

In Support of LATF-Adopted Revisions to AG 49 to
Create Consistent Consumer Protections for Indexed Universal Life Illustrations

December 9, 2016

Summary of Comments

The Center for Economic Justice (CEJ) supports adoption by the A Committee of the LATF-adopted changes in Actuarial Guideline 49 (AG 49) to apply the requirements of Sections 4 and 5 of AG 49 to indexed universal life (IUL) illustrations for new business and in-force policies on or after the effective date. These changes create consistent consumer protections by applying the AG49 protections for non-guaranteed crediting rates in IUL illustrations to avoid unreasonable and unrealistic illustrations. The changes also promote efficiency and cost-savings for insurers and regulatory oversight. The arguments against the proposed change – “retroactive application” and “consumer confusion” – are glaringly inaccurate, without any evidentiary support, highly illogical and profoundly anti-consumer.

CEJ urges a change in the effective date to March 1, 2017. The proposed effective date of July 1, 2017 is much longer than needed for industry to implement this needed consumer protection for updated illustrations for in-force policies. AG 49 has been effective for new business for over a year which means that the industry has the infrastructure in place to produce AG49-compliant crediting rates. There is no need to provide industry with over six months lead time simply to utilize a crediting rate based on a methodology industry is already using. Delaying the implementation date to July 1, 2017 extends the period in which existing IUL policyholders may continue to receive updated illustrations with unreasonable and unrealistic illustrations.
Discussion

The purpose of AG 49 is to protect consumers from the use of unrealistic non-guaranteed crediting (interest) rates in illustrations for indexed universal life insurance. AG 49 was developed and adopted on an expedited basis to stop the use of abusive and unreasonable projected returns for the policy. It is useful to recall the purpose of AG 49 – a fundamental consumer protection guideline to ensure consumers presented with IUL illustrations received useful information to assist in their decision-making.

Because of the expedited nature of the development and adoption of AG 49, LATF committed to the Life A Committee to continue work on AG 49 after initial adoption to address ongoing issues. One of those issues is now before LATF – whether to apply the non-guaranteed illustration crediting rate calculation and capping requirements of Sections 4 and 5 of AG 49 to all illustrations on or after a future effective date. Stated differently, the proposal is to apply the crediting rate requirements of AG 49 for both new business illustrations and for updated illustrations on or after the effective date for in force policies.

It is important to state clearly what the proposed change is not doing – the proposal will not require revision of an illustration provided prior to the effective date.

It is also important to be clear what aspect of an IUL illustration is affected by this change – the crediting rate and the methodology for the illustrating insurer to calculate the crediting rate for the non-guaranteed scale. The proposal does not change any aspect of the IUL policy. The proposed change may impact the crediting rate the insurer uses for an updated illustration – in those instances in which the crediting rate would be higher than permitted by AG 49.

A crediting rate for the non-guaranteed scale of an illustration is already subject to change. The crediting rate for an updated illustration for an in-force policy may change from the crediting rate used in a prior illustration under pre-AG 49 methodologies because the performance of the underlying index has changed. ACLI has confirmed this during the August 2016 LATF meeting in San Diego, explaining that an insurer offering an illustration for a replacement policy will use the same crediting rate assumptions for an updated illustration of the existing policy as used for the replacement policy illustration to ensure a fair comparison of the products. Changing the crediting rate in an updated illustration from that used in a prior illustration is neither a retroactive change to the existing policy or a structurally-difficult endeavor for insurers.
The benefits of the proposed change are many and obvious:

1. Consistent consumer protection

The proposal will ensure consistent consumer protection regarding crediting rates for the non-guaranteed illustration by applying AG 49 to all illustrations on or after the effective date – regardless of whether that illustration is for new business or an updated illustration of an in-force policy. It would be illogical to provide different consumer protection for two consumers evaluating the same policy, but differing only by a few months in the date of purchase.

2. Better information for consumers reviewing their IUL products

As discussed above, the purpose of AG49 was to stop the use of unrealistic and unreasonable crediting rates for illustrations of future earnings with an IUL policy. The application of AG49 requirements for the development of a maximum crediting rate provides consumers with better information and, consequently, empowers consumers to make better decisions for themselves.

3. Easier and less costly compliance for insurers

Under the current AG49, an insurer must calculate AG49-compliant crediting rates for new business IUL policies on or after September 1, 2015. But AG49 does not currently apply to updated illustrations on IUL policies issued before September 1, 2015. This means that insurers must maintain and utilize the non AG 49 compliant crediting rate methodologies and be able to demonstrate to regulators which of perhaps many methodologies were used in calculating the crediting rate for illustrations on or after September 1, 2015 depending on when the policy was issued. Clearly, it will be far easier for insurers to maintain compliance with a single set of requirements for crediting rate methodologies on or after an effective date than to maintain compliance for multiple methodologies.

4. Easier and less costly oversight for regulators

The same logic applies to ease of regulatory oversight of crediting rate methodologies and calculations as for insurer compliance. It will be far easier – and, consequently, less costly for regulators and insurers – to have a single set of requirements for crediting rate methodology and calculations on or after the effective date.
The arguments against the proposal are without merit and include the following:

1. “Retroactive application of a rule or regulation”

Some industry commenters claim the proposal is an impermissible retroactive change to a contract. This is clearly incorrect. The proposed change to AG 49 will not change any contractual feature of an existing IUL policy. Opponents of the proposal have not – and cannot – point to any contractual feature of the IUL policy that would be “retroactively” changed by the proposed change to AG 49.

We suggest that it is an abuse of process at LATF for opponents of the proposed change to AG 49 to claim “retroactive” application and seek to delay a LATF decision by demanding NAIC legal review without identification of any contract feature that could be changed by the proposal.

2. “Consumer confusion”

Opponents of the proposed change have claimed that consumers will be confused if they receive an updated illustration with a lower, more realistic crediting rate for the non-guaranteed scale illustration. Putting aside that, despite months of opportunity to support this claim, no evidence – or logic – has been presented in support of this claim of consumer confusion.

We assert that the claim of consumer confusion is patently absurd – that a consumer who purchased an IUL policy with unrealistically-high crediting rates for the non-guaranteed scale illustration acted rationally – despite bad information – and these same consumers when presented with more realistic information – better information for an informed evaluation – will become irrational and make bad decisions with their policies. This argument is profoundly anti-consumer – asserting that consumers are better off without the illustration protections of AG 49.

The logical extension of the opponents’ “consumer confusion” argument – that when provided more realistic non-guaranteed illustrations, the consumer will irrationally replace the IUL policy – is that consumers are better off continuing to get unrealistic illustrations and be surprised to learn that they have to pay additional premiums because the policy did not perform as illustrated. Surely, consumers are in a better position to discuss these issues with their producer or insurer based on realistic illustration than to be surprised.
Finally, we note that “consumer confusion” argument is based on the premise that when faced with AG49 compliant non-guaranteed crediting rates, consumers will react by cancelling or replacing their policies. Yet, opponents offer no evidence to support this claim. The available evidence suggests this will not be the case. If opponents were correct, then we would have expected to see a sharp drop in IUL sales following implementation of AG49. That has not occurred. According to a company that tracks IUL sales, IUL sales have remained strong since AG49 became effective at the end of third quarter of 2015:

Third quarter indexed universal life (IUL) sales were $452.9 million, compared with sales of $478.6 million for the third quarter of 2015. When evaluating third quarter IUL sales, results were up nearly 3.0% when compared with the previous quarter, and down over 5.0% when compared to the same period last year. “It is amazing to see that indexed life sales continue to thrive in a post-AG49 environment,” professed Sheryl J. Moore, President and CEO of both Moore Market Intelligence and Wink, Inc. She added “This is the second-largest third quarter sales have been, in the history of the product line. IUL continues to thrive!”

The 2016Q3 results are not an aberration. Wink reported the following for 2016Q2 sales:

Second quarter indexed universal life (IUL) sales were $441.0 million, compared with sales of $458.0 million for the second quarter of 2015. When evaluating second quarter IUL sales, results were up over 2.0% when compared with the previous quarter, and down nearly 4.0% when compared to the same period last year. “Many projected that AG49 would not only limit illustrated rates on indexed life, but that it would kill the product line,” protested Sheryl J. Moore, President and CEO of both Moore Market Intelligence and Wink, Inc. She added “Not if the IUL industry has anything to do with it! Sales are already nearly at 2015’s levels, before the regulation took effect.”

In summary, the “consumer confusion” argument is without empirical or logical support and must not be a reason to stop this important consumer protection.

3. “Conflict with another NAIC model”

During the October 20, 2016 LATF call, one LATF member asked if the proposed change to AG49 creates conflicts for producers in the Life Insurance and Annuities Replacement Model Regulation. We would again suggest that it is an abuse of process at LATF to broadly suggest conflict with other rules or statutes without referencing some specific “conflict.” Nevertheless, we have reviewed the model in question and find no reference to any requirements for the crediting rate for the non-guaranteed scale in an updated illustration for the existing policy. For example, the model defines “policy summary” for universal life insurance products:

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1 “WINK releases third quarter 2016 indexed life sales.”
For universal life policies, means a written statement that shall contain at least the following information: the beginning and end date of the current report period; the policy value at the end of the previous report period and at the end of the current report period; the total amounts that have been credited or debited to the policy value during the current report period identifying each by type (e.g., interest, mortality, expense and rides); the current death benefit at the end of the current period on each life covered by the policy; the net cash surrender value of the policy as of the end of the current period; and the amount of outstanding loans, if any, as of the end of the current report period.

As for alleged problems or conflicts for the producer, there are none. Section 4A states:

A producer who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts.

If the answer is yes, then the producer and applicant must sign a disclosure described in Appendix A of the model. That disclosure includes the following:

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.

Clearly, the consumer protections of AG 49 applied to an in-force illustration, as referenced in the paragraph above, is consistent with the purposes of the replacement model regulation and with consumer protection, generally.

Effective Date

CEJ urges a change in the effective date to March 1, 2017. The proposed effective date of July 1, 2017 is much longer than needed for industry to implement this needed consumer protection for updated illustrations for in-force policies. AG 49 has been effective for new business for over a year which means that the industry has the infrastructure in place to produce AG49-compliant credit rates. There is no need to provide industry with over six months lead time simply to utilize a crediting rate based on a methodology industry is already using. Delaying the implementation date to July 1, 2017 extends the period in which existing IUL policyholders may continue to receive update illustrations with unreasonable and unrealistic illustrations.
Comments of the Center for Economic Justice
to the NAIC IUL Illustration (A) Subgroup
Amending the Effective Date Provision of AG 49

July 31, 2016

The Center for Economic Justice submits the following comments regarding the effective date provisions of AG 49.

When originally adopted by LATF, AG 49 staggered implementation by phasing in the requirements for the “illustrated scale” and the “disciplined scale,” effective September 15, 2015, and, then later, requirements for policy loan illustrations and additional standards, effective March 1, 2016. The actuarial guideline applies the requirements to policies sold on or after these dates and not to policies in-force on or after these dates.

CEJ urges the effective date provisions be changed deleting the word “sold” as follows:

1. Effective Date
   This Actuarial Guideline shall be effective for all new business and in force life insurance illustrations on or after September 1, 2016, as follows:

   i. Sections 4 and 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after September 1, 2015.

   ii. Sections 6 and 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

   Since March 1, 2016 has come and gone, there is no longer a need for two effective dates and setting the date into the near future will reduce confusion without harming consumer protection.

   The effect of this change is that all illustrations produced after the effective dates will be subject to the consumer protections of AG 49. Under the current language, illustrations produced after the effective dates for policies sold prior to the effective date are not subject to the guideline. There are several compelling reasons for this change.
1. **Consistent consumer protections for all IUL illustrations after the effective dates.** Under the current language some consumers receiving new illustrations will receive protection against inflated and misleading crediting rates while other consumers will not. For example, assume two consumers with the identical IUL policy. One purchased the policy (“was sold”) on July 1, 2015 and the other purchase the policy on October 1, 2015. Both consumers request an update illustration in July 2016. The first consumer continues to get an illustration without the AG 49 protections while the second consumer does receive the protection – even though both are receiving an illustration of the same policy on the same day. This is unfair, deceptive and misleading to the first consumer.

2. **The proposed change is not a retroactive change to the policy.** The proposed change has no impact on illustrations already provided to the consumer – only to illustrations provided after the proposed change to remove “sold” is enacted.

3. **The proposed change will reduce illustration expenses for insurers.** Under the current guideline, the insurer must maintain at least two methods of calculating the crediting rates used in the illustrations and the documentation to support the two or more methods. Under the proposed change, the insurer will only need to maintain the AG-49 compliant method of calculating crediting rates and associated documentation for that one method.

4. **The proposed change will simplify regulatory oversight of illustration crediting rates.** Under the current guideline, market conduct regulators will need to examine multiple crediting calculation methods for illustrations after the effective date because the crediting calculations will vary on current illustrations depending on when the policy was sold. The proposed change will greatly simplify market regulation review of compliance with AG 49.

5. **The proposed change will simplify the implementation of the recent changes to AG 49 regarding multiple scales within a policy.** The changes to AG 49, adopted this year, did not include any effective date changes to AG 49 or effective dates specific to the changed provisions. The result is that AG 49 will provide guidance applicable to policies sold between 2015 and 2016, but before the guidance was adopted in 2016. Our proposed changes to the effective date provision eliminate this issue because AG 49 will apply – in its entirety – to new illustrations regardless of the sold-by date.

   During an earlier meeting in which the effective date issue was discussed, an industry representative suggested, among other things, that LATF should consider the impact on insurer solvency resulting from policyholder behavior significantly different than originally estimated if the proposed change in the effective date provision was enacted. The comment was startling, as it implied that illustrations under AG 49 would be so radically different for policyholders sold IUL policies before the effective date that large numbers of policyholders would now drop their policies. If this is true, the consumer protection afforded by the proposed change is hugely important to allow consumers to make informed decisions based on reasonable and not misleading information.
Supplemental Comments of the Center for Economic Justice

to the NAIC IUL Illustration (A) Subgroup

Amending the Effective Date Provision of AG 49

August 19, 2016

The Center for Economic Justice submits the following responses to the comments submitted by ACLI, AAA and ALIA regarding the effective date provisions of AG 49.

CEJ supports application of AG 49 for illustrations provided for new and in-force policies as set out in our July 31, 2016 letter. We suggested the following revision to the Effective Date section:

1. Effective Date
   This Actuarial Guideline shall be effective for all new business and in force life insurance illustrations on or after September 1, 2016, as follows:

   i. Sections 4 and 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after September 1, 2015.

   ii. Sections 6 and 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

The proposed language makes clear that previously-provided illustrations are not implicated by the guideline nor is there a requirement to re-issue an illustration. The effect of this change is that all illustrations produced after the effective dates will be subject to the consumer protections of AG 49.

ALIA and ACLI: “Retroactive” Application

The ACLI and ALIA mischaracterize the proposed change as “retroactive” application of the guideline to existing policies and then criticize their mischaracterization as “unprecedented.” The proposal is not “retroactive” application. The proposed change will not require any insurer to revise or replace any illustration provided before the effective date. Rather, the proposed change applies to all illustrations provided on or after the effective date and, consequently, will not impact previously-issued illustrations.
AAA, ACLI and ALIA: “Confusion for Consumers”

The purpose of AG49 is to ensure the use of reasonable – and not unrealistic – crediting rates for IUL illustrations. The basic premise behind the “consumer will be confused” comment is bizarre: When presented with an updated illustration showing a lower illustrated crediting rate, consumers will be confused because the crediting rate has gone down. Given that even under pre-AG49 credit rate methodologies the crediting rate can change over time, it is unclear why an updated illustration with a lower crediting rate will confuse consumers. More importantly, it is absurd to argue that consumers should continue to receive illustrations with unrealistic crediting rates because providing the realistic illustrated crediting rate – necessary for a rational consumer to make an informed judgment – will somehow confuse the consumer.

The ALIA comments raise concern about IUL sales and the role of illustrations. ALIA writes:

We are very concerned about the negative impact on existing policyholders. Policyholders with in-force policies that were previously illustrated at a higher rate than the AG 49 maximum would be required to be informed that a reduced rate for their in-force projections must now be used. For example, a policyholder that had received an illustration using a rate of 7% would be told that the premium to achieve their objective must be increased because the carrier is now required to impose a maximum illustration rate of 6%. That policyholder would also be told that a premium increase will be necessary to meet their goals - even if the actual experienced performance to date was better than the originally illustrated 7%.

First, a consumer with a policy issued before the effective date would receive an updated illustration either because of a request by the consumer or because the insurer already periodically provides updated illustrations to the policyholder. There is no requirement to inform policyholders “that a reduced rate for their in-force projects must now be used.” If the consumer does request or receive an updated illustration with a significantly-lower illustrated crediting rate, it is reasonable for the consumer to ask why illustrated crediting rate has changed. A reasonable response by the insurer would be: Insurance regulators were concerned about unrealistic crediting rates used for illustrations and have established guidelines for insurers to use more realistic crediting rates. The new crediting rates were developed using the new guidelines established by regulators.”

Second, the example provided by ALIA indicates that premium charges are based on illustrated crediting rates and that changes in illustrated crediting rates will alter the premium requirements of the insurer. If this is the case, there are far bigger problems with IULs than simply inflated crediting rates. But, if ALIA has accurately explained the role of illustrated crediting rates in determining IUL premiums, then it is even more important for a consumer to receive updated illustrations with realistic crediting rate illustrations.
ACLI also asserts consumers will confused, though offers no evidence or logic for the assertion. ACLI writes:

Providing an illustration on a different basis than prior illustrations can cause confusion and will give the perception that the product has changed, or is not the same as was originally sold, even if the product has had no changes. Such confusion could provide improper incentive for lapse or replacement.

As noted above, updated illustrations may contain a different illustrated crediting rate than the one used in the original illustration even using the insurer’s pre-AG 49 methodology because the performance of the index has changed. But, the ACLI comment implies that a consumer who purchased a policy with an unrealistic illustrated credit rate was rational and not confused, but a consumer presented with an illustration using a realistic crediting rate would become hapless, confused and irrational. At best, the ACLI proposition is illogical. At worst, it is a cynical effort to prevent consumers from having the accurate information needed to make an informed decision.

ACLI has provided no empirical evidence or academic research for either the “consumers will be confused” argument or its assertion that AG 49 was only intended for pre-sale illustrations and “will have limited impact” in post-sale illustrations. ACLI’s argument is contradictory – on the one hand, application of AG 49 to updated illustrations will have limited impact, but, on the other hand, it will lead consumers to irrationally abandon policies. The reasoning for applying AG 49 requirements consistently to all illustrations issued on or after an effective date is clear – regardless of whether the illustration is pre-sale or post-sale, regardless of whether a consumer is using the illustration to decide on purchasing a new policy or evaluating the suitability of an existing policy, the consumer will receive the most realistic information needed to make an informed decision.

AAA also asserts consumer confusion without any empirical support for the claim. AAA writes:

Changing the format, content, and disciplined current scale from previous illustrations may cause confusion for consumers, since the perception could be that the policy’s nonguaranteed elements have changed when, in fact, they have not. As a result, customers could react in ways that may not be in their best interest.

As with ACLI and ALIA, the AAA comments are premised on the assertion that the prior illustration was crystal clear and the consumer was sufficiently informed to make an informed and rational decision, but presented with more realistic illustrated crediting rates and clearer content and format, this same consumer will transmogrify into an irrational, confused being. Whatever the degree of rationality exhibited by a consumer, we find no excuse for continuing to use unrealistic crediting rates for IUL illustrations.
CEJ Comments to IUL Illustration Subgroup
August 19, 2016
Page 4

ACLI: “Industry Expenses”

ACLI writes:

Illustration systems are often developed specific to the product. Once that product is no longer being sold, those systems are no longer actively maintained. Being required to modify numerous systems that have been set aside, for a very limited purpose, with no demonstrated benefits seems to be a waste of industry resources.

The ACLI comment implies that once a product is no longer sold, the insurer no longer maintains the system that generated the illustrations for that product. This seems implausible because, if true, an insurer would not be able to provide updated illustrations requested by consumers for IULs continuing in force after product sales ended. The comment is also inconsistent with the prior ACLI comment about illustrations for replacements.

As set out in our July 31, 2016 comments and the AAA comment letter, applying AG 49 to all illustrations for sales and in-force policies issued on or after a future effective date will clearly reduce insurer costs by eliminating the need to maintaining multiple illustration systems and reduce compliance costs for insurers and regulators.

In summary, the arguments against the proposal to revise the Effective Date section of AG 49 are without empirical support or logic.
Supplemental Comments of the Center for Economic Justice
to the NAIC IUL Illustration (A) Subgroup

Amending the Effective Date Provision of AG 49

October 10, 2016

The Center for Economic Justice (CEJ) submits additional analysis in support of the proposal to
revise AG 49 to require AG 49-compliant interest rates be used for all illustrations on or after the
effective date.

The arguments in favor of the change, submitted by CEJ, AXA and the AAA include:¹

- Consistent application of the consumer protection of AG 49 for all consumer receiving an
  illustration on or after the effective date;
- Realistic illustrated interest rates for consumers receiving an updated illustration for a
  policy issued before the effective date;
- Ease of compliance for insurers and regulatory oversight by regulators compared to; a
  system of multiple interest rate regimes depending upon the date of policy issuance;
- Reduced expenses for insurers from elimination of multiple systems of interest rate
  calculations.

The arguments against the change, submitted by ACLI, AAA and ALIA include:²

- Confusion for consumers receiving an updated illustration;
- More expenses for insurers to maintain multiple systems.

During the discussion of AG 49 at the LATF meeting in San Diego, both arguments in
opposition were shown to be without merit.

Regarding expenses, ACLI admitted their argument was untrue. ACLI originally asserted:³

Illustration systems are often developed specific to the product. Once that product is no
longer being sold, those systems are no longer actively maintained. Being required to
modify numerous systems that have been set aside, for a very limited purpose, with no
demonstrated benefits seems to be a waste of industry resources.

¹ AXA letter of July 31, 2016; AAA letter of August 1, 2016, CEJ letters of July 31, 2016 and August 19, 2016
³ ACLI letter of July 31, 2016
CEJ Comments AG49 Effective Date
October 10, 2016
Page 2

During the LATF discussion in San Diego, however, ACLI admitted this claim had no merit. When asked about interest rates used for illustration in a replacement scenario, ACLI explained that the same interest rate was used for the replacement policy illustration and the existing policy updated illustration.

When asked about illustrations used for replacements, ACLI said:\(^4\)

an inforce illustration is used to either review a policy’s performance or to compare against another policy in a replacement situation. He said that, in a replacement situation, the inforce illustration and the illustration for the proposed replacement product both use the same specified interest rates.

Clearly, if the insurer can utilize the same interest rate for a current (prospective) replacement policy illustration as for the existing policy illustration, the insurer has the ability to use an interest rate compliant with AG 49 for updated illustrations of policies issued before the effective date. The original ACLI argument about alleged expenses associated “modifying numerous systems that have been set aside” is without merit.

Regarding alleged confusion among consumers, neither ACLI, AAA nor ALIA offered any empirical evidence to support their consumer confusion claim. While this consumer confusion claim is without merit on its face – somehow a consumer faced with a realistic interest rate in an illustration will be confused while a consumer faced with an unrealistic interest rate would be rational – ACLI, again, contradicted its original argument during the LATF meeting.

ACLI stated that during a replacement scenario, the same interest rate was used for the replacement policy illustration and the existing policy updated illustration. Consequently, industry practice, according to the ACLI, contradicts ACLI’s claim that using a different interest rate in an updated illustration than in the original illustration or using an interest rate compliant with AG 49 rather than an interest rate produced by the original pre-AG 49 methodology is “confusing” to consumers.

In conclusion, the arguments against applying Sections 4 and 5 to all illustrations on or after the effective date have been shown to be without merit. We urge LATF to revise AG 49 to make this important and overdue change to AG 49.

\(^4\) Draft Minutes of August 24-25, 2016 LATF meeting
November 12, 2019

Mr. Fred Andersen  
Chair, NAIC IUL Illustration (A) Subgroup  
Mr. Reggie Mazyck  
Life Actuary, NAIC

Re: Questions on IUL Illustrations

Dear Mr. Andersen and Mr. Mazyck,

Global Atlantic Financial Group, and Accordia Life and Annuity Company, appreciate the continued efforts of the IUL Illustrations Subgroup regarding the illustrations of Indexed Universal Life (IUL) products under Actuarial Guideline 49 (AG49), including the most recent exposure draft released on November 1, 2019. We look forward to continued engagement on this topic in the future.

Our March 8, 2019 comment letter recommended the following key areas of focus for any AG49 update:

1. The use of leverage via implied or explicit additional charges to the policy owner,
2. How the value of leverage is illustrated, and
3. How the outcome of leverage flows into illustrations that use participating loans.

We are pleased that the proposed changes to AG49 focus on these key areas and our comments below pertain to the questions asked with the November 1, 2019 exposure draft release. The proposed changes address a complex topic. Before adopting any changes, we encourage additional time be taken to both fully understand the issues and thoroughly vet the proposed updates.

Should the effective date for new policies be the later of 5 months after LATF adoption or 3 months after NAIC Executive/Plenary adoption?

An effective date corresponding to the later of 5 months after LATF adoption or 3 months after NAIC Executive/Plenary adoption is acceptable provided the version approved is materially consistent with current drafts. If substantial changes are made, additional time may be needed to effect the changes within illustration systems.

Should the revised guidelines be in place for inforce illustrations for policies sold before the effective date for new policies?

We support making the revised guidelines applicable for inforce policies sold before the effective date for new policies, assuming sufficient time is provided to implement the changes within inforce illustration systems. While requiring such policies to illustrate per the new guidelines may create confusion in some instances, having some IUL policies illustrate differently than other IUL policies due to their issue date can cause confusion for policyholders who look to compare policies with issue dates before and after adoption of the rule changes. Having the updated guidelines applicable to
all IUL brings uniform practice, a goal of AG49. We therefore recommend applicability to all inforce policies.

**Does the approach of having the disciplined current scale earned rate including or excluding the Supplemental Option Budget lead to the result of the multiplier product illustrating about the same as a non-multiplier product?**

For a result of multiplier products illustrating about the same as non-multiplier products, attention must be given to each of Sections 3, 4, 5 and 6. For this result within the disciplined current scale earned rate, the return on the Supplemental Option Budget, not its inclusion or exclusion, is required.

**If neither of the approaches mentioned in 3a leads to this result, is there an alternative approach that leads to this result such as providing explicit guidance in Section 4?**

As indicated above, each of Sections 3, 4, 5 and 6 must be considered to enact this result. We believe further improvements to the currently exposed draft are needed to meet the goal while at the same time eliminating unintended consequences and ambiguity.

Ambiguity is created due to Section 4.E of the current draft. Section 3.C.vi provides for multiple Benchmark Index Accounts due to different levels of account charges. Sections 4.A and 4.B provide for separate maximum crediting rates for each benchmark account. These account charges seem to meet the definition of a Supplemental Option Budget. The maximum illustrated rate per Section 4.E’s use of the Supplemental Option Budget does not seem to align with that of Sections 4.A and 4.B, thereby creating ambiguity that needs to be addressed.

Unintended consequences are created due to Section 6.B. Consider a loan interest rate of 4%. The total index credits cannot exceed 5%. Products may have a Supplemental Option Budget of 150bps. In this scenario, limiting the total index credits to 5% would result in a 3.5% net credited rate after the account charge. 100bp of loan leverage allowed for non-multiplier products is not available per the proposed wording for a multiplier product. The goal is to illustrate the same, yet the current draft exposure has the unintended consequence of disadvantaging multiplier products.

---

Thomas A. Doruska  
Head of Life Product Development

David P. Wilken  
President, Life
November 13, 2019

Fred Andersen
Chief Life Actuary
Minnesota Department of Commerce
Chair, NAIC IUL Illustration (A) Subgroup

Re: Comments to Exposure Questions 3a & 3b Regarding Actuarial Guideline 49

Fred:

This letter represents a joint response submitted on behalf of the following companies (the “Ad Hoc IUL Coalition”) responses to Questions 3a and 3b that were exposed on November 1; 2019.

Pacific Life
Lincoln Financial
Sammons Financial Group
John Hancock
National Life Group
Securian Financial

We appreciate the opportunity to provide the IUL Illustration Subgroup with our comments to these questions.

3a. Does the approach of having the disciplined current scale earned rate including or excluding the Supplemental Option Budget lead to the result of the multiplier product illustrating about the same as a non-multiplier product?

The self and lapse support tests require a comparison of accumulated policy cash flows to policyholder value (i.e. cash surrender value). The example below demonstrates the cash flows related to the index accounts that should be reflected in the self and lapse support tests. The example assumes that the
supplemental option budget is a negative cash flow when the options are purchased. The example demonstrates that the return from the supplemental option budget (assumed to be equal to the cost) must be included as a cash flow to offset the cost. Including this cash flow results in the policy cash flows growing by the same amount as the cash value of the policy. If the return from the supplemental option budget is not included as a cash flow, then the cash value grows by more than the policy cash flows, resulting in a multiplier product illustrating worse than a non-multiplier product.

Assumptions
Annual net investment earnings rate = Base account option budget = 4.5%
Base account option budget = 4.5%
Base account option return = 1.45 * 4.5% = 6.525%
Multiplier = 25%
Supplemental option budget = Base account option budget * multiplier = 4.5% * 25% = 1.125%
Supplemental option budget return = 1 * 1.125% = 1.125%
Account value charge to support multiplier = 1.125%

Scenario 1 - No multiplier, no Supplemental option budget
Scenario 2 - 25% Multiplier, Supplemental Option Budget = 1.125%, Supplemental option return included = 1.125%
Scenario 3 - 25% Multiplier, Supplemental Option Budget = 1.125%, Supplemental option return not included = 0%

<table>
<thead>
<tr>
<th>Scenario</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiplier</td>
<td>0%</td>
<td>25%</td>
<td>25%</td>
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<tr>
<td>Supplemental Option Budget return included in cash flows</td>
<td>n/a</td>
<td>Yes</td>
<td>No</td>
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Policy cash flows

<table>
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<tr>
<th>Scenario</th>
<th>1</th>
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</thead>
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<tr>
<td>Annual net investment earnings rate</td>
<td>4.500%</td>
<td>4.500%</td>
<td>4.500%</td>
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<tr>
<td>Base account option budget</td>
<td>-4.500%</td>
<td>-4.500%</td>
<td>-4.500%</td>
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<tr>
<td>Base account option return</td>
<td>6.525%</td>
<td>6.525%</td>
<td>6.525%</td>
</tr>
<tr>
<td>Supplemental Option Budget</td>
<td>0.000%</td>
<td>-1.125%</td>
<td>-1.125%</td>
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<tr>
<td>Supplemental option budget return</td>
<td>0.000%</td>
<td>1.125%</td>
<td>0.000%</td>
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<tr>
<td>Net impact on policy cash flows</td>
<td>6.525%</td>
<td>6.525%</td>
<td>5.400%</td>
</tr>
</tbody>
</table>

Policy cash surrender value

<table>
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<th>Scenario</th>
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<th>2</th>
<th>3</th>
</tr>
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<tr>
<td>Assumed annual index interest credited rate</td>
<td>6.525%</td>
<td>7.650%</td>
<td>7.650%</td>
</tr>
<tr>
<td>Account value charge to support multiplier</td>
<td>0.000%</td>
<td>-1.125%</td>
<td>-1.125%</td>
</tr>
<tr>
<td>Net impact on policy cash surrender value</td>
<td>6.525%</td>
<td>6.525%</td>
<td>6.525%</td>
</tr>
</tbody>
</table>

Regarding the question of including the supplemental option budget in the DCS earned rate, we believe that clarity is needed in the Section 5A of the guideline. One interpretation is that the supplemental option budget return should be included as part of the earned rate underlying the DCS. Another interpretation is that the return from the supplemental option budget is simply a return of the hedge cost and should not increase the earned rate. The example below demonstrates this alternative interpretation. A solution may be to clearly describe how the hedge return is to be included in the testing and whether it should be part
of the earned rate. If it is not part of the earned rate, the guideline should specify how the hedge return is incorporated in the testing.

**Alternative Interpretation:**

In calculating the net earned rate, the excess of the Hedge Proceeds over the Hedge Cost is added to Investment Income.

Net Earned Rate = Annual Net Investment Earnings Rate + Gain From Hedges.

In Scenario 1 (no Multiplier), the Hedge Payout is 6.525%, and the Hedge Cost is 4.500%.
Net Earned Rate = 4.500% + (6.525% - 4.500%) = 6.525%
This is the same answer as above.

In Scenarios 2 and 3 (Multiplier), the Total Hedge Payout is (6.525% + 1.125%) for 7.650%, and the Total Hedge Cost is (4.500% + 1.125%) for 5.625%
Net Earned Rate = 4.500% + (7.650% - 5.625%) = 6.525%

As the cost of the hedge purchased with the Supplemental Option Budget is clearly deducted in the determination of the Net Earned Rate, the definition of the Maximum Earned Rate need only consider the Gain from this hedge, which is 0% * 1.125%.
This approach assumes that the cost of the supplemental option budget is not a negative cash flow in the accumulation of policy cash flows.

If the cost of the hedge purchased with the Supplemental Option Budget were somehow not considered to represent a reduction in Investment Income, then the definition of the Maximum Earned Rate would need to include the full Supplemental Option Budget.
In this case, the "Net Earned Rate" would be 7.650% if we exclude the cost of the hedge purchased with the Supplemental Option Budget but include the cost of the hedge purchased with the Basic Option Budget.
This approach assumes that the cost of the supplemental option budget is a negative cash flow in the accumulation of policy cash flows.
3b. If neither of the approaches mentioned in 3a leads to this result, is there an alternative approach that leads to this result such as providing explicit guidance in Section 4?

Given the uncertainty over how Section 5A of the guideline is to be interpreted we are not prepared to say at this time whether an alternative approach is needed. Following clarification of our questions regarding interpretation we will consider whether further response to this question is required.

Respectfully Submitted,

Scott R. Harrison
Harrison Law Office, P.C.

cc: Reggie Mazyck, NAIC
November 12, 2019

Fred Andersen
Chief Life Actuary
Minnesota Department of Commerce
Chair, NAIC IUL Illustration (A) Subgroup

Re: Comments to Exposure Questions 1 & 2 Regarding Actuarial Guideline 49

Fred:

This letter is submitted on behalf of the following companies (“the Coalition”).

Lincoln Financial Group
Pacific Life
Sammons Financial Group
John Hancock Insurance

This letter serves as our response to questions 1 & 2 as set forth in the IUL Illustration Subgroup’s November 1, 2019 exposure. Our comments to questions 3a and 3b are contained in a separate letter submitted on behalf of an Ad Hoc Coalition of companies that formed to address those particular items.

We appreciate the opportunity to provide the Subgroup with our views on the November 1 exposure questions. We also appreciate the Subgroup’s recognition of the complexities associated with the proposed changes to AG 49 and the need for a timetable that allows sufficient opportunity for thoughtful review and analysis of proposed changes.
1. **Should the effective date for new policies be the later of five months after LATF adoption or three months after NAIC Executive/Plenary adoption?**

The exposure question contemplates that companies will need at least five months to implement the final changes to AG49 for new policies. We agree. Based upon our companies’ experience with the time and effort involved with making changes to policy illustration systems and related business processes, five months is a reasonable timeframe.

The question also contemplates that the implementation timeline could begin tolling before revisions are reviewed by the Life Insurance and Annuities (A) Committee and before final adoption by NAIC Exec/Plenary. The Coalition believes that the NAIC review and approval procedure for guidelines and models is essential to ensure appropriate input from all States and stakeholders. It is through this process the changes to AG49 will be considered final. Impacted companies will need to know what the final changes are before they can begin to implement them. Since there is a chance that the proposed revisions may not be the ones that are ultimately approved and adopted by the NAIC Executive/Plenary, the Coalition is extremely uncomfortable with any implementation period beginning before the full NAIC has reviewed and approved any changes to AG49.

Nonetheless, the Coalition understands that some regulators have expressed a strong desire to complete this process as soon as possible. The Coalition respectfully requests that should the implementation timeline begin tolling prior to final approval of any revisions by the NAIC Exec/Plenary that it be conditional upon the ability of companies could obtain additional time if needed should the changes to AG49 that are formally adopted by the NAIC differ from LATF’s recommendations.

2. **Should the revised guidelines be in place for inforce illustrations for policies sold before the effective date for new policies?**

As a policy matter the Coalition generally opposes the application to inforce policies of changes to existing regulatory requirements. The decision whether to apply any guideline or model to inforce business is an important policy decision that has broad impacts on consumers, producers, insurance markets, and companies. Applying model or guideline changes to inforce policies should only be done when a clear and compelling consumer benefit can be demonstrated.

No such compelling justification exists here. In fact, requiring companies to provide inforce illustrations to policyholders reflecting the proposed changes to the guideline would frustrate the purpose of the inforce illustration, create significant confusion for policyholders, and could create the conditions for unhealthy market activities such as improper replacements and churning.

Policyholders should have every expectation that inforce illustrations will provide a meaningful, accurate basis for comparison of the policy’s performance against previous illustrations. An inforce illustration serves an entirely different purpose than an illustration provided at the time of sale. With an inforce illustration, the decision to purchase has already been made and the policyowner depends upon inforce illustrations to provide a comparison of how their policy is performing from prior years. Applying the proposed revisions to inforce illustrations would deny
policyholders critical information about their policy’s performance relative to their expectations at the time of purchase, make meaningful comparisons extremely difficult if not impossible, make premium planning decisions more difficult, and would ensure that consumers receive incomplete and even distorted information. This could also lead to the perception that the underlying product is not performing as described in the illustration provided at the time of sale - when in fact the product mechanics have not changed.

It has been suggested that the 2016 application of the crediting rates to enforce policies under AG 49 serves as precedent for LATF to follow in this instance. We respectfully disagree. The imposition of new limits on crediting rates in 2016 is not an “apples to apples” comparison with the illustration of multipliers. A crediting rate is an *input* to a product illustration. A multiplier, on the other hand, is an optional *product feature* that is selected and paid for by the policyholder. A better comparison from AG49 can be found in the treatment of Sections 6 and 7, which were not applied to illustrations of policies issued before AG49’s effective date. The treatment of policy loans is relevant precedent for a different method of illustration for policies issued before a guideline change became effective.

As noted above, applying these proposed changes to enforce policies will result in illustrations that bear little to no resemblance to as-sold illustrations provided by the company. This could incentivize replacement recommendations by those seeking to capitalize on policyholder confusion and frustration. Such replacements may expose consumers to surrender charges, higher cost of insurance rates, and new contestable periods due primarily to a prohibition against generating enforce illustrations on comparable basis as the as-sold illustration.

For each of these reasons the guideline revisions should apply only to policies sold on or after the effective date of any changes.

Thank you again for the opportunity to comment. We appreciate the chance to provide input to the Subgroup and look forward to further discussions.

Respectfully Submitted,

[Signature]

Scott R. Harrison
Harrison Law Office, P.C.

cc: Reggie Mazyck, NAIC
November 12, 2019

Via e mail to Reggie Mazyck (RMazyck@naic.org)

Fred Anderson, Deputy Commissioner of Insurance
Minnesota Department of Commerce
Chair, NAIC IUL Illustration (A) Subgroup

Re: IUL Illustration Subgroup Request for Comments re Proposed Revisions to AG 49

Dear Mr. Anderson:

This letter will provide the comments of the National Association of Insurance and Financial Advisors (NAIFA) regarding the IUL Illustration Subgroup’s request for comments on certain questions relating to IUL illustrations, specifically question 2: “Should the revised guidelines be in place for inforce illustrations for policies sold before the effective date for new policies?”

Founded in 1890 as The National Association of Life Underwriters (NALU), NAIFA is one of the nation’s oldest and largest associations representing the interests of insurance professionals from every Congressional district in the United States. NAIFA members assist consumers by focusing their practices on one or more of the following: life insurance and annuities, health insurance and employee benefits, multiline, and financial advising and investments. NAIFA’s mission is to advocate for a positive legislative and regulatory environment, enhance business and professional skills, and promote the ethical conduct of its members.

As a general matter, NAFIA opposes the retroactive application of laws and regulations, including NAIC guidelines or models, to existing products. Retroactively
applying revisions made to NAIC models to inforce business/products is likely to confuse consumers and adversely impact the consumer/producer relationship and should only be considered when very compelling reasons exist.

NAIFA does not see any such compelling reasons in the current matter. If the proposed changes to AG 49 were to be applied retroactively to inforce business, it will result in consumer confusion and make it more difficult for consumers to comprehend how what is already a complex product is performing.

It is important to keep in mind that the AG 49 revisions being considered will only affect how the performance of these products is illustrated and will not change any of the terms or provisions of the IUL policy itself. Explaining to policyholders that there has been no change to the underlying product they purchased but that some of the potential benefits of the product can no longer be illustrated in the manner previously used due to changes in regulatory actuarial guidelines will be an exceedingly difficult task for the producer. Retroactive application is likely to cause confusion, erode the consumer’s confidence in his/her producer and could unfairly damage the reputation of producers who used illustrations that were in compliance with the rules in place at the time of sale.

Furthermore, retroactive application of the proposed AG 49 revisions may lead to the client’s perceiving that the policy is not performing as expected or as described in the original illustration, which could lead to inappropriate and costly surrenders and replacements of products. This would impose unnecessary costs on consumers, because they would be replacing a policy based on revised illustration requirements rather than on actual changes to the product itself.

NAIFA recognizes that regulators have concerns about some features of IUL products are illustrated and that the NAIC is therefore conducting an important review of AG 49. NAIFA members sell a wide variety of life insurance products from a broad range of companies, and NAIFA supports efforts to improve consumer understanding of these products and the important role they can play in financial planning. NAIFA does, however, request that the Subgroup be cognizant of the potential unintended impact that actions being considered by the Subgroup, such as those discussed in this letter, could have on both insurance producers and consumers.
NAIFA appreciates the opportunity to provide input to the Subgroup and thanks you for your work on this issue. If you have any questions, please feel free to contact me at gsanders@naifa.org.

Sincerely,

Gary A. Sanders
Counsel and Vice President, Government Relations
November 13, 2019

Fred Andersen
Chief Life Actuary
Minnesota Department of Commerce
Chair, NAIC IUL Illustration (A) Subgroup

Re: Comments to Exposure Questions Regarding Actuarial Guideline 49

We appreciate the opportunity to comment on the November 1 exposure questions.

Question 1: Should the effective date for new policies be the later of five months after LATF adoption or three months after NAIC Executive/Plenary adoption?

Recognizing that regulators have expressed urgency around this change, National Life Group would be supportive of the 5 month /3 month recommendation for the changes that would be required based on the draft updates to AG 49 that have been shared. Additional time may be needed if any modifications are made to the exposure. It's worth noting that beginning implementation after LATF approval, but prior to Executive/Plenary approval, is not typical.

Question 2: Should the revised guidelines be in place for inforce illustrations for policies sold before the effective date for new policies?

We recommend not applying revised guidelines to inforce illustrations for policies sold prior to changes made to AG49 language. If the basis of inforce illustrations are changed while the underlying product features have not changed, it could cause undue consumer confusion and disruption. This is consistent with how sections 6 and 7 are handled in the current version of the actuarial guideline for policies sold on or after the effective date.

Questions 3a/3b:

3a. Does the approach of having the disciplined current scale earned rate including or excluding the Supplemental Option Budget lead to the result of the multiplier product illustrating about the same as a non-multiplier product?

3b. If neither of the approaches mentioned in 3a leads to this result, is there an alternative approach that leads to this result such as providing explicit guidance in Section 4?

Our understanding of the stated objective is: if a product includes a charge to fund the multiplier, that product should illustrate the same as a comparable product design without a supplemental option budget. To accomplish this, the cost of the hedge should be offset with the hedge payoff. This is to ensure there is no double counting of the supplemental option budget or hedge payoff. In the absence of an explicit charge, the funding for the multiplier could come from the company’s net earned rate and may result in different total index credits.

We look forward to working with the rest of the industry and regulators to further clarify these questions.

Sincerely,
Ata Azarshahi
Pete Rothermel  
VP, CFO – Individual Life  
Nationwide Life Insurance Company  
Nationwide Life and Annuity Insurance Company  
One Nationwide Plaza, 1-10-201  
Columbus, Ohio 43215  
(614) 249-5947  
rotherp@nationwide.com

November 12, 2019

Mr. Fred Andersen  
Cc: Mr. Reggie Mazyck

Re: The NAIC IUL Illustration (A) Subgroup requested comments by November 12, 2019 on the following questions related to IUL illustrations. We also recommend a change in Section 6B on Policy Loans to more fully limit loan leverage to 100 basis points. We would be happy to discuss any questions you may have.

1. Should the effective date for new policies be the later of 5 months after LATF adoption or 3 months after NAIC Executive/Plenary adoption?

If Actuarial Guideline (AG) 49 is substantially similar to the November 1 version, we support the timeline noted here. If there are significant revisions, then we would like the opportunity to review and may suggest a longer timeline.

2. Should the revised guidelines be in place for inforce illustrations for policies sold before the effective date for new policies?

If the revisions are put in place for inforce policies, we recommend this apply one year after the effective date of the revised AG 49. This would allow time for customer and producer education.

3a. Does the approach of having the disciplined current scale earned rate including or excluding the Supplemental Option Budget lead to the result of the multiplier product illustrating about the same as a non-multiplier product?

The question of whether including or excluding the Supplemental Option Budget from Section 5A will lead to the desired result depends on how a company reflects hedge cash flows in their DCS testing.

Section 3.4.1(a) of Actuarial Standard of Practice 24: Compliance with the NAIC Life Insurance Illustrations Model Regulation states that in DCS testing, “investment return factors may be net of investment expenses or, alternately, investment expenses may be treated separately as expenses.” Below we describe these two methods for determining investment returns in DCS testing for an IUL product, and we show why the Supplemental Option Budget should be excluded from the DCS earned rate using Method 1 but included when using Method 2. We do not think that DCS testing is easier to pass under Method 1 or 2, nor do we think that either method should be preferred over the other.
Method 1: Investment Returns are Net of Investment Expenses

This method recognizes that hedge costs and general account investment earnings in the DCS cash flows approximately offset. Only the net investment return, which is the return from the hedge assets, limited to 145% times the Annual Net Investment Earnings Rate (NIER), is reflected in the DCS cash flows. Under this method, the cost of funding a multiplier is not a negative cash flow in the DCS, so it is not a cost that needs to be offset. For companies that use this method, the supplemental option budget should be excluded from Section 5A.

Maximum Net Investment Return = 145% * NIER

Method 2: Investment Expenses are Treated Separately as Expenses

Under this method, a company reflects both the gross investment returns and the corresponding investment expenses separately. This results in approximately the same net investment return as in Method 1, however there is an explicit negative cash flow to reflect hedge costs. A product with charges used to fund a multiplier will have higher hedge costs than an identical product without charges to fund a multiplier. Since these higher hedge costs are reflected in the DCS cash flows under this method, Section 5A needs a positive adjustment for the Supplemental Option Budget. This will offset the multiplier hedge costs and get to a net result that is neutral between multiplier and non-multiplier products under this interpretation.

Gross Investment Return = Gross Portfolio Earnings + Return from Hedge Assets

Investment Expenses = Core Hedge Costs + Multiplier Hedge Costs
                  + Other Investment Expenses & Default Costs

Net Investment Return = Gross Investment Return – Investment Expenses

= NIER + (Return from Hedge Assets – Core Hedge Costs – Multiplier Hedge Costs)

Note: NIER and Core Hedge Costs approximately offset

= Return from Hedge Assets – Multiplier Hedge Costs

Maximum Net Investment Return = 145% * NIER – Multiplier Hedge Costs

Note: Supplemental Option Budget is needed to offset Multiplier Hedge Costs

To accommodate both methods fairly, we suggest that the word “net” be added to the currently proposed wording in 5A as follows: “If an insurer engages in a hedging program for indexed Credits, the assumed net annual earned rate underlying the disciplined current scale...” Along with this change, we then suggest 5A(iii) read “0% times the Supplemental Option Budget.” We note that Section 5 places limits on DCS testing assumptions and does not directly limit illustrations. However, if allowance is not made appropriately for how multiplier product features can affect DCS testing, it may be more difficult or less difficult to pass DCS testing for products with a multiplier.
3b. If neither of the approaches mentioned in 3a leads to this result, is there an alternative approach that leads to this result such as providing explicit guidance in Section 4?

To limit multipliers in illustrations, Section 4 should be updated in addition to the Section 5 changes suggested above. We would also like to note that much of the discussion and proposed changes to AG 49 have centered around products with charges that are used for multipliers. There are also products with charges that are used to offer a higher cap, and how these will fit into the proposed changes to AG 49 is unclear.

Section 6B. Policy Loans

We suggest that the wording in Section 6B be adjusted as follows:

“If the illustration includes a loan, then the total amount credited as a result of the loan balance, including Indexed Credits and all other illustrated benefits and bonuses that impact the policy's account value, shall not exceed the sum of explicit illustrated loan charges and asset-based charges applicable to the loan balance by more than 100 basis points.”

Without including “all other illustrated benefits and bonuses that impact the policy's account value”, an IUL illustration could exceed the 100 basis point limit through other product features. Additionally, we believe that “asset-based charges” should be included to prevent products with a multiplier from illustrating worse than a product without a multiplier.

We view the actions that we have articulated above as being important preliminary steps to apply reasonable limits within IUL illustrations. We also look forward to continuing to work with the NAIC on the more holistic changes that need to be made to illustrations to provide more consumer clarity.

Again, we would welcome the opportunity to discuss our position further with you. I can be reached at (614) 249-5947.

Regards,

Pete Rothermel
VP, CFO – Individual Life
November 12, 2019

Filed Electronically

Fred Andersen
Chair, IUL Illustration (A) Subgroup
National Association of Insurance Commissioners

Re: Illustration of Index Multipliers under AG 49

Fred:

Thank you for the opportunity to respond to the questions exposed by the IUL Illustration (A) Subgroup on November 1 related to Actuarial Guideline 49 (“AG 49”). Pacific Life joins in the letter submitted by the Coalition, and submits this letter to underscore the importance of applying the currently proposed changes to AG 49 on a prospective basis only.

The primary purpose of infuse illustrations is to help consumers manage their life insurance policies into the future. Infuse illustrations allow consumers to adjust expectations based on the policy’s actual performance, relative to the assumptions contained in the as-sold illustration. To the extent actual policy performance differs from that assumed in the as-sold illustration, consumers may use infuse illustrations to help vary premium or coverage amounts. Instead, prohibiting the illustration of a multiplier feature for consumers who have already purchased the product – while the feature continues to function on these products – will lead to consumer confusion and a loss of confidence, and will frustrate the essential purpose of infuse illustrations.

The decision whether to apply any NAIC guideline retroactively is an important policy decision that has broad impacts on consumers, state insurance markets, insurance producers and companies. As such, Pacific Life respectfully requests that the Subgroup limit the proposed changes to prospective application, similar to its prior treatment of policy loans under Section 6 of AG 49.1

Very truly yours,

Ernest Armijos

1 See AG 49, Section 1.C, Effective Date.
November 13, 2019

Fred Andersen
Acting Deputy Commissioner of Insurance
Minnesota Department of Commerce
85 7th Place East, Suite 280
St. Paul, MN 55101

Dear Fred:

Thanks for your work and the Subgroup’s work to update the IUL Illustrations regulation (AG49). Below are our thoughts on the most recent exposed version of AG49 and answers to the questions proposed by the subgroup on November 1st.

General thoughts:

- Securian believes that the conversation and proposed changes to AG49 are a positive and necessary step forward and appreciate the thought and work put in by the subcommittee to get the industry to this point.
- Securian directionally agrees with the changes being made. We also believe that there are several outstanding issues that are not in relation to Section 5A of AG49 that deserve attention to assure transparency and clarity for consumers.
  - Section 4: for greatest clarity, Securian would suggest clearer language in Section C to bring consistency on how carriers illustrate non benchmark indices. We have made recommendations in the past and re-iterate them below.
  - Section 4: Securian agrees with Suggestion 4E in the most recent exposed draft of AG49—Tying the maximum total amount of crediting in any year of the illustration to the Annual Earned interest rate underlying the Disciplined Current Scale defined in Section 5 of AG49
  - Section 6: Securian agrees that Policy loans and the application of 100bps should include all credits
  - Securian believes that several of the Additional Disclosure items discussed would provide increased consumer transparency and understanding and would like the group to continue to pursue them.
    - Developing uniform policy cost and sequence of return disclosures being our top two items to focus on after AG49 gets finalized.
- Securian recognizes the process has been grueling to this point and encourages everyone to see the changes come to a conclusion by years end.

Comments to the questions posed on Nov 1st

- Q1: Should the effective date for new policies be the later of 5 months after LATF adoption or 3 months after NAIC Executive/Plenary adoption?
  - Securian believes 5 months after LATF adoption is an appropriate amount of time to make the required changes and receive final approval from the NAIC Executive/Plenary committee.
  - Securian believes that after LATF adoption the expectations for future illustrative practices will have been set for IUL illustrations.
• We believe that the NAIC Executive/Plenary adoption is going to approve the recommendation of LATF and therefore waiting for a timeframe after the NAIC adoption is unnecessary.
• We understand that it will take time for carriers (including Securian) to change their illustration systems to accommodate the new regulation.
• Based upon our experience and consulting with other carriers, 5 months seems like a reasonable amount of time to make the changes considering the amount of time that has elapsed to date.

• Q2: Should the revised guidelines be in place for Inforce illustrations for policies sold before the effective date for new policies?
  o Securian believes that the recommended changes to AG49 should be applied to inforce contracts without regard to when they were sold.
  • The existing AG49 and changes to the model illustration law have created a precedent suggesting application to inforce contracts sold prior to the regulations being updated/adopted.
  • The Subgroup’s direction indicates that greater clarity and transparency is required on all IUL contracts with multipliers.
  • Securian believes that if the adopted changes do not apply to inforce contracts two things will happen:
    • Carriers that currently have large multipliers will continue to show current illustrations, which the subgroup has already determined aren’t appropriate, till the last possible date.
    • Inforce illustrations will continue to reinforce the unrealistic expectations set by original sales illustration. It is always better to reset expectations sooner than later.
  • There would be additional work on the carrier’s part to support two sets of illustration code for policies on the same policy form that are sold before and after the effective date. This would be confusing to agents, consumers and the carriers.

• Q3a: Does the approach of having the disciplined current scale earned rate including or excluding the Supplemental Options Budget lead to the result of the multiplier product illustrating about the same as a non-multiplier product?
  o We believe that changes included in the last exposed draft of AG49 do a reasonable job in having products that have a charged for multiplier/bonus illustrate very similarly to a non-multiplier product.
  o As with the original draft of AG49 the existence of the 145% in Section 5A will allow for a “included” multiplier/bonuses to illustrate slightly better than a product without one.
  o We believe that the most recent draft including 0% of the Supplemental Options budget will be effective in limiting the benefits of charged for multipliers.
  o Securian believes that if you include the Supplemental Options Budget we need to define further what constitutes cash flows from DSC testing standpoint to ensure there isn’t the ability to game the system. We are still currently thinking about what the added definitions would look like and plan to have some comments in Q3b but plan to further build them out by the next call for comments at the end of this month.

• Q3b: If neither of the approaches mentioned in 3a leads to this result, is there an alternative approach that leads to this result such as providing explicit guidance in Section 4?
  o Need to introduce new definitions
    • Base Options Budget: The lesser of the Annual Net Investment Earnings Rate and the portion of the Annual Net Investments Earnings Rate used to provide the Cap, Floor, and Participation Rate of the index being tested.
• **Supplemental Options Budget**: The total amount spent to generate the Index Credits of the index being tested minus the Base Options Budget of the index being tested. The amount is expressed as a percentage of the policy’s indexed account value.

• **Hedging Cash Flows**: For the purpose of DCS testing hedging cash flows will be defined as such
  - **Hedging Expense**: The expected cost of the hedging instruments used to support the Index Credits of the index being tested.
  - **Hedging Payoff**: Cannot exceed the Supplemental Options Budget of Index being tested.

With the definition of Hedging Cash Flows then 5A could change to be
  - Base Options Budget plus
  - Base Options Budget * 45% plus
  - 100% times the Supplemental Options Budget

Without the definition of Hedging Cash Flows I am still leaning to 5A needing to be
  - Base Options Budget plus
  - Base Options Budget * 45% plus
  - 0% times the Supplemental Options Budget

We believe this would make all multipliers regardless of if they are “included or charged for” illustrate the same as a non-multiplier product.

Again, if you would like to have a discussion about any of these topics please reach out to me and I would be happy to expand upon them.

Respectfully,

Seth Detert
Director & Actuary, Life & Annuity Products
Draft: 11/26/19

IUL Illustration (A) Subgroup
Conference Call
November 1, 2019

The IUL Illustration (A) Subgroup of the Life Actuarial (A) Task Force met via conference call Nov. 1, 2019. The following Subgroup members participated: Fred Andersen, Chair (MN); Ted Chang (CA); Andy Greenhalgh (CT); Mike Yanacheak (IA); Vincent Tsang (IL); Rhonda Ahrens (NE); Bill Carmello (NY); Peter Weber (OH); Mike Boerner and John Carter (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA). Also participating was: Rachel Hemphill (TX).

1. Discussed Comments on the IUL Illustration Menu of Options

Mr. Andersen acknowledged that the targeted timeline was aggressive. He said to avoid mistakes, the plans for addressing the changes to Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49) are being extended. He said the immediate focus is to address the remaining major issues by Nov. 14 and clear up the technical issues in time for exposure of the revisions at the Fall National Meeting. One of the major issues identified was the impact of the effective date on in-force illustrations. A second major issue is that companies need four to five months of lead time for the implementation of new standards. Mr. Andersen said the proposed revision to AG 49 provides a May 1, 2020, effective date. Birny Birnbaum (Center for Economic Justice—CEJ) said the effective date cannot be determined until the revisions are final. He suggested an effective date that is three months after revisions are final. Mr. Andersen said members of industry have suggested five months of lead time. Mary Bahna-Nolan (Pacific Life) said five months is more realistic, given that companies tend to prohibit system changes in the month of December. Mr. Boerner clarified that the timing being discussed is in reference to adoption by the Life Actuarial (A) Task Force. Mr. Andersen said he will redraft the AG 49 revisions to reflect the discussion. Reggie Mazyck (NAIC) said the effective date of the initial version of AG 49 was five months after its adoption by the Task Force.

Mr. Andersen asked whether the new illustration standards should apply to in-force illustrations. Ms. Hemphill said the issue of in-force policies is very different from the issue of sales illustrations. She said applying the standards to in-force policies would be somewhat problematic. Ms. Ahrens said in-force policies should be grandfathered. Mr. Tsang said he believes the new standard should apply to in-force policies being considered for replacement.

Donna Megregian (Reinsurance Group of America—RGA) said the earned rate of the disciplined current scale (DCS) does not drive what goes into the policy. She agreed to provide a numerical example in the following weeks. Mr. Andersen suggested that Ms. Megregian could discuss the issue further at the Fall National Meeting. Mr. Yanacheak opined that Section 4 of AG 49 is the appropriate place for changes.

Mr. Andersen said the issues on which comments will be solicited for the next conference call are:

1) The timing of the effective date of changes to the guideline.
2) The potential impact on in-force illustrations.
3) Coordination of Section 4 and Section 5.
4) Whether the supplemental option budget should be included in the DCS test.

Having no further business, the IUL Illustration (A) Subgroup adjourned.
The IUL Illustration (A) Subgroup of the Life Actuarial (A) Task Force met via conference call Sept. 16, 2019. The following Subgroup members participated: Fred Andersen, Chair (MN); Ted Chang (CA); Andy Greenhalgh (CT); Mike Yanacheak (IA); Vincent Tsang (IL); Rhonda Ahrens (NE); Bill Carmello (NY); Peter Weber (OH); Mike Boerner and John Carter (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed Comments on the IUL Illustration Menu of Options

The Subgroup heard comments on the two questions exposed at the Summer National Meeting. The first question asked, “Should a product with a multiplier feature illustrate a higher scale than a product without multiplier features?” The second question asked, “To what extent should the 145% disciplined current scale (DCS) factor apply to charges supporting bonuses and multipliers?”

Mr. Andersen said the Subgroup will narrow the range of potential solutions. Those solutions will then be offered to the Life Actuarial (A) Task Force for consideration. He said once the Task Force decides on a direction, the task of implementing a solution will be the responsibility of the Subgroup. He provided five possible options for discussion:

1) The illustrated rate is not adjusted to offset multiplier charges, resulting in a multiplier product not illustrating, as well as a non-multiplier product.

2) The illustrated rate is adjusted to exactly offset multiplier charges, resulting in a multiplier product illustrating the same as a non-multiplier product.

3) The illustrated rate is adjusted up to 1% annually to a level that slightly more than offsets multiplier charges, resulting in a multiplier product illustrating slightly better than a non-multiplier product.

4) The illustrated rate is adjusted by 1%–2% annually, resulting in a multiplier product that illustrates significantly better than a non-multiplier product.

5) The illustrated rate is adjusted by more than 2% annually, resulting in a multiplier product that illustrates substantially better than a non-multiplier product.

Donna Megregian (American Academy of Actuaries—Academy) discussed the Academy comment letter (Attachment Twenty-Seven-A). She said because of their differing risk profiles, it may be reasonable that multiplier and non-multipliers illustrate differently. She indicated that more clarification of the possible options is necessary and that more disclosure is required.

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comment letter (Attachment Twenty-Seven-B) in largely consistent with the Academy letter. He said illustrations should appropriately reflect the risk profile of all the features in the policy. He noted that the mechanics of the policy should be understandable for the policyowner. Mr. Bayerle agreed that further clarification from state insurance regulators is necessary.

Birny Birnbaum (Center for Economic Justice—CEJ) said the CEJ comment letter (Attachment Twenty-Seven-C) indicates a preference for possibility #2. He suggested that the Subgroup’s actions should be focused on addressing illustration excesses, before sending the issue to the Life Insurance and Annuities (A) Committee for consideration of enhanced disclosures for all products. Mr. Birnbaum stressed the importance of consumer testing of any enhancements to disclosures.
Ernest Armijos (Pacific Life) said the comment letter from Lincoln Financial Group, Pacific Life and Sammons Financial Group (Coalition) (Attachment Twenty-Seven-D) advocates application of the 145% to all options in the disciplined current scale testing and setting guardrails to protect consumers against continually increasing charges. The comment provides an example of disclosure enhancements that displays a breakout of charges, provides information on the potential impact of index volatility on accumulated values and the downside risk of the product including the multiplier. He indicated that the Coalition preference is closer to possibility #5.

The Nationwide comment letter (Attachment Twenty-Seven-E) indicated that products with multipliers, bonuses and additional credits should be permitted to illustrate a higher scale than a non-multiplier product, with a reasonable limit. The letter recommends limiting charges to 50% of the product hedge budget. The Nationwide comments favor a proposal that is close to possibility #4.

Mr. Armijos said the Pacific Life comment letter (Attachment Twenty-Seven-F) is supportive of the Coalition letter and reiterates Pacific Life’s belief that any proposed limit on illustrations should reflect sound actuarial principles and reasonable assumptions.

Seth Detert (Securian Financial) said the comment letter (Attachment Twenty-Seven-G) jointly submitted by Securian Financial, Penn Mutual and Mutual of Omaha lays out three alternatives. The first alternative aligns with possibility #1 or possibility #2. The second and third alternatives align with possibility #3 or possibility #4. He said the letter also provides several disclosure proposals and recommends modifications to the language related to the illustration of the arbitrage limit for variable and indexed loans.

In a separate comment letter (Attachment Twenty-Seven-H), Securian Financial addresses that company’s principles applicable to the illustrations and provides a demonstration (Attachment Twenty-Seven-I) of providing transparency to consumers.

Ms. Ahrens said the illustration of multipliers should be allowed, and there should be discussion about the applicability of the 145% DCS factor to all charges.

Mr. Carmello said illustration disclosures should be enhanced. He expressed support for possibility #2.

Mr. Weber said his preference lies between possibility #3 and possibility #4.

Mr. Sartain said he supports the Securian Financial proposal.

Mr. Yanacheak said he supports possibility #4 or possibility #5.

Mr. Andersen said the next discussion of the issue will occur during a Life Actuarial (A) Task Force conference call.

Having no further business, the IUL Illustration (A) Subgroup adjourned.
September 4, 2019

Mr. Fred Andersen
Chair, IUL Illustration (A) Subgroup
National Association of Insurance Commissioners

Dear Mr. Andersen,

The Life Illustrations Work Group (“the Work Group”) of the American Academy of Actuaries \(^1\) appreciates the opportunity to provide comments on the questions exposed August 2, 2019, by the IUL Illustration (A) Subgroup regarding the illustrations of Indexed Universal Life (IUL) products under Actuarial Guideline XLIX (AG 49). These comments pertain to those questions.

1. Should a product with a multiplier feature illustrate a higher scale than a product without multiplier features?

The Work Group believes that products with multiplier features could reasonably illustrate differently than products without multiplier features, assuming the products with multipliers have a different risk/return profile than products without a multiplier. The different risk return profiles could cause products with multipliers to illustrate higher or lower than products without multiplier due to factors such as option costs, different market exposure, and other product features. We are also supportive of making illustrations clearer with regard to the potential higher costs associated with the multiplier features.

2. To what extent should the 145% disciplined current scale factor apply to charges supporting bonuses and multipliers?

The Work Group’s response to this question is dependent on the intent of the 145% factor and what it applies to. As stated in our June 27, 2019, letter, some actuaries could interpret the 145% factor as imposing a limit on the return of the general account assets when hedging is used, while other actuaries may interpret the 145% factor as imposing a limit on the return on the assets supporting the hedge. Other interpretations may apply. Given the variety of possible interpretations, the Work Group thinks clarification is needed on the intent of the 145% factor, and what it applies to when charges are used to purchase additional assets that may enhance returns on IUL products.

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\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
The Work Group appreciates the efforts of the IUL Illustration Subgroup to review AG 49. If you have any questions or would like further dialogue on the above topics, please contact Ian Trepanier, life policy analyst, at trepanier@actuary.org.

Sincerely,

Donna Megregian, MAAA, FSA
Chairperson, Life Illustrations Work Group
American Academy of Actuaries
September 6, 2019

Mr. Fred Andersen
Chair, NAIC IUL Illustration (A) Subgroup

Re: Indexed Universal Life (IUL) Illustration Subgroup Questions

Dear Mr. Andersen:

The American Council of Life Insurers (ACLI)\(^1\) appreciates the opportunity to submit the following responses to most recent questions posed by the IUL Illustration Subgroup. ACLI supports life insurance policy illustrations that help consumers determine the policy that is best suited for their needs. Consumers need to understand the risk/reward trade-offs inherent in the various policies and indices being considered. In that vein, we submit the following responses:

**Question 1:** Should a product with a multiplier feature illustrate a higher scale than a product without multiplier features?

**ACLI Response:** Consistent with our prior comments, ACLI believes that illustrations should appropriately convey to customers the risk/reward profile of all product features.

**Question 2:** To what extent should the 145% disciplined current scale factor apply to charges supporting bonuses and multipliers?

**ACLI Response:** Consistent with our prior comments, ACLI is supportive of clarification around the application of the 145% disciplined current scale (DCS) factor.

In an effort to help regulators understand the application of the 145% DCS factor under two interpretations, descriptions of the two interpretations are provided below and numeric examples of the calculation of the year one total net earnings rate are provided in Appendix One. These examples are simplified to convey the general application of the two interpretations, and do not directly correspond to any one company’s interpretation. Appendix One presents three examples: a product without a multiplier, and a product with a multiplier under the following two interpretations:

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\(^1\) The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. 90 million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. Learn more at [www.acli.com](http://www.acli.com).
Interpretation #1: The maximum interest earnings rate that applies to a multiplier’s option budget is 145% of the net investment earnings rate of the General Account assets excluding the hedges allocated to the product (4.5% * 145% = 6.525% as shown in the example).

Interpretation #2: The maximum interest earnings rate that applies to a multiplier’s option budget is 45%. We note that under this interpretation, the same results are obtained if you use the options budget x 45% or if you use the notional amount x 145% x net investment earnings rate (NIER). However, we chose not to illustrate that for ease of comparison of the two primary interpretations.

Mechanically, the calculation of the total net earnings rate of the two interpretations are similar, except for the assumed return rate on the option budget. The total net earnings rate in both interpretations can be decomposed into two components: the base policy net interest earnings (which can be further decomposed into the general account net interest earnings and the base policy options net interest earnings), and the multiplier’s net interest earnings. The calculation of these values are as follows:

A. General account net interest earnings: account value after charges times the NIER.

B. Base policy options net interest earnings: base policy option budget (notional amount after charges times option cost) times the maximum 45% return.

C. Base policy net earnings: the sum of A and B. Additionally, this could also be calculated directly as the product of the notional value after charges times the NIER times the 145% limit.

D. Multiplier net interest earnings: multiplier’s option budget times the assumed return. This return is what would vary between the two interpretations:

   Under Interpretation #1, it is assumed to be the option budget times NIER times the 145% limit.

   Under Interpretation #2, it is assumed to be the option budget times 45%. We note that Interpretation #2 is equivalent to the notional amount of the multiplier (the multiplier times the base notional amount) times the NIER times 145% all less the option budget.

Additional information and assumptions can be found in the appendix. We have separately provided these examples as an Excel Spreadsheet (Attachment 1) to allow regulators and interested parties to step through the calculations.

We look forward to a discussion of these questions on a future Subgroup call. Thank you.

Sincerely,

Brian Bayerle
Senior Actuary

cc Reggie Mazyck, NAIC
## Simple Examples of Section 5A Interpretations

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Simplifying Assumptions</th>
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<tbody>
<tr>
<td>Net investment earnings rate (NIER) (= base policy’s option budget) = 4.5%</td>
<td>1) No premiums and no charges other than multiplier charge</td>
</tr>
<tr>
<td>Multiplier = 50%</td>
<td>2) No lapses and deaths</td>
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<tr>
<td>Multiplier’s charge (= multiplier’s option budget) = 2.200%</td>
<td>3) Span a single policy year only</td>
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### General Account Net Interest Earnings

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<thead>
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<th>a</th>
<th>Account Value @ B of Y before Multiplier Charge</th>
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<td>b</td>
<td>Multiplier’s Charge</td>
<td>Not Applicable</td>
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<tr>
<td>c = a - b</td>
<td>Account Value @ B of Y after Multiplier Charge</td>
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<tr>
<td>d = NIER</td>
<td>GA Net Investment Earnings Rate</td>
<td>4.50%</td>
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<tr>
<td>e = c x d</td>
<td>General Account Net Interest Earnings</td>
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### Base Policy’s Option Net Interest Earnings

| f = c | Base Policy’s Notional Amount | $100,000 |
| g = f x NIER | Base Policy’s Options Budget | $4,500 |
| h = 45% | Return on Options Budget | 45% |
| i = g x h | Base Policy’s Option Net Interest Earnings | $2,025.00 |
| j = e + i | Base Policy’s Net Interest Earnings | $6,525.00 |
| k = j / c | 145% of net investment earnings rate (NIER) | 6.525% |

### Multiplier’s Net Interest Earnings

| l = f x Multiplier | Multiplier’s Notional Amount | $48,900 |
| m = b | Multiplier’s Options Budget | $2,200 |
| n | Return on Options Budget | 6.525% |
| o = m x n | Multiplier’s Net Interest Earnings | $143.58 |
| p = j + o | Total Net Interest Earnings | $6,525.00 |

### IUL Product with a Multiplier

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W:\National Meetings\2019\Fall\TF\LA\IUL Illustration SG09 16\ACLI Comments on Exposed IUL Questions
Comments for the Center for Economic Justice

To the NAIC IUL Illustration (A) Subgroup

Questions Regarding Proposed Changes to AG 49

September 6, 2019

In response to the problem of misleading illustrations associated with new products designed to game AG 49, the subgroup requested stakeholder comment on two questions:

- Should a product with a multiplier feature illustrate a higher scale than a product without multiplier features? **CEJ Answer: No.**

- To what extent should the 145% disciplined current scale factor apply to charges supporting bonuses and multipliers? **CEJ Answer: The 145% scale factor should be changed to 100%**

Discussion:

CEJ believes there is clear evidence that new IUL products that feature bonuses and multipliers have been designed to create fabulous illustrations – illustrations which demonstrate extraordinary accumulation and returns for the policyholder but which are misleading and deceptive.

What is the evidence? First, AG 49 was created to stop the use of unrealistic crediting rates which produced unrealistic and misleading illustrations of product operation. After AG 49, we see product designs that, despite lower crediting rates and much greater expenses than for prior products, produce significantly greater accumulation values.

Second, we see significant amounts of premium-financed IUL – meaning that people are borrowing money to “invest” in an IUL. Why would such a sales practice ever be successful? Because the illustrations show steady crediting rates significantly greater than the loan interest rates charged and, consequently, showing a risk-free arbitrage opportunity that, in reality, doesn’t exist.
Third, we are seeing product designs that contradict the stated purposes of IULs – to protect policyholders’ assets against downside risk – by putting consumers into products that are effectively pure option bets and riskier than if the consumer invested in the index itself. And with the asset charges associated with the bonuses and multipliers, the risk of downside loss is created. The argument that these products provide “consumer choice” is a red herring. Suppose a consumer wants to buy a government bond to avoid risk. Do we now see government issuers creating bond-option combinations to give consumers a “choice” of risk return? Of course not. If a consumer wants a riskier investment, they buy something other than a bond. If a consumer wants an insurance product that includes downside risk, they buy something other than an IUL policy that promises volatility protection and lack of downside risk. It is a fundamental contradiction to suggest that consumers are seeking “risk-return choices” within a product specifically created to eliminate risk to the consumer.

Fourth, if the new multiplier/bonus products were, in fact, created to meet consumer demands, we would expect to see the same features demanded by consumers for fixed indexed annuities. Putting aside the complete absence of any evidence of such consumer demand, the use of bonuses and multipliers is generally not found with FIA products. The fact that indexed products designed with bonuses and multipliers are found in IUL and not with FIA makes clear that the new multiplier/bonus designs are not responding to consumer demands but intended to juice the sales process with fabulous illustrations.

Fifth, we see illustrations that, because of unrealistic accumulation values and sequence and loan interest rate arbitrage, indicate a policyholder can “borrow” money from the IUL and never repay the loan with little or no impact on overall accumulation or premium payments – effectively, illustrating an IUL as if it were an ATM machine.

The entire illustration regime for life insurance and annuities requires a thorough overhaul – illustrations intended to explain the operation of a product are doing the opposite. Illustrations are omitting the significant risk of return sequence, among other problems. So the question becomes, what are the best immediate actions to take as a path to the broader rehabilitation of illustrations?

**For AG 49 and IUL Illustrations, that path consists of:**

1. Reducing the options budget for illustrations to 100%
2. Requiring products with bonus/multiplier features to illustrate the same as products without such features.
3. Eliminating loan arbitrage by requiring loan rates be no less than crediting rates for purposes of the illustration
4. Adopting these changes as soon as possible with a recommendation to the Life Insurance A Committee that these changes are a tourniquet to stanch the bloodletting and that a broader examination of and development of a re-imagined approach to illustrations is needed to better demonstrate the operation of the product, to overcome the limitations and misleading features of current illustrations and to ensure a consistent approach across all indexed products.
With regard to the two specific questions posed by the subgroup (and the issue of loan arbitrage), we suggest that anything short of an outright ban on the practices in question will simply allow insurers to find new ways to game the requirements of AG 49. Given the absence of any requirement to show volatility of returns or impact of sequence of returns, any opportunity to game the crediting rate limitation in AG 49 will be taken to make a company’s product illustration more “competitive.” Limiting what can be illustrated does not stop an insurer from developing new product features and explaining those product features to the consumer. Rather, limiting what can be illustrated stops the use of misleading illustrations to create misleading sales.

Regulators have the opportunity to limit the damage that will inevitably occur to consumers and to the life insurance industry as a result of overly complex products marketed with misleading illustrations that will fail to perform as suggested and may leave consumers far worse off than with simpler, lower fee products. We’ve seen the scandals with vanishing premium, unexpected dramatic increases in costs of insurance for universal life and others. We urge regulators to take action before more damage is done.
September 6, 2019

Fred Andersen
Deputy Commissioner of Insurance
Minnesota Department of Commerce
Chair, NAIC IUL Illustration (A) Subgroup

Re: Comments to the IUL Illustration (A) Subgroup Questions regarding Actuarial Guideline 49

Fred:

This letter is submitted on behalf of the following companies (“the Coalition”).

Lincoln Financial Group
National Life Group
Pacific Life
Transamerica

Thank you for the opportunity to respond.

This letter provides the Coalition’s response to questions that were exposed for comment by the IUL Illustration Subgroup on August 2, 2019. In addition, this letter also (1) addresses other points raised during the Subgroup discussion at the recent NAIC Summer National Meeting in New York City, and (2) proposes a solution that enhances consumer protections and regulatory controls over IUL products containing multipliers while ensuring that IUL products can continue to evolve to meet consumer needs.

The Coalition believes multiplier features offer consumers meaningful value and are an appropriate choice for some consumers. They offer consumers the potential to meet long-term
protection and accumulation needs at a lower premium than other IUL designs. That said, we acknowledge regulatory concerns about the effect of multipliers on current product illustrations and the potential to influence consumer expectations. As discussed in more detail below, the Coalition proposal offers a three-part solution that includes new guardrails on how illustrations reflect multiplier features.

A. Responses to IUL Illustration (A) Subgroup Questions:

1. Should a product with a multiplier feature illustrate a higher scale than a product without multiplier features?

Response: Yes. A core purpose of product illustrations is to foster consumer education. Therefore, product illustrations should incorporate actual product mechanics. In the case of multiplier features, an illustration should include both the associated additional charges and credits. For at least some product designs, this would lead to a higher disciplined current scale and a lower guaranteed scale, thus demonstrating potential benefits and risks of the multiplier feature.

It has been suggested that it may be possible to describe multiplier features to customers without the benefit of including such features in product illustrations. We believe that such an approach is contrary to existing regulatory guidance and would be detrimental to consumers for the following reasons:

- It would conflict with the educational goals of both the NAIC’s Life Insurance Illustrations Model Regulation\(^1\) and AG49\(^2\) by denying consumers the illustration of actual product mechanics.

- It would leave producers on their own to determine how best to describe the effect of multipliers. Unlike riders that provide supplemental benefits (such as waiver of premium or accidental death benefit), the cost and benefits of multipliers are not easily described and must be illustrated to demonstrate the impact on the account value. We believe that consumers are best served if the information provided about multipliers has a degree of consistency across products.

- It would mislead consumers about the benefits and risks of multipliers. Even if the benefits of a multiplier are not illustrated, insurers may nonetheless be obligated to illustrate any related charges in order to comply with the Life Illustrations Model Regulation, effectively ensuring that IUL products with multiplier features would illustrate at a lower rate than IUL products without such features. Such a proposal would not help consumers understand a multiplier feature or its risks.

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\(^1\) "The purpose of this regulation is to provide rules for life insurance policy illustrations that will protect consumers and foster consumer education." Life Insurance Illustrations Model Regulation, Sec. 1 (2001).

\(^2\) "This guideline . . . [requires] additional consumer information . . . that will aid in consumer understanding. Actuarial Guideline XLIX, Background (2016).
Finally, the Coalition acknowledges that Section 5A of AG49 does not explicitly address how product illustrations should reflect multiplier features. For the following reasons, we believe that the most reasonable reading of the current language of AG49 is that the full inclusion of multipliers in product illustrations is currently allowed:

- It is widely acknowledged that multiplier features were uncommon at the time that AG49 was promulgated. The drafting of the guideline did not contemplate such features. Accordingly, the guideline is silent on how such features should be treated.

- The language in Section 5A established a principle for how purchased options should be handled in an AG49-compliant illustration. In the absence of specific guidance, it is a logical extension to apply the same principle to options supporting a multiplier that have identical economic value.

2. **To what extent should the 145% disciplined current scale factor apply to charges supporting bonuses and multipliers?**

**Response:** Options funded by any source, whether by the Net Investment Earned Rate or by policy charges (whether explicitly dedicated to a product feature or implicitly included in typical policy charges), are economically identical. As such, the 145% disciplined current scale factor should be applied to all options in the DCS testing.

It has been suggested that a way to create a guardrail on multipliers would be to reduce the assumed return on options that support multiplier-related features. Not only is this economically inconsistent, it would lead to practical challenges when applied to products where such charges for such options are not explicitly identified. Therefore, we do not believe that such a guardrail would be effective in practice, at least on a standalone basis.

**B. Proposal to Add Guardrails and Enhanced Disclosure:**

Acknowledging regulatory concerns, the Coalition proposes a three-part solution that would involve modifying AG49 to clarify the treatment of multipliers, impose new guardrails, and enhance consumer education through disclosure. We believe that this solution would enhance both consumer protection and education.

With respect to guardrails, as a guiding principle we believe that any proposed limit on the illustration of benefits should be derived from sound principles and reasonable assumptions. The new guardrails should ensure that illustrations of multipliers are consistent with regulatory goals. They should also avoid creating an illustration advantage to economically similar product features, which could include various designs of index accounts, including accounts with multipliers, higher caps or other parameters.
Specifically, we propose:

1. Imposing a set of guardrails that would involve some combination of the following:
   a. Allowing the illustration of benefits only up to a stated maximum percentage of implicit and explicit indexed account value-based charge;
   b. Allowing the illustration of benefits only up to a maximum indexed-based multiplier;
   c. Limiting the difference between multiplier-related benefits and charges in the DCS; and/or
   d. Allowing the application of the 145% to the hedge budget up to a stated maximum percentage of the account value.

2. Clarifying that the 145% limitation imposed by Section 5A of AG49 is applicable to all options in the DCS testing, for reasons described above. Below are two potential ways to achieve this:
   a. Revise Section 5A of AG49 to state: If an insurer engages in a hedging program for index-based interest, the assumed earned interest rate underlying the disciplined current scale shall not exceed 145% of the annual net investment earnings rate plus any explicit or implicit charges supporting the hedge budget.
   b. Revise Section 5 of AG49 to state: If an insurer engages in a hedging program for index-based interest, the ratio of the assumed hedge payout to the assumed hedge cost may not exceed 145%. Further, to ensure clarity, add the following: The cost of the hedge shall be included as a cash flow out, and the payout of the hedge shall be included as a cash flow in. Hedge cash flows and liability cash flows, including taxes, will be accumulated at the annual net investment earnings rate of the general account assets (excluding hedges for index-based credits) allocated to support the policy.

3. Providing more effective disclosure to consumers by:
   a. Requiring a mandatory breakout of charges on illustrations. These sections are typically already available but are not currently mandatory.
   b. Requiring consumers to receive clear and concise information on: (1) the potential impact on accumulated values of index volatility; and (2) downside risks of the product, including any multiplier. An example of how this could be done can be found in Appendix 1.
We appreciate the opportunity to provide input to the Subgroup and look forward to further discussions.

Respectfully Submitted,

Scott R. Harrison
Harrison Law Office, P.C.

cc: Reggie Mazyck, NAIC
Appendix I

XYZ Company
Illustration Summary

Basic Description
Indexed Universal Life policies provide policyholders with the ability to allocate their cash value to Indexed Accounts. When placed in Indexed Accounts, their cash value will be credited based on the growth of an underlying index subject to a minimum rate (the floor) and a maximum rate (the cap).

This crediting methodology means that these accounts are unlikely to see the same return year after year. Illustrations are regularly prepared using a single illustrated rate in all years for ease of understanding and additional illustrations, such as the alternate scale illustration and the guaranteed illustration, are included to help understand potential outcomes under more conservative assumptions. However, because of the nature of the indexed accounts, showing the impact of non-linear returns helps better understand this policy.

Range of Possibilities
The graph and charts below show the cash value pattern as well as other key policy metrics under a low and high indexed return scenario and compares it to the illustrated scenario that you chose for your illustration.
The scenarios’ used in this analysis are based on historical experience and in accordance with Actuarial Guideline 49. More detail on how these were selected can be found on pg. Y of this illustration.

The Order of the Indexed Returns Matter

It is possible to have an average rate of return equal to the illustrated rate occur in many ways. It does not need to be the same number every year. The order in which the returns happen in a sequence of returns will impact your policy. Below is chart demonstrating how your policies performance would be impacted.
Certain features you select on your policy will impact the Range of Possibilities as well as the Order of Returns. It is important to discuss with your life insurance producer to decide what is right for you.

I have received and read a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be higher or lower. The life insurance producer has told me that they are not guaranteed. I understand this is an illustration and not a contract. For full policy details, I will refer to the contract.

APPLICANT’S SIGNATURE  DATE

I certify that this illustration has been presented to the applicant and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with this illustration nor have I made any promises about the expected future Index Credits of this contract.

LIFE INSURANCE PRODUCER’S SIGNATURE  DATE
The Low and High scenario are based on the same historical scenarios that the maximum Ag49 lookback rate are based on. They are the 25-year sequences that result in the lowest and highest compound annual growth rate. The 25-year period is repeated for the length on the illustration period. Scenarios A and B are similar in concept.
Re: The IUL Illustration Subgroup requested comments by August 30, 2019 on the following questions related to IUL illustrations. The comment due date was later extended to September 6, 2019.

1. Should a product with a multiplier feature illustrate a higher scale than a product without multiplier features?
2. To what extent should the 145% disciplined current scale factor apply to charges supporting bonuses and multipliers?

Dear Mr. Andersen:

Broadly-speaking, we feel that the objective of life insurance product illustrations should be to help consumers make informed financial decisions by adequately demonstrating the potential risk and return opportunities. Disallowing the inclusion of a multiplier does not guarantee a proper view of the risk-return tradeoff, however allowing the inclusion of a multiplier without improvements to illustration effectiveness may also not give a proper view of risk and return.

Today's illustrations show a level index return each year. These illustrations can span decades. A more typical pattern of returns would have returns that were positive for five to seven years followed by a year or two of zero. While we believe that sales professionals are accountable for reviewing the risks and return opportunities associated with life insurance policies with consumers, we also see an opportunity for improvement in the way these products are illustrated.

With this broader opportunity in mind, we have also provided comments and suggestions below on the two specific questions posed on July 15, 2019. We would be happy to discuss any questions you may have.
1. **Should a product with a multiplier feature illustrate a higher scale than a product without multiplier features?**

Products with multipliers, bonuses, and additional credits should be permitted to illustrate, to some extent, a higher scale than the product would without these features, but with a reasonable limit. Purposes of an Indexed Universal Life policy range from providing life insurance protection to efficient wealth transfer. When charges that enhance the hedge budget to pay for multipliers, bonuses, and additional credits rival or exceed the underlying product hedge budget (approximately the annual net investment earnings rate), the emphasis of the product shifts and this may not be consistent with the purpose of this product. Therefore, applying a reasonable limit in illustrations on the charges used to enhance the hedge budget is appropriate.

We recommend limiting charges to 50% of the product hedge budget (approximately the annual net investment earnings rate), which would place a reasonable ceiling on the charges used to enhance the hedge budget. For example, a hedge budget of 4% would result in a limit of 2%.

2. **To what extent should the 145% disciplined current scale factor apply to charges supporting bonuses and multipliers?**

The 145% disciplined current scale factor should apply to charges supporting bonuses, multipliers, and additional credits. However, as described above, charges used to enhance the hedge budget for illustrations should have a reasonable limit.

We view the actions that we have articulated above as being important preliminary steps to apply reasonable limits within the IUL product. We also look forward to continuing to work with the NAIC on the more holistic changes that need to be made to illustrations to provide more consumer clarity.

Again, we would welcome the opportunity to discuss our position further with you. I can be reached at (614) 249-5947.

Regards,

Pete Rothermel  
VP, CFO IPS – Individual Life & NBSG
September 6, 2019

Filed Electronically

Fred Andersen
Chair, IUL Illustration (A) Subgroup
National Association of Insurance Commissioners

Re: Comments to the IUL Illustration (A) Subgroup Questions regarding Actuarial Guideline 49

Fred:

Thank you for the opportunity to provide our comments with respect to the questions exposed subsequent to the Subgroup’s August 1 meeting.

Pacific Life reiterates its support for the positions contained in the letter submitted by the Harrison Law Office on behalf of Pacific Life and three other IUL carriers. We believe that the establishment of new illustration guardrails, along with enhanced information regarding volatility of credits, can help address consumer education and level expectations.

With respect to guardrails, Pacific Life believes that it is critical that any proposed limit on the illustration of benefits be derived from sound principles and reasonable assumptions. This methodology will help regulators best target changes to AG 49.

We appreciate the opportunity to provide input to the Subgroup, and look forward to further discussions.

Respectfully Submitted,

Ernest Armijos

Enclosures
August 30, 2019

Fred Andersen
Acting Deputy Commissioner of Insurance
Minnesota Department of Commerce
85 7th Place East, Suite 280
St. Paul, MN 55101

Dear Fred,

The undersigned companies present this proposal in response to the NAIC request for comments set forth by the Life and Annuity Task Force on August 5, 2019.

Respectfully,

Seth Detert, Securian Financial
Seth Harlow, Mutual of Omaha
Andrew Martin, Penn Mutual

The IUL Illustration Subgroup requested comments by August 30, 2019 on the following questions related to IUL illustrations:

- Should a product with a multiplier feature illustrate a higher scale than a product without multiplier features?
- To what extent should the 145% disciplined current scale factor apply to charges supporting bonuses and multipliers?

We categorized our comments and requests for direction into two items related to these topics. We would be happy to discuss our comments with you or the members of LATF.

Item #1 –Can charges impact assumed earned interest underlying the DCS. AG49 Section 5A

- We would like a change to AG49 Section 5A to clarify how charges within a contract that support index parameters, bonuses, multipliers, or any form of additional credits should be interpreted:
- Current AG49 wording
  - “If an insurer engages in a hedging program for index-based interest, the assumed earned interest rate underlying the disciplined current scale shall not exceed 145% of the annual net investment earnings rate (gross portfolio earnings less provisions for investment expenses and default costs) of the general account assets (excluding hedges for index-based credits) allocated to support the policy.”
- Recommended additions to the current wording
  - Alternative #1: The annual net investment earnings rate cannot include or be increased by any policy charges that are used to support index parameters, bonuses, multipliers, or any form of additional credits.
  - Alternative #2: If there are policy charges that are used to support index parameters, bonuses, multipliers, or any form of additional credits, the annual net investment earnings rate can be increased by the lesser of: (a) the amount of charges assessed;(b) a percentage of the charges assessed such that the charges as a percentage of account value does not exceed the guaranteed floor of the indexed account being tested.
• Alternative #3: If there are policy charges that are used to support index parameters, bonuses, multipliers, or any form of additional credits, the annual net investment earnings rate can be increased by the lesser of: (a) the amount of charges assessed; (b) a percentage of the charges assessed such that the charges as a percentage of account value does not exceed the guaranteed interest rate on the fixed account of the policy.

• We also recommend additional changes to AG 49 Section 5 to clarify how policies with multiple indexes should be tested. Each recommendation would be a unique sub bullet of AG 49 Section 5.
  • Recommended Addition #1: Each individually marketed product is required to be tested for self-support and lapse support individually. There cannot be aggregation of marketed products that share a single policy form.
  • Recommended Addition #2: Each indexed account needs to be tested for self-support and lapse support individually. To the extent that multiple indexed accounts produce the exact same illustrated values, they can be aggregated.

Item 2 – Variable/index loans and the 1% arbitrage limit. AG49 Section 6

• We believe that variable/index loans should continue to be illustrated, however we would support changing the language in AG49 above to make it clear that the “illustrated rate credited to the loan balance” is inclusive of all policy credits.

• Current AG49 wording
  o If the illustration includes a loan, the illustrated rate credited to the loan balance shall not exceed the illustrated loan charge by more than 100 basis points.

• Recommended changes to the wording
  o If the illustration includes a loan, the aggregate rate for all amounts credited to the loan balance (including all bonuses, multipliers, or any form of additional credits) shall not exceed the amount of loan interest charged by more than 100 basis points of the loan balance.
August 30, 2019

Fred Andersen
Acting Deputy Commissioner of Insurance
Minnesota Department of Commerce
85 7th Place East, Suite 280
St. Paul, MN 55101

Re: National Association of Insurance Commissioners – Life Actuarial (A) Task Force – IUL Illustration (A)
Subgroup Request for Comments on Actuarial Guideline 49

Dear Fred,

I want to take this opportunity to thank you again for your leadership on the critically important issue of making updates to Actuarial Guideline 49 (AG49). The entire industry wants to accomplish the same goal: providing invaluable benefits to our customers in their times of need. It is only through a partnership among carriers and the regulators that we can accomplish that worthy goal.

I would like to begin by re-iterating Securian Financial’s principles on this complex issue:

- Securian Financial believes in transparency for the consumer and the advisor; without transparency, there cannot be understanding. Today, the way the industry illustrates some product designs lacks the necessary transparency for consumers and advisors to understand how the product performs and the associated risks.
- Securian Financial believes in providing clarity for the insurance carriers with regards to satisfying AG49 and other regulations; without clarity, there is an unlevel playing field. Today, there are strong differences of opinion as to how to interpret AG49 and the Model Illustration Law.
- Securian Financial believes in product innovation and consumer choice. However, Securian Financial does not believe all product innovations need to be illustrated. There are several product innovations today (e.g. certain indices, riders such as critical illness, etc.) that are discussed and presented to the consumer every day without being illustrated.
- Securian Financial believes illustrations should set appropriate expectations for future performance. We believe that some of the multipliers and participating loans currently being illustrated are setting overly aggressive expectations for the consumers. Securian Financial does not see any logic that would suggest a year over year cash value growth of 10+ percent inside an index universal life policy is appropriate.

To assist in bringing those principles to life, there is an attachment to this letter with several pages that demonstrate further transparency to the consumer, including

- A mock-up of an additional options page. This would be an example of how a carrier could conceptually talk about the risk and reward of the consumer incurring a higher level of charges to
potentially participate in a higher level of returns. By making this option an additive page and not part of the base illustration, transparency and understanding would be significantly increased while allowing carriers the freedom to innovate in their product designs.

- A mock-up of an additional page describing variable/index loans versus fixed loans. This page could be used in the case where the base illustration does not allow for variable/index loans to illustrate more favorably than fixed loans. Much like additive charges that create the potential for additional return, variable/index loans create additional risk in exchange for the potential for additional return.
- A mock-up of a charges disclosure page.
- A mock-up of a sequence of returns page. One attribute that would assist in consumer understanding how an indexed universal life policy operates would be to show a non-level return scenario. The attachment shows one conceptual way to show the impact of non-level returns.

As you see in each of the mock-ups, Securian Financial believes the information provided is important enough to require a client and advisor signature to ensure the disclosures are understood.

Securian Financial fully realizes and appreciates that these are simply drafts of what might become part of required disclosures, but we want to put the concepts on paper to match the words we have been saying and to provide a starting point for discussion.

If the industry decides to move forward with these concepts, Securian Financial will be more than willing to dedicate our time and resources to moving quickly from draft stage to final stage in partnership with other carriers and the regulators.

In addition, Securian Financial has submitted a letter in conjunction with some other carriers articulating position statements with which we believe all carriers could be comfortable and specific recommended changes to AG49. I wanted to take this opportunity to re-iterate Securian Financial’s stance on a few of the core issues:

- Securian Financial believes there should be a tight limit as to the amount of policy level charges that can be used to increase the indexing parameters and/or bonus mechanics. There is some suggested language in the multi-carrier letter, but Securian Financial encourages you to consider a concrete limit with regard to how much of the assumed earned rate can be multiplied by the 145% factor that resides in AG49. There was a wisdom to the crafting of the current version of AG49, which uses an explicitly defined historical average of the S&P 500 to calculate the maximum illustrated rate. The corollary here would be to explicitly define a historical average of General Account-like assets to calculate the maximum earned rate that can be multiplied by the 145% factor. An example would be a 20-year average of the Moody’s Corporate Bond Index for 10-year bond instruments.
- Securian Financial believes the industry would be in a better position if variable/index loans were not allowed to be illustrated, but instead explained on a concept page as described above.
- Securian Financial believes there should be some clarification made to the illustration actuary testing and certification requirements, including:
  - Changes need to be made to eliminate the aggregation of multiple marketed products using the same base policy form; each marketed product needs to pass on its own.
  - Each separately illustrated index account needs to pass on its own.
Fred, thank you for the several instances where you have taken your valuable time to meet with me and other representatives from Securian Financial. We know there is no perfect outcome here and stand ready to assist you in any way we can.

Respectfully,

Robert J Ehren
The below is an example of what a charges disclosure page could look like.

### Cumulative Current Charges Summary

<table>
<thead>
<tr>
<th>Year</th>
<th>Age</th>
<th>Net Outlay</th>
<th>COI Charge</th>
<th>Other Charges</th>
<th>Total Charges</th>
<th>Interest &amp; Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>45</td>
<td>$10,000</td>
<td>$1,039</td>
<td>$4,292</td>
<td>$5,331</td>
<td>$397</td>
</tr>
<tr>
<td>5</td>
<td>49</td>
<td>$50,000</td>
<td>$6,306</td>
<td>$22,257</td>
<td>$28,563</td>
<td>$6,314</td>
</tr>
<tr>
<td>10</td>
<td>54</td>
<td>$100,000</td>
<td>$16,385</td>
<td>$46,782</td>
<td>$63,167</td>
<td>$24,802</td>
</tr>
<tr>
<td>25</td>
<td>69</td>
<td>$250,000</td>
<td>$94,257</td>
<td>$95,331</td>
<td>$189,588</td>
<td>$251,598</td>
</tr>
<tr>
<td>50</td>
<td>94</td>
<td>$500,000</td>
<td>$317,685</td>
<td>$431,422</td>
<td>$749,107</td>
<td>$2,119,924</td>
</tr>
</tbody>
</table>

I have reviewed and understand the charges in the policy as presented. I understand that the charges are non-guaranteed and credits are as illustrated. Actual charges and credits may vary.

---

Policy Owner

Agent

Date

Date
The below is an example of Non-level return summary page could look like.

### Non-Level Return Summary

Illustrated values are based on an S&P 500 Index with a 0% floor, 10.5% Cap, 100% Participation rate

<table>
<thead>
<tr>
<th>Year</th>
<th>Age</th>
<th>Cumulative Net Outlay</th>
<th>Guaranteed Values</th>
<th>Illustrated Values</th>
<th>Worst Scenario*</th>
<th>Best Scenario*</th>
<th>Difference between Best and Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>55</td>
<td>$35,000</td>
<td>$26,508</td>
<td>$30,517</td>
<td>$31,642</td>
<td>$31,642</td>
<td>-</td>
</tr>
<tr>
<td>5</td>
<td>60</td>
<td>$175,000</td>
<td>$131,492</td>
<td>$172,074</td>
<td>$156,732</td>
<td>$165,655</td>
<td>$(8,923)</td>
</tr>
<tr>
<td>10</td>
<td>65</td>
<td>$350,000</td>
<td>$256,884</td>
<td>$400,335</td>
<td>$387,704</td>
<td>$368,496</td>
<td>$19,208</td>
</tr>
<tr>
<td>15</td>
<td>70</td>
<td>$525,000</td>
<td>$382,483</td>
<td>$731,115</td>
<td>$611,333</td>
<td>$724,188</td>
<td>$(112,855)</td>
</tr>
<tr>
<td>20</td>
<td>75</td>
<td>$525,000</td>
<td>$309,489</td>
<td>$986,810</td>
<td>$690,043</td>
<td>$898,786</td>
<td>$(208,743)</td>
</tr>
<tr>
<td>25</td>
<td>80</td>
<td>$525,000</td>
<td>$141,029</td>
<td>$1,367,682</td>
<td>$776,248</td>
<td>$1,435,319</td>
<td>$(659,071)</td>
</tr>
</tbody>
</table>

I have reviewed and understand the credits in the policy as presented are constant every year. I

Policy Owner ___________________________ Date ___________________________

Agent ___________________________ Date ___________________________

* To find the Best and the Worst Scenarios we calculated the geometric average annual credited rate for the S&P 500 for each daily 25-year period starting 12/31/1948 and ending with the 25-year period that ends on 12/31 of the prior calendar year.
Historical data
The 30-year historical index performance table shows past index performance along with a hypothetical crediting rate using our current growth cap, floor and participation rate. We also provide the historical compound average returns over designated periods for your illustrated indexed account options. Please keep in mind that historical performance does not represent future performance for these indexed accounts.

This product has index account options available to you that increase the charges in the contract in exchange for higher caps and/or higher credits to the policy, based upon the index return.

These are the options available on this policy:
• A is S&P 500 with 10% cap, no charge, no multiplier
• B is S&P 500 with 10% cap, 1.5% charge, 30% multiplier
• C is S&P 500 with 10% cap, 5% charge, 100% multiplier

Below is a chart of the last 30 years of S&P 500 returns to demonstrate the higher volatility of index crediting results, but also the potential for higher returns.

<table>
<thead>
<tr>
<th>Date</th>
<th>S&amp;P Growth Rate</th>
<th>Index A Segment Charge</th>
<th>Total Index Credit %</th>
<th>Index B Segment Charge</th>
<th>Total Index Credit %</th>
<th>Index C Segment Charge</th>
<th>Total Index Credit %</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/14/89</td>
<td>27.95%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/20/90</td>
<td>-5.93%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.50%</td>
<td>-1.50%</td>
<td>5.00%</td>
<td>-5.00%</td>
</tr>
<tr>
<td>12/19/91</td>
<td>15.87%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/17/92</td>
<td>13.83%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/16/93</td>
<td>6.41%</td>
<td>0.00%</td>
<td>6.41%</td>
<td>1.50%</td>
<td>8.21%</td>
<td>5.00%</td>
<td>16.44%</td>
</tr>
<tr>
<td>12/15/94</td>
<td>-1.73%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.50%</td>
<td>-1.50%</td>
<td>5.00%</td>
<td>-4.44%</td>
</tr>
<tr>
<td>12/14/95</td>
<td>35.49%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/19/96</td>
<td>20.88%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/18/97</td>
<td>28.10%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/17/98</td>
<td>23.52%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/16/99</td>
<td>20.24%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/14/00</td>
<td>-5.49%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.50%</td>
<td>-1.50%</td>
<td>5.00%</td>
<td>-5.00%</td>
</tr>
<tr>
<td>12/20/01</td>
<td>-14.99%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.50%</td>
<td>-1.50%</td>
<td>5.00%</td>
<td>-5.00%</td>
</tr>
<tr>
<td>12/19/02</td>
<td>-22.43%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.50%</td>
<td>-1.50%</td>
<td>5.00%</td>
<td>-5.00%</td>
</tr>
<tr>
<td>12/18/03</td>
<td>23.18%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/16/04</td>
<td>10.47%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/15/05</td>
<td>5.63%</td>
<td>0.00%</td>
<td>5.63%</td>
<td>1.50%</td>
<td>7.21%</td>
<td>5.00%</td>
<td>14.44%</td>
</tr>
<tr>
<td>12/14/06</td>
<td>12.16%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/20/07</td>
<td>2.43%</td>
<td>0.00%</td>
<td>2.43%</td>
<td>1.50%</td>
<td>3.11%</td>
<td>5.00%</td>
<td>6.23%</td>
</tr>
<tr>
<td>12/18/08</td>
<td>-39.37%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.50%</td>
<td>-1.50%</td>
<td>5.00%</td>
<td>-5.00%</td>
</tr>
<tr>
<td>12/17/09</td>
<td>23.81%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/16/10</td>
<td>13.39%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/15/11</td>
<td>-2.18%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.50%</td>
<td>-1.50%</td>
<td>5.00%</td>
<td>-5.00%</td>
</tr>
<tr>
<td>12/20/12</td>
<td>18.75%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/19/13</td>
<td>25.35%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/18/14</td>
<td>13.91%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/17/15</td>
<td>-0.94%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.50%</td>
<td>-1.20%</td>
<td>5.00%</td>
<td>-2.41%</td>
</tr>
<tr>
<td>12/15/16</td>
<td>10.78%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/14/17</td>
<td>17.24%</td>
<td>0.00%</td>
<td>10.00%</td>
<td>1.50%</td>
<td>12.81%</td>
<td>5.00%</td>
<td>19.00%</td>
</tr>
<tr>
<td>12/20/18</td>
<td>-6.96%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.50%</td>
<td>-1.50%</td>
<td>5.00%</td>
<td>-5.00%</td>
</tr>
</tbody>
</table>

Compound Average 7.60% 0.00% 6.38% 1.50% 7.66% 5.00% 10.70%

Important to note that in calculating the annual return we took into consideration the index charge
What has been illustrated is a fixed policy loan, but your policy does have the option of a variable or indexed loan. Here is the description of your loan options:

Here is an example of 2 patterns of index returns and the impact of those returns on your policy values.

## Assuming illustrated indexed account return of 6.00%

<table>
<thead>
<tr>
<th>Year</th>
<th>Age</th>
<th>Amount</th>
<th>Loan Interest</th>
<th>Loan Balance</th>
<th>Interest Credited</th>
<th>Fixed Loan Account Value</th>
<th>Net Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>45</td>
<td>10,000</td>
<td>500</td>
<td>10,500</td>
<td>450</td>
<td>10,450</td>
<td>500</td>
</tr>
<tr>
<td>2</td>
<td>46</td>
<td>10,000</td>
<td>1,025</td>
<td>21,525</td>
<td>920</td>
<td>21,370</td>
<td>1,525</td>
</tr>
<tr>
<td>3</td>
<td>47</td>
<td>10,000</td>
<td>1,576</td>
<td>33,101</td>
<td>1,412</td>
<td>32,782</td>
<td>319</td>
</tr>
<tr>
<td>4</td>
<td>48</td>
<td>10,000</td>
<td>2,155</td>
<td>45,256</td>
<td>1,925</td>
<td>44,731</td>
<td>549</td>
</tr>
<tr>
<td>5</td>
<td>49</td>
<td>10,000</td>
<td>2,763</td>
<td>58,019</td>
<td>2,462</td>
<td>57,557</td>
<td>450</td>
</tr>
<tr>
<td>6</td>
<td>50</td>
<td>-</td>
<td>2,901</td>
<td>60,920</td>
<td>2,573</td>
<td>59,347</td>
<td>(1,179)</td>
</tr>
<tr>
<td>7</td>
<td>51</td>
<td>-</td>
<td>3,046</td>
<td>63,966</td>
<td>2,688</td>
<td>62,288</td>
<td>(1,536)</td>
</tr>
<tr>
<td>8</td>
<td>52</td>
<td>-</td>
<td>3,198</td>
<td>67,164</td>
<td>2,809</td>
<td>65,355</td>
<td>(1,925)</td>
</tr>
<tr>
<td>9</td>
<td>53</td>
<td>-</td>
<td>3,538</td>
<td>70,523</td>
<td>2,936</td>
<td>68,587</td>
<td>(2,948)</td>
</tr>
<tr>
<td>10</td>
<td>54</td>
<td>-</td>
<td>3,526</td>
<td>74,049</td>
<td>3,068</td>
<td>71,081</td>
<td>(2,809)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Assuming illustrated indexed account return of 0% and 6.00% alternating

<table>
<thead>
<tr>
<th>Year</th>
<th>Age</th>
<th>Amount</th>
<th>Loan Interest</th>
<th>Loan Balance</th>
<th>Interest Credited</th>
<th>Fixed Loan Account Value</th>
<th>Net Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>45</td>
<td>10,000</td>
<td>500</td>
<td>10,500</td>
<td>450</td>
<td>10,450</td>
<td>500</td>
</tr>
<tr>
<td>2</td>
<td>46</td>
<td>10,000</td>
<td>1,025</td>
<td>21,525</td>
<td>920</td>
<td>21,370</td>
<td>1,525</td>
</tr>
<tr>
<td>3</td>
<td>47</td>
<td>10,000</td>
<td>1,576</td>
<td>33,101</td>
<td>1,412</td>
<td>32,782</td>
<td>319</td>
</tr>
<tr>
<td>4</td>
<td>48</td>
<td>10,000</td>
<td>2,155</td>
<td>45,256</td>
<td>1,925</td>
<td>44,731</td>
<td>549</td>
</tr>
<tr>
<td>5</td>
<td>49</td>
<td>10,000</td>
<td>2,763</td>
<td>58,019</td>
<td>2,462</td>
<td>57,557</td>
<td>450</td>
</tr>
<tr>
<td>6</td>
<td>50</td>
<td>-</td>
<td>2,901</td>
<td>60,920</td>
<td>2,573</td>
<td>59,347</td>
<td>(1,179)</td>
</tr>
<tr>
<td>7</td>
<td>51</td>
<td>-</td>
<td>3,046</td>
<td>63,966</td>
<td>2,688</td>
<td>62,288</td>
<td>(1,536)</td>
</tr>
<tr>
<td>8</td>
<td>52</td>
<td>-</td>
<td>3,198</td>
<td>67,164</td>
<td>2,809</td>
<td>65,355</td>
<td>(1,925)</td>
</tr>
<tr>
<td>9</td>
<td>53</td>
<td>-</td>
<td>3,538</td>
<td>70,523</td>
<td>2,936</td>
<td>68,587</td>
<td>(2,948)</td>
</tr>
<tr>
<td>10</td>
<td>54</td>
<td>-</td>
<td>3,526</td>
<td>74,049</td>
<td>3,068</td>
<td>71,081</td>
<td>(2,809)</td>
</tr>
</tbody>
</table>
Date: November 18, 2019

Please allow me to submit the following comments on behalf of Virginia regarding the following exposure:

**Actuarial Guideline 49 (AG 49) – Draft for 11/15/19 Exposure**

1. **Benchmark Index Account.** Section 3.C would seem to allow an Indexed Account with a multiplier to be a Benchmark Index Account and as such could lead to very high maximum credited rate in 4.B and possible double-counting in 4.E. For example, consider a product where only one Index Account is offered under a S&P 500 one-year point-to-point crediting rate strategy with a 5% account charge to fund an interest credit multiplier of 2.0 which doubles the option budget and the potential Indexed Credits. The Indexed Account would seem to meet all of the criteria in Section 3.C. To address this, I propose adding an additional requirement ix. for Benchmark Index Accounts in Section 3.C as follows:

   ix. The Supplemental Option Budget shall be 0%.

2. **Limits on Illustrated Bonuses or Other Enhancements.** Section 4.E is problematic in that it creates the potential for double-counting of interest credit multipliers. However, if Section 4.E is removed, then there is no explicit reference to limitations of bonuses or other enhancements in Section 4. Some actuaries have interpreted this to mean there is no explicit limit to illustrated bonuses or other enhancements in Section 4 and illustrate an index rate plus a bonus or other enhancement, so that the total credited benefits exceed the maximum illustrated rate (see Q.4.13 in the Life Illustrations Practice Note, updated February 2019 version). I propose adding a new Section 4.E, that would clarify that the maximum credited rate in Section 4.B is meant to set a bound for all types of indexed-related credits:

   E. The Indexed Credits under the illustrated scale for any policy year shall not exceed:

   i. the account or accumulation value of the policy, before any policy charges are deducted, multiplied by

   ii. the applicable rate calculated in 4(B).

   If interest is credited less frequently than once per year, the limit above may be applied in total over the interest crediting period so that the total Indexed Credits over the interest crediting period do not exceed the above limit. For example, if a two-year point-to-point indexed crediting strategy is used over policy years 9 and 10, the applicable rate in 4(B) is 6.0%, and the account value in policy years 9 and 10 is $100 and $110, respectively, then the total Indexed Credits for policy years 9 and 10 shall not exceed $12.60.

Thank you for providing me the opportunity to submit this comment.

Craig Chupp, FSA, MAAA
Life and Health Insurance Actuary
Virginia Bureau of Insurance
craig.chupp@scc.virginia.gov
Phone: (804) 371-9131
Mr. Fred Andersen  
Cc: Pat Allison  

Dear Fred:

The NAIC IUL Illustration (A) Subgroup requested proposals for edits to AG 49 and responses to the items below (in blue) by November 25, 2019. The attached draft AG49 provides a framework to address these items. The changes have the following goals:

- Multiplier and non-multiplier strategies will illustrate the same at the maximum illustrated rate,
- Strategies that modify the Benchmark Index Account (e.g. Cap buy-ups) will be addressed, and
- Illustrations for all types of index strategies will be subject to a consistent limit based on a company’s investment earned rate.

Given the limited timeframe for comments, we welcome the opportunity to collaborate further and discuss questions.

2. Section 4.E., to ensure relevance and consistency with Section 5 in light of changes to Section 5 and to ensure the coordination with Sections 4A and 4B to produce a clear and appropriate calculation.

The attached draft proposes language in Section 4 to create clear illustration limits that are applied across different types of index strategies. We believe the resulting illustrations will align with the regulators’ stated goals and avoid advantaging or disadvantaging any particular index strategy design. The new language covers index strategies that include charges to modify the Benchmark Index Account (such as Cap buy-ups), charges to support a multiplier bonus, both, or neither. These various index strategies will be consistently limited to a maximum net effective illustrated rate of 145% times the Annual Net Investment Earnings Rate (NIER).

To achieve this, the “Supplemental Option Budget”, as defined in the exposure draft, was replaced with two separate definitions in Sections 3G and 3H. The distinction is between charges used to support higher index crediting parameters (e.g. Cap buy-ups), which could create a new Benchmark Index Account, versus charges used to fund multipliers, which are applied outside of the maximum credited rate for the Benchmark Index. This bifurcation is
needed so that the charges can be reflected in the appropriate place in Sections 4B and 4C. Charges that affect the Benchmark Index Account, such as for Cap buy-up strategies, should not be added on top of the lookback rate in 4B(i) to prevent inappropriate double counting, but should be added in 4B(ii) to avoid disadvantaging these product designs. On the other hand, if a charge does not affect the lookback rate, such as for multipliers, it is added after the maximum credited rate is determined. This is accomplished in Section 4C in the attached draft. We believe when placing limits on illustrations which have charges deducted from the account value, defining the charges themselves rather than their relationship to a hedge budget provides more clarity, consistency in interpretation, and accuracy.

The numerical example below demonstrates how these product features will each be limited to the same net illustrated rate with the proposed language. This fits with the current wording of allowing multiple Benchmark Index Accounts, but ultimately limits all strategies to 145% times the NIER or, if less, to the maximum credited rate for their respective Benchmark Index Account.

Examples of proposed 4 (B) and 4 (C) language:

<table>
<thead>
<tr>
<th></th>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
<th>Example 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Strategy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Net Investment</td>
<td>4.5%</td>
<td>4.5%</td>
<td>4.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Earnings Rate (NIER)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cap</td>
<td>10%</td>
<td>10%</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Index Bonus (Multiplier)</td>
<td>0%</td>
<td>50%</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td>Index Parameter Charges</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Index Bonus Charges</td>
<td>0%</td>
<td>3%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Cap Buy-Up</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Historical Credited Rate for Benchmark Index Account</td>
<td>6%</td>
<td>6%</td>
<td>7.4%</td>
<td>7.4%</td>
</tr>
<tr>
<td>145% * NIER + Index Parameter Charges</td>
<td>6.53% = 1.45 * 4.5% + 0%</td>
<td>6.53% = 1.45 * 4.5% + 0%</td>
<td>7.53% = 1.45 * 4.5% + 1%</td>
<td>7.53% = 1.45 * 4.5% + 1%</td>
</tr>
<tr>
<td>Minimum Credited Rate</td>
<td>6%</td>
<td>6%</td>
<td>7.4%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Maximum Indexed Credits</td>
<td>6%</td>
<td>6%</td>
<td>7.4%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Less Index Charges</td>
<td>6%</td>
<td>6% - 0% - 0%</td>
<td>7.4% - 1% - 0%</td>
<td>7.4% - 1% - 3%</td>
</tr>
</tbody>
</table>

Note: These examples demonstrate the mechanics of the formulas in the draft. They are representative, but do not show all possible strategy designs. All Indexed Credits are limited to a maximum net rate of 145% * NIER.
3. Section 5B (new part of Section 5), to ensure:
   a. Inappropriate double counting of credits or charges is avoided;
   b. Clarity is added, including defining the new term “net” in 5B(A); and
   c. Cap buy-ups are appropriately addressed.
   Supplemental math examples may be provided to add clarity.

The attached language in Section 5 was expanded to more clearly describe the rate as a net rate. The drafting note provides further clarification. The risk of inappropriate double counting resulting from Section 5 is avoided with Section 5B(A) being a net limit and specifying that the limit is 145% of the NIER which does not include additional charges. Additional edits to Section 5 are not needed for cap buy-ups, which are addressed in our proposed changes to Section 4.

4. Section 6B to ensure the 100 basis point loan limits is applied as intended.

The current language for Policy Loans only applies the 100 bps limit to Indexed Credits. If all types of bonuses are not included in this limit, it may be possible for the limit to be exceeded through other product features not directly tied to an index. Section 6B in the attached draft has updated language to address this concern.

Also, the Subgroup will accept proposals on potential compromise approaches for the inforce application issue, in case the Life Actuarial Task Force decides to take a compromise route instead of a straight-forward inclusion or exclusion of the new guidance to inforce illustrations.

If the revisions are put in place for inforce policies, we recommend this apply one year after the effective date of the revised AG 49. This would allow time for customer and producer education. Specific wording suggestions for this compromise have not been included in the attached draft AG49.

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We look forward to continuing discussions on ways to improve the attached language and, long term, on more holistic changes to illustrations to provide greater consumer clarity.

Regards,

Pete Rothermel
VP, CFO - Individual Life
Proposed AG 49 edits reflecting “possibility 2” supported by LATF, multipliers illustrating the same as non-multipliers

**Actuarial Guideline XLIX – Draft to discuss on 11/1/19 subgroup call – potential basis for exposure on 11/14/19 call**

**THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION TO POLICIES WITH INDEX-BASED INTEREST**

**Background**

The *Life Insurance Illustrations Model Regulation* (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an external index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

1. Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
2. Limits the policy loan leverage shown in an illustration.
3. Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

**Text**

1. **Effective Date**

   This Actuarial Guideline shall be effective as follows:

   A. Sections 4 and 5A, except as noted in iv., shall be effective for all new business and in force life insurance illustrations on policies sold on or after September 1, 2015.

   B. Effective March 1, 2017, Section 4 and Section 5A, except as noted in iv., shall be effective for all in-force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold.

   C. Sections 6A and 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

   D. Sections 4E, 5B, and 6B shall be effective for all policies sold on or after May 1, 2020.

2. **Scope**

   This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:

   A. The policy is subject to Model #582.

   B. Interest credits are linked to an external index or indices.

3. **Definitions**

   A. **Alternate Scale**: A scale of non-guaranteed elements currently being illustrated such that:
i. The credited rate for each Index Account does not exceed the lesser of the maximum credited rate for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does not offer a Fixed Account with the illustrated policy, the credited rate for each Index Account shall not exceed the average of the maximum credited rate for the illustrated scale and the guaranteed credited rate for that account. However, the credited rate for each Index Account shall never be less than the guaranteed credited rate for that account.

ii. If the illustration includes a loan, the illustrated rate total amount credited as a result of the loan balance, including Indexed Credits and all other illustrated benefits and bonuses that impact the policy’s account value, shall not exceed the illustrated loan charges does not exceed the illustrated loan charge.

iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. Annual Net Investment Earnings Rate: Gross portfolio annual earnings rate, less provisions for investment expenses and default cost, of the general account assets (excluding hedges for Indexed Credits) allocated to support the policy. Any asset-based charges or other policy charges that are used to increase the total amount spent to generate the Indexed Credits of the policy Index Parameter Charges and Index Bonus Charges are not included in Annual Net Investment Earnings Rate.

C. Benchmark Index Account: An Index Account with the following features:

i. The interest calculation is based on the percent change in S&P 500® Index value only, over a one-year period using only the beginning and ending index values. (S&P 500® Index ticker: SPX)

ii. An annual cap is used in the interest calculation.

iii. The annual floor used in the interest calculation shall be 0%.

iv. The participation rate used in the interest calculation shall be 100%.

v. Interest is credited once per year.

vi. Account charges do not exceed the account charges for any corresponding Index Accounts within the policy in any policy year. If Index Accounts with different levels of account charges are offered with the illustrated policy, more than one Benchmark Index Account may be used in determining the maximum illustrated crediting rates for the policy’s Index Accounts, subject to the requirements of 5.D. However, for each Index Account within the policy, only one Benchmark Index Account shall apply. Any rate calculated in 4 (B) shall not apply for an Index Account if the account charges for the applicable Benchmark Index Account exceed the account charges for that Index Account in any policy year. Account charges include all charges applicable to an Index Account, whether deducted from policy values or from premiums or other amounts transferred into such Index Account.

vii. Additional amounts credited are not less than the additional amounts credited for any corresponding Index Accounts within the policy in any policy year. Any rate calculated in 4 (B) shall not apply for an Index Account if the additional amounts credited for the applicable Benchmark Index Account are less than the additional amounts credited for that Index Account in any policy year. Additional amounts include all credits that increase policy values, including but not limited to experience refunds or bonuses.

viii. There are no limitations on the portion of account value allocated to the account.

D. Fixed Account: An account where the credited rate is not tied to an external index or indices.

E. Index Account: An account where the credited rate is tied to an external index or indices.

F. Indexed Credits: Any interest credit, multiplier, factor, bonus, or other enhancement to policy values that is linked directly or indirectly to an index or indices.
G. Supplemental Option Budget Index Parameter Charges: Any asset-based charges or other policy charges that are
deducted from the account value to support index parameters (e.g., cap rate, participation rate, floor rate) explicitly
used to increase the total amount spent to generate the Indexed Credits of the policy. This amount is expressed as a
percent of the policy’s indexed account value.

*Drafting Note: This is intended to capture charges that modify the Benchmark Index Account lookback rate, such
as cap buy-up strategies, or cause development of a hypothetical Benchmark Index Account. Section 3(C) vi could
be updated to use these defined terms.*

H. Index Bonus Charges: Any asset-based charges or other policy charges that are deducted from the account value to
support bonuses, such as multipliers or other enhancements to policy values, that are linked to an index or indices.
This amount is expressed as a percent of the policy’s indexed account value.

*Drafting Note: This is intended to capture charges that support multipliers or other bonuses that are applied outside
of the Benchmark Index Account lookback rate. This is the counterpart to the Index Parameter Charges. A charge
could fall under the definition in either 3G or 3H, or be split between both; however this is not intended to allow
any one charge to be double counted in both definitions.*

4. Illustrated Scale

The credited rate for the illustrated scale for each Index Account shall be limited as follows:

A. Calculate the geometric average annual credited rate for each applicable Benchmark Index Account for the 25-year
period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for
2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the
25-year period that ends on 12/31 of the prior calendar year.

i. If the insurer offers an applicable Benchmark Index Account with the illustrated policy, the
illustration actuary shall use the current annual cap for the applicable Benchmark Index Account
in 4(A).

ii. If the insurer does not offer an applicable Benchmark Index Account with the illustrated policy,
the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable
current annual cap for a hypothetical, supportable Index Account that meets the definition of a
Benchmark Index Account, and shall use that cap in 4(A).

B. For each applicable Benchmark Index Account, the arithmetic mean of the geometric average annual credited rates
calculated in 4(A) shall be the maximum credited rate(s) for the illustrated scale shall be the minimum of (i) and (ii):

i. The arithmetic mean of the geometric average annual credited rates calculated in 4(A)

ii. The sum of (145% times the Annual Net Investment Earnings Rate), plus (any Index Parameter
Charges adjusted for timing differences between when the charges are taken out and when interest
is credited).

C. Total Indexed Credits may not exceed the sum of the maximum credited rate calculated in 4(B) plus any Index
Bonus Charges, adjusting for timing differences between when the charges are taken out and when interest is
credited.

C. For other Index Accounts using other equity, bond, and/or commodity indexes, and/or using other crediting
methods, the illustration actuary shall use actuarial judgment to determine the maximum credited rate for the
illustrated scale. The determination shall reflect the fundamental characteristics of the Index Account and the
parameters shall have the appropriate relationship to the expected risk and return of the applicable Benchmark Index
Account. In no event shall the credited rate for the illustrated scale exceed the applicable rate calculated in 4(B)
or shall the total Indexed Credits exceed the limit calculated in 4(C).
E. At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

F. The table below illustrates four examples of the calculation of the maximum credited rate for the illustrated scale and the maximum illustrated Indexed Credits. Example 1 assumes Index Parameter Charges and Index Bonus Charges are zero. Example 2 assumes Index Bonus Charges are positive. Example 3 assumes Index Parameter Charges are positive. Example 4 assumes both Index Parameter Charges and Index Bonus Charges are positive.

<table>
<thead>
<tr>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
<th>Example 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Net Investment Earnings Rate (NIER)</td>
<td>4.5%</td>
<td>4.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Cap</td>
<td>10%</td>
<td>10%</td>
<td>13%</td>
</tr>
<tr>
<td>Index Bonus, [Multiplier]</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Index Parameter, Charges</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Index Bonus Charges</td>
<td>0%</td>
<td>3%</td>
<td>0%</td>
</tr>
</tbody>
</table>

4 (B) i Historical Credited Rate for Benchmark Index Account
- 6% = 6%
- 6% = 6%
- 7.4% = 7.4%
- 7.4% = 7.4%

4 (B) ii 145% * NIER + Index Parameter Charges
- 6.53% = 1.45 * 4.5% + 0%
- 6.53% = 1.45 * 4.5% + 0%
- 7.53% = 1.45 * 4.5% + 1%
- 7.53% = 1.45 * 4.5% + 1%

4 (B) Maximum Illustrated Credited Rate
- 6% = Min(6%, 6.53%)
- 6% = Min(6%, 6.53%)
- 7.4% = Min(7.4%, 7.53%)
- 7.4% = Min(7.4%, 7.53%)

4 (C) Maximum Indexed Credits
- 6% = 6% + 0%
- 9% = 6% + 3%
- 7.4% = 7.4% + 0%
- 10.4% = 7.4% + 3%

4 (C) Maximum Indexed Credits less Index Charges
- 6% = 6% - 0% - 0%
- 6% = 9% - 0% - 3%
- 6.4% = 7.4% - 1% - 0%
- 6.4% = 10.4% - 1% - 3%

Drafting note: These examples demonstrate the mechanics of the formulas in Section 4. They are representative but do not show all possible strategy designs. Ultimately, all Indexed Credits are limited to a maximum net rate of 145% * NIER.

If charges that fund a Supplemental Option Budget are deducted from the illustrated cash value, then Indexed Credits generated by the return from the Supplemental Option Budget within the scenario being illustrated may be illustrated in an amount up to, but not exceeding, such charges.

Drafting note: The intention is to specify that designs with multipliers or other enhancements should not illustrate better than non-multiplier designs.

5A. Disciplined Current Scale

The earned interest rate for the disciplined current scale shall be limited as follows:

A. If an insurer engages in a hedging program for index-based interest, the assumed earned interest rate underlying the disciplined current scale shall not exceed 145% of the annual net investment earnings rate (gross portfolio earnings less provisions for investment expenses and default costs) of the general account assets (excluding hedges for index-based credits) allocated to support the policy.

B. If an insurer does not engage in a hedging program for index-based interest, the assumed earned interest rate underlying the disciplined current scale shall not exceed the annual net investment earnings rate of the general account assets allocated to support the policy.
C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all benefits including illustrated bonuses.

D. If more than one Benchmark Index Account is used for an illustrated policy, each set of Index Accounts that correspond to each Benchmark Index Account must independently pass the self-support and lapse-support tests under Model #582, subject to the limitations in 5 (A), (B), and (C). All experience assumptions that do not directly relate to the Index Accounts as to expenses, mortality, investment earnings rate of the general account assets, lapses, and election of any Fixed Account shall equal the assumptions used in the testing for the entire policy.

5B. Disciplined Current Scale

The annual earned interest rate for underlying the disciplined current scale shall be limited as follows:

A. If an insurer engages in a hedging program for index-based interest Indexed Credits, the assumed annual net investment performance underlying the disciplined current scale, inclusive of all general account assets and hedge assets that support the policy and net of default costs and investment expenses, including the amount spent to generate the Indexed Credits of the policy, shall not exceed 145% of the Annual Net Investment Earnings Rate.

Drafting Note: The focus was shifted from the earned rate to the investment performance to distinguish the term from that in the Model Regulation and avoid creating inconsistency with Section 4. The limit is based on a Net rate, so it does not include multiplier returns in the 145% limit. This would still allow reflecting the multiplier hedge return in DCS testing up to the amount spent to hedge the multiplier, as long as the corresponding hedge cost is also reflected, resulting in a net effect of 0.

i. the Annual Net Investment Earnings Rate, plus

ii. 45% times the Annual Net Investment Earnings Rate, plus

iii. 0% times the Supplemental Option Budget.

145% of the annual net investment earnings rate (gross portfolio earnings less provisions for investment expenses and default costs) of the general account assets (excluding hedges for index-based credits) allocated to support the policy.

A.B. If an insurer does not engage in a hedging program for index-based interest Indexed Credits, the assumed annual earned interest rate underlying the disciplined current scale for the policy shall not exceed the Annual Net Investment Earnings Rate of the general account assets allocated to support the policy.

B.C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all Indexed Credits and all other illustrated benefits and including illustrated bonuses.

D. If more than one Benchmark Index Account is used for an illustrated policy, each set of Index Accounts that correspond to each Benchmark Index Account, including all illustrated Indexed Credits that apply to an Indexed Account, must independently pass the self-support and lapse-support tests under Model #582, subject to the limitations in 5 (A), (B), and (C). All experience assumptions that do not directly relate to the Index Accounts and Indexed Credits as to expenses, mortality, investment earnings rate of the general account assets, lapses, and election of any Fixed Account shall equal the assumptions used in the testing for the entire policy.

The table below illustrates two examples of the calculation of the assumed annual earned interest rate underlying the disciplined current scale and assumes the insurer engages in a hedging program. Example 1 assumes the insurer’s Supplemental Option Budget is zero. Example 2 assumes the insurer’s Supplemental Option Budget is positive.

<table>
<thead>
<tr>
<th>Annual Net Investment Earnings Rate</th>
<th>Example 1</th>
<th>Example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4.5%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>
### Supplemental Option Budget (as % of Indexed Account Value)

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>2.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum Annual Earned Interest Rate underlying the Disciplined Current Scale</strong></td>
<td>6.53% = 1.45 * 0.045 + 0 * 0</td>
<td>6.53% = 1.45 * 0.045 + 0 * 0.025</td>
</tr>
</tbody>
</table>

#### 6A. Policy Loans

If the illustration includes a loan, the illustrated rate credited to the loan balance shall not exceed the illustrated loan charge by more than 100 basis points.

#### 6B. Policy Loans

If the illustration includes a loan, the total index credits amount credited as a result of illustrated rate credited to the loan balance, including Indexed Credits and all other illustrated benefits and bonuses that impact the policy’s account value, shall not exceed the sum of the interest rate charged to the loan and any asset-based charges for Indexed Credits applicable to the loan balance illustrated loan charge by more than 100 basis points. For example, if the loan charge plus asset-based charges for Indexed Credits is 6% of the loan balance, Indexed Credits and all other illustrated benefits and bonuses that impact to the loan balance cannot exceed 7%, regardless of product features available.

#### 7. Additional Standards

The basic illustration shall also include the following:

- **A.** A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.
- **B.** A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).
- **C.** For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period.
November 25, 2019

Mr. Fred Andersen  
Chair, NAIC IUL Illustration (A) Subgroup  
Mr. Reggie Mazyck  
Life Actuary, NAIC

Re: Questions on IUL Illustrations

Dear Mr. Andersen and Mr. Mazyck,

Global Atlantic Financial Group, through Accordia Life and its predecessor companies, has been continuously offering IUL products since the product was first introduced in the 1990’s, longer than any other carrier in the market today. We participated in the development of the original AG49 and thank the IUL Illustrations Subgroup for the opportunity to provide input to discussions on potential AG49 updates with this, our fourth comment letter of 2019.

Our March comment letter recommended that the underlying intention of AG49 be applied to all components of interest credits, inclusive of multipliers.

AG49’s goals of consistency and transparency were at the heart of our June comment letter recommendations of:

- Whether explicit or implicit charges are used to create a higher hedging budget, the resulting interest credit should follow the same underlying guidance of AG49 for interest crediting absent such charges, and
- The 100bp loan leverage limit should be applied collectively to all sources of index returns.

We reiterated these items within our comment letter from earlier this month as we noted that:

- Products with multipliers would not illustrate the same as non-multiplier products as each benchmark account has a unique maximum illustrated rates while, per Section 4E, multiplier products are subject to a separate limit.
- Products with multipliers would not illustrate the same as non-multiplier products as, per Section 6B, different loan leverage amounts result for multiplier and non-multiplier products due to the charges for the multiplier.

Global Atlantic believes the current draft wording fails to bring all IUL illustrations in line with the underlying intention of AG49. We therefore recommend that additional time be taken to ensure that any AG49 updates:

1. Provide consistent guidance for interest crediting regardless of the source of hedging budget,
2. Generate consistent loan leverage limits regardless of product design, and
3. Create no bias in the manner for which hedge budgets are derived or investment returns are generated.

AG49 provides uniformity in illustrating IUL’s index value proposition. Products that offer higher index growth potential due to a higher cap, for example, are provided a higher maximum illustrated rate reflective of that increased potential. A product’s growth potential does not change based on the source of the hedge budget. Any AG49 updates should continue to provide for maximum illustrated rates commensurate with the growth potential and should not vary the maximum rate based on the source of the hedge budget.

AG49 provides a 100bp maximum difference between the rate charged on loaned funds and the rate credited on loaned funds. The intent of this provision is to limit the index value proposition to 100bps on loaned funds. Ensuring this value proposition limit is applied to the total index credit will not only result in compliance with the spirit of AG49 but also achieve the illustrated consistency being sought between multiplier and non-multiplier products.

AG49 directs the illustration actuary on earned rate assumption within the disciplined current scale given the use of hedge assets on IUL products. Limitations for this assumption are appropriate. The return on the hedge asset does not depend on the asset source; any limitations should not depend on the source of the asset. A consistent limitation within Section 5B would create the uniform practice desired without bias or incentive to certain product designs or hedge budget bifurcation.

With a consistent limitation in Section 5B, we believe Section 4E can be removed. For consistent loan leverage limits, we believe Section 6B should read “If the illustration includes a loan, the total index credits to the policy loan balance shall not exceed the illustrated loan charge, including any asset-based or other policy charges deducted to hedge the Index Credits as a result of the loan balance, by more than 100 basis points.”

In summary, Global Atlantic recommends further refinement of proposed updates to facilitate consistent and uniform illustration of the index value proposition while ensuring the spirit of AG49 through appropriate loan leverage and disciplined current scale limits.

Thomas A. Doruska
Head of Life Product Development

David P. Wilken
President, Life
Introduction to VBT Analysis Process

Academy Life Experience Committee and SOA Preferred Mortality Oversight Group ("Joint Committee")

NAIC 2019 Fall National Meeting - Life Actuarial (A) Task Force - Austin, Texas

Agenda

- Monitoring 2015 VBT for when to modify
- Metrics to be reviewed
- Triggers for action
- Potential corrective actions
- Next steps

Monitoring 2015 VBT for Need to Modify

- In VM-20, Section 9.C, companies are required to use an Industry Mortality Table for determining their prudent best estimate mortality.
- The industry mortality table is currently based on the 2015 VBT and corresponding RR Tables, advanced forward to the valuation date using prescribed mortality improvement factors published by the Society of Actuaries (SOA).

Monitoring 2015 VBT for Need to Modify, cont’d

- Once PBR is mandatory, there will be a significant increase in the number of contributing companies and amount of exposure and claims via the mandatory data collection within VM-51.
- The “Joint Committee” is recommending a method based on analytics to determine when there is sufficient change in the underlying mortality relative to the experience to warrant changes to the table.
Metrics to Be Reviewed

- Confidence Intervals (CI) based on normal distribution
  - CI of expected deaths vs. actual deaths
  - CI of A/E’s vs. 100% reference
  - Proposed 95% CI; can be parameterized
  - CI of [A-E]
- Amount based only
  - VBT based on amount-based experience
- Test 3rd moments to test if statistically <> 0
- Track/check Bühlmann coefficients based on recent data

New Calculated Fields—to Be Added to Individual Life Mortality data

- Expected deaths and A/E’s with and without mortality improvement adjustment to current observation year
- Based on 2019 YE VM-35/AG38 mortality improvement factors
- Components to calculate Variance
  - By count and amount
  - To be used in CI calculation (normal distribution)
- Will facilitate Limited Fluctuation and Bühlmann Credibility calculations
- Components to calculate 3rd Moment
  - By count and amount
  - May be used in a future, enhanced CI calculation that takes skewness into account; current limitations in software capabilities and budget prevent this today

Data Partitions for Review

- Determine how many years of data to use
- Will partition and review CI’s and [A-E] of data by
  - Face amount bands
  - Gender
  - Age groups—quinquennial age groups for oldest attained ages
  - Duration groups
  - Nonsmoker/smoker status; will consider going down to preferred levels but lack of credibility may preclude this
- Each partition will be fully credible (~5,000 claims) based on frequency and severity

Trigger for Action

- Determine total number of partitions
- Determine total number of partitions outside CI
- [A-E] by amount results used to determine materiality
- If number outside CI greater than expected, action needed by VBT team
- For example, if using 95% CI and 200 partitions
  - 10 partitions should be outside of CI, 5 above and 5 below
- Monitor trends, if nearing the limit—create watchlist, may do additional analysis
### Potential Corrective Actions on Current VBT

- Slope adjustments using multiplicative factors
- Adjustments to mortality improvement factors
- New VBT developed
- $|A-E|$ by amount results used to prioritize areas of the VBT to adjust

### Software

- Recommend Tableau as delivery platform for data and calculations
- Benefits of Tableau
  - VBT team able to work with large ILEC datasets
  - CI calculations can be added using new calculated fields
  - Grouping feature can be used to create partitions of the data
  - Create visual displays of the data and areas of concern
- Current Limitations of Tableau
  - CI calc with skewness requires a new "R" function to be developed and a Linux server. Will complete a proof of concept in 2020 and determine whether to proceed with a future implementation.

### Next Steps

- Provide MIB and NAIC with request to add new calculated fields and complete Bühlmann calculations
- MIB to add new fields to 2009–2017 data
- NAIC to add new fields to 2015 test data and 2018+
- Complete Tableau calculations and visualizations in first half 2020
- Present to LATF in Summer 2020

### Appendix
New Calculated Fields

Contact Information

Mary Bahna-Nozain, MAAA, FSA, CERA
Chairperson, Academy Life Experience Committee and SOA Preferred Mortality Oversight Group

Ian Trepanier
Life Policy Analyst
American Academy of Actuaries
info@actuary.org

© 2019 National Association of Insurance Commissioners
October 7, 2019

To: NAIC Life Actuarial Task Force
    Kent Sullivan, Chair

Re: Amendment Proposal 2019-56, Revisions to VM-51 Data Elements for AUW

Thank you for the opportunity to provide input on this proposal.

While we can appreciate the interest in collecting additional data, we struggle to understand the practical value potential of the current proposal. Because of several specific concerns noted below, especially regarding consumer data privacy and security, we believe that this proposal requires a tighter focus, and would benefit from further discussion and revision.

1. Privacy and Security
   The privacy and security of our applicants’ information is of the utmost importance to us. We go to great lengths to protect that information, and to comply with all regulations regarding the same. We would be very concerned about the sharing of any data, especially highly sensitive medical information at the individual level, with third parties and outside of our data environment.

2. Data Complexity
   Additionally, the depth and complexity of this expanded data scope increase the likelihood that carriers make different interpretations, resulting in non-uniform submissions for certain data elements. This in turn will render those elements unusable (or worse, misleading), effectively defeating the intended purpose of the expanded data.

3. Underwriting Regime Definitions
   Fundamentally, we struggle to see how the additional data breadth and granularity will actually enable more effective mortality table construction or establishment of more appropriate reserves.

The recent perceived innovations in the underwriting process, commonly referred to as “accelerated” underwriting, are in many respects an extension of existing common practice (e.g. consider how medical records, aka “APS”, are typically only ordered at older ages and higher face amounts, or for cause). There is no obvious reason why this most recent underwriting iteration would necessitate a substantial overhaul to the data collection methodology for this process.

Also, the recent perceived underwriting innovations are very immature, and rapidly evolving. It is probable that in just a few years, many of the data elements currently being explored will no longer be relevant, and that new items will have emerged as well. Trying to collect information on some of these new elements is likely to be wasted effort.
If more specific knowledge about how a policy was underwritten would add value to the various stakeholders, there seem to be several viable and more practical alternatives, such as submitting metadata about the type underwriting or tests used, rather than case-level data and test results.

4. Operational Costs

And finally, this expansion does generate a high degree of operational difficulty and cost. The issues are myriad, and include lack of available data, data maintained in disparate locations, and data maintained in image rather than structured format. The proposed phasing in of the requirements does not address the fundamental issue – namely, that a significant capital investment will be required to enable compliance, yet, as mentioned above, there is no clear expected value to be gained, for neither the carrier nor the consumer. Increasing the operating costs of carriers ultimately results in increased prices in market to be borne by consumers.

We thank you for your consideration, and look forward to continued dialogue on this important issue.

Sincerely,

Brian Guntli, FSA, MAAA
Director and Actuary
Allstate Life Insurance Company
October 7, 2019

Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force

Re: Accelerated Underwriting Data Elements

Dear Mike:

The American Council of Life Insurers (ACLI)\footnote{ACLI is a Washington, D.C.-based trade association with approximately 290 member companies operating in the United States and abroad. ACLI advocates in state, federal, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers' products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing 95 percent of industry assets, 93 percent of life insurance premiums, and 98 percent of annuity considerations in the United States. Learn more at www.acli.com.} appreciates the opportunity to comment on the exposed Accelerated Underwriting Data Elements on behalf of our member companies.

The ACLI has significant concerns about the current scope of the proposal, which are outlined below. These concerns echo many of the concerns we expressed in our November 7, 2017 letter. We are concerned that in its current state, the request does not serve the needs of consumers, regulators, or industry. ACLI would recommend that this APF be assessed in much greater detail through thorough dialogue on the regulatory and predictive value of the additional data elements, especially as regards the vision for turning the additional data into more effective reserving or other practical benefits. In addition, ACLI would encourage further review of retrospective elements and the timing of prospective elements.

1. Consumer Privacy and Confidentiality

ACLI member companies treat the privacy and security of our customers’ information very seriously, and would be very concerned about the sharing of data, especially highly sensitive and unique medical information at the individual level, with third parties and outside of our data environment. These concerns include, but are not limited to, elements capturing the following data:

   i. Personal history information captured in items 86-101;
   ii. Family history information captured in items 128-152;
   iii. Detailed medical results captured in item 104-106, 108-109, 111-112;
   iv. Other personal information captured in item 118, 121-127.

2. Level of Granularity

ACLI believes that there should be a discussion of the appropriateness of collecting underwriting data at the policy level rather than at the level of the underwriting regime for the policy. This can include elements similar to existing items 73-85, but applied generally for the underwriting practices the company follows within certain age groups, face amounts, or risk classes. An underwriting-regime-level of
detail should generally be sufficient for studying life mortality, and categorizing experience into similar underwriting frameworks as needed. While many companies collect such data on an individual basis, we are concerned about it being required for reporting purposes for both consumer privacy and the sheer amount of data to be collected.

Further, the depth and complexity of this expanded data request increase the likelihood that carriers make different interpretations, resulting in non-uniform submissions for certain data elements. This in turn renders those elements unusable (or worse, misleading), effectively defeating the intended purpose of the expanded data.

ACLI acknowledges that more granular data might be beneficial as mortality improvement assumptions are able to set using insured population data, and should be part of the conversation about the level of granularity in the data collection.

3. Applicable Timing of the Data Elements

We believe there needs to be greater clarification of time expectation of the new elements. For example, if an element is mandatory in 2021, given the lag in reporting, it would imply companies would need to be collecting that data in 2019, before the APF would be fully adopted through the Valuation Manual updating process. It is an unrealistic expectation for companies to plan on retaining such data before the requirements are finalized. We would advise further deferring these additional elements no less than 1 to 2 years to properly allow companies an opportunity to update their internal processes to maintain such data.

Even if we are incorrect in our assumptions on timing, many of these fields are likely too new to consistently gather useful data. We do not think the timing is reasonable for elements related to marketing data or credit-based risk score, for example.

4. Operational Burden

This dramatic expansion of required data elements and the accompanying timetable for collection create an undue operational burden for many companies. The issues are myriad: lack of available data, data maintained in disparate locations, and data maintained in unstructured formats such as images or PDFs. Many member companies operate under disciplined and lean technology structures, with prescribed system change protocols and release dates scheduled in advance; in this environment, it can take many months or even years to implement changes. The proposed phasing in of the requirements does not address the fundamental issue – namely, that a significant capital investment will be required to enable compliance, yet, as mentioned in the opening general commentary, there is no expected value to be gained from this exercise, neither for the carrier nor the consumer.

We look forward to a discussion of these issues.

Sincerely,

cc Reggie Mazyck, NAIC
Comments for the Center for Economic Justice
To the Experience Reporting Subgroup of LATF
VM-51 Experience Reporting

November 10, 2019

The Center for Economic Justice offers the following comments in response to the VM-51 exposure draft released following the Summer 2019 National Meeting.

All page references are to the page numbers in the LATF meeting materials for the Summer 2019 national meeting.

Page 93

The scope of reporting includes direct written business and assumption reinsurance where the assuming company is legally responsible for benefits and claims paid but excludes reinsurance assumed from a ceding company to avoid double counting by an insurer and by its reinsurer.

It would be useful to provide examples of which entity is responsible for reporting what experience in various situations. For example, when does the direct writer’s responsibility for reporting end (if ever) if it utilizes assumption reinsurance or some other mechanism? What is the direct insurer’s responsibility if the assumption reinsurer is an alien insurer?

Page 98

For the “segment type” data field, is a data element “primary insured additional permanent rider” needed?

Page 98

For the “type of application” data field, the data elements mix how the application information is assembled (paper, electronic form, verbal) with how the application information is delivered – (internet, paper). This data element should be clarified – perhaps to “method of collecting information from the consumer” with data elements for paper form completed by consumer, electronic form completed by consumer, phone application. Data elements for multiple approaches might be necessary.
In addition, a number of insurers are utilizing data pre-fill for applications in which the insurer utilizes third-party sources to obtain information about the consumer from sources other than the consumer. A Y/N data element for “consumer data obtained from third-party sources” might be useful to distinguish applications that relied upon only data provided by the consumer or upon consumer-supplied data plus third-party data.

For the “applicant type” data field, can a COLI or BOLI or Trust-Owned also be either individual or group? It might be useful to break applicant type into two or three items – individual or group and type of group.

For the “gender” data field, is clarification or expansion needed to recognize transgender people?

For the “smoker and non-smoker classes” data fields, why are smoker and non-smoker classes separated into two data fields? Perhaps the two data fields could be combined into one data field – class – while keeping all the segments listed. With new methods of underwriting, smoker/non-smoker may become one characteristic of several that determine a class. For illustration, an insurer might develop a 10-class system in which smoker/non-smoker, credit score, social media score and more are used to determine class placement. Another approach would be to have separate data fields for the components of class determination, such as a separate data field just for smoker/non-smoker.

Also, to be meaningful for any type of aggregation purposes, a data field is needed to report the total number of smoker and non-smoker classes. Third-preferred class for an insurer with three classes is significantly different from third-preferred class for an insurer with ten classes.

Finally, with the advent of AUW and scoring algorithms, the number of classes may grow exponentially. That has been the experience on the property casualty side. For example, for personal auto, Allstate went from nine classes to 384 in the mid 2000’s and now employs tens or hundreds of thousands of classes.
CEJ Comments to LATF Experience Reporting Subgroup: VM 51
November 10, 2019
Page 3

Page 110

For the “Length of Surrender Charge Period” data field, what is the purpose or intended use of these data? We ask because the reporting options are ten-year periods that seem too broad for meaningful analysis. It seems like the more granularity would facilitate better data analysis. In addition, we suggest that instead of a series of ten-year periods for reporting options, this data element simply require the length of the surrender charge period in years. The statistical agent will be able to create time periods if needed, but the specific number of years will permit more robust analysis.

Page 110:

For the “Distribution Channel” data field, two concepts are mingled – distribution and marketing. Some of the reporting options refer to the intermediary distributing the product – career, independent, broker, IMO, financial planner – while other options refer to marketing – website, direct mail, print media, tv, telephone. The data element should be clarified and limited to distribution channel. If type of marketing is relevant, than a separate data field is advisable.

In any event, reporting choices should be defined to ensure the choices are mutually exclusive or that a reporting option is provided to permit multiple selections.

Page 120

For the “Type of Underwriting Requirement” data field, two concepts are mingled – type of underwriting and method of acquisition (guaranteed issue, term conversion, group conversion, exercise of a guaranteed insurability option). These latter categories seem to be variations of “not underwritten” and belong in a different data field.

Definitions of the terms – traditional, simplified, guaranteed, accelerated underwriting – are needed to ensure the choices are mutually exclusive and understandable to reporting companies.

Page 120

For the “Is financial data of any kind used in a marketing pre-screening process?” data field, “financial data” should be defined as it is a very broad concept. This data element might be broken out into consumer credit information and non-credit consumer financial data.

Page 121

For the “Was there an underwriter review?” data field, we suggest the choices be expanded to unknown, yes via algorithm only, yes via human, no.
CEJ Comments to LATF Experience Reporting Subgroup: VM 51
November 10, 2019
Page 4

Page 121

For the “After the policy is issued, is monitoring employed?” data field, we suggest adding Yes, wearable or other internet-enabled devices

Page 121

For the “Was the application designed with Sentinel Value or Behavioral Economics considerations?” data field, the definition of “Sentinel Value” describes a particular application design while the definition of “Behavioral Economics” describes a field of research. We suggest this data field needs further consideration and more specificity towards specific techniques or practices. Ask if these issues were considered is overly broad.

Page 122

For the “predictive analytics for marketing selection (lead generation)” data field, we suggest some refinement is needed. For decades, insurers have obtained lists of consumers from consumer reporting agencies (credit bureaus) who met certain qualifications (such as a minimum credit score). This was/is a crude form of predictive analytics. We suspect the intent of this data field is to identify more refined approaches that might utilize non-credit data. We suggest the following reporting options: unknown, no, yes based only consumer credit information, yes based only non-credit consumer data, yes based on consumer credit information plus additional data.

Page 122

For the “predictive analytics for underwriting triage or risk classification” data field, we suggest some refinement is needed. Traditional underwriting and risk classification utilizes predictive analytics based on mortality tables and selected consumer characteristics. The term “predictive analytics” should be defined to distinguish the information sought with this data field from traditional predictive analytics used for underwriting and risk classification.

Pages 123 to 125

The data fields on these pages relate to health status and medical conditions of the consumer. We assume that all of these fields intend to collect these data as of the date of application, but a statement in that regard would be useful. We would note that with insurers’ access to data from consumers’ wearable devices and more widespread use of electronic medical records, insurers can update medical condition information routinely and rapidly.
For the financial and credit data fields, we offer the following. “Credit data” presumably means data from a credit bureau, which is technically known as a consumer reporting agency pursuant to the Fair Credit Reporting Act, which is the federal law that permits the use of such information for insurance underwriting. While, historically, some insurers reviewed consumer credit reports to identify specific events – such as a bankruptcy or other public record – for the past 25 years, insurers have utilized consumer credit data indirectly through the use of credit-based insurance scores.

In addition, “credit data,” understood as information in a consumer credit report, was historically limited to information on lines of credit – mortgages, auto loans, personal loans, credit cards – and consisted of payment history, amounts and types of credit and public records such as bankruptcy and loans in collection. However, in recent years, credit bureaus have begun to add “alternative” data to consumer credit files, including utility, telecom and rental payments.

We provide this background to suggest that data items 113, 114 and 115 could be refined to Financial Data Other Than a Consumer Credit Report; Consumer Credit Data Other Than a Credit-Based Scoring Algorithm and Credit-Based Insurance Score or Other Credit-Based Algorithm.

On page 126, there are three data elements related to driving – motor vehicle records, driving record – moving violation and driving record – specific violations. On page 127, we find the data field “driving record.” It is unclear what the data field on page 127 is attempting to capture that is not already captured in the page 126 data fields.

In addition, some vendors provide motor vehicle record information that expands upon that available in an individual state’s motor vehicle record. For example TransUnion provides a series of products related to driving violations1

Driving violations have historically been categorized as minor or major. Speeding may be a minor or major violation depending on how excessive the speeding is.

Based on the above, we suggest the following.

Data Field: Driving Record Information Used: No, Yes Major Violations Only, Yes All Violations, Yes, All Violations and Other Driving Record Information

1 https://www.transunion.com/resources/transunion/doc/products/resources/P-driverrisk-ig.pdf
Other Considerations

We suggest data fields that ask if the insurer utilized social media and facial analytics for underwriting (limited to the decision to accept or reject the applicant) or risk class placement.
VM-51: Experience Reporting Formats

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Appendix 1: Mortality Data Elements and Format ........................................................................
Appendix 2: Plan Design Data Elements and Format ....................................................................
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Section 1: Introduction

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

B. Each statistical plan shall contain the following information:

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

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

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

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

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

6. The experience data reports to be produced.

Section 2: Statistical Plan for Mortality

A. Type of Experience Collected Under This Statistical Plan

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

B. Scope of Business Collected Under This Statistical Plan

The scope of data to be collected under this statistical plan is individual ordinary life line of business.

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Direct written business issued in the U.S.;
Assumption reinsurance of an individual ordinary life line of business, where the assuming company is legally responsible for all benefits and claims paid;
Policies issued as conversions from term or group contracts;
Term/paid up riders or additional amounts of insurance purchased through dividend options; and
Terminations (both death and non-death).

Not included in scope:
Separate lines of business, such as SI/GI, worksite, individually solicited group life, direct response, final expense, pre-need, home service, credit life and COLI/BOLI/charity-owned life insurance (CHOLI);
Reinsurance assumed from a ceding company, to avoid double-counting of experience submitted by an issuer and by its reinsurers;
Policies that cover more than two lives on the base policy segment; and
Child term riders.

Such business is to include direct written business issued in the U.S., and all values should be prior to any reinsurance ceded. Therefore, reinsurance assumed from a ceding company shall be excluded from data collection to avoid double-counting of experience submitted by an issuer and by its reinsurers, however, assumption reinsurance of an individual ordinary life line of business, where the assuming company is legally responsible for all benefits and claims paid, shall be included within the scope of this statistical plan. The ordinary life line of business does not include separate lines of business, such as SI/GI, worksite, individually solicited group life, direct response, final expense, pre-need, home service, credit life and COLI/BOLI/charity-owned life insurance (CHOLI).

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

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

ii. For policies issued on or after Jan. 1, 1990, companies must:
   a) Document the percentage that the face amount of policies excluded are relative to the face amount of submitted policies issued on or after Jan. 1, 1990;
   b) Certify that this requirement presents a hardship due to fields not readily available in their systems/databases or legacy computer systems that continue to be used for older issued policies and differ from computer systems for newer issued policies.

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

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

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

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

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be two years prior to the reporting calendar year. For example, if the current calendar year is 2018 and that is the reporting calendar year, the company is to report the experience data for policies that were in-force or issued in calendar year 2016, which is the observation calendar year.

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

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

ii. Report terminations that occurred during calendar year 20XX and reported before July 1, 20XX+1. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during the second quarter, and data is to be submitted according to the requirements of the Valuation Manual in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Dec. 31 of the reporting calendar year.

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

Companies subject to reporting pursuant to the criteria stated in Section 2.C are required to complete the data elements and formats forms in Appendix 1 and Appendix 2 as appropriate, and also complete the Experience Data Elements and Formats as defined in underwriting specification data elements as defined in Appendix 43.

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

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

Terminations, each policy number represents a policy issued as a result of ordinary underwriting. If a single life policy, the base policy on a single life has the policy number and a segment number of 1. On a joint life policy, each life has separate records with the same policy number. The base policy on the first life has a segment number of 1, and the base policy on the second life has a segment number of 2. Policies that cover more than two lives are not to be submitted. Term/paid up riders or additional amounts of insurance purchased through dividend options on a policy issued as a result of ordinary underwriting are to be submitted. Each rider is on a separate record with the same policy number as the base policy and has a unique segment number. The details on the rider record may differ from the corresponding details on the base policy record. If underwriting in addition to the base policy underwriting is done, the coverage is given its own policy number. Terminations (both death and non-death) are to be submitted. Terminations are to include those that occurred in the observation year and were reported by June 30 of the year after the observation year.
Plans of insurance should be carefully matched with the three-digit code in item 19, Plan. These plans of insurance are important because they will be used not only for mortality experience data collection, but also for policyholder behavior experience data collection. It is expected that most policies will be matched to three-digit codes that specify a particular policy type rather than select a code that indicates a general plan type.

F. Experience Data Reports Required by This Statistical Plan

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

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

3. As long as a company is licensed in a state, that state insurance regulator will be given access to a company’s experience data that is stored on a confidential database at the Experience Reporting Agent. Access by the state insurance regulator will be controlled by security credentials issued to the state insurance regulator by the Experience Reporting Agent.
### Appendix 1: Mortality Data Elements and Format

#### Section 1: Basic Policy Information

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded. If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L.</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>PROSPECTIVE RETROSPECTIVE PHASE IN PERIOD</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>1–5</td>
<td>5</td>
<td>NAIC Company Code</td>
<td>Your NAIC Company Code</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>6–9</td>
<td>4</td>
<td>Observation Year</td>
<td>Enter Calendar Year of Observation</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>10–29</td>
<td>20</td>
<td>Policy Number</td>
<td>Enter Policy Number. For Policy Numbers with length less than 20, left justify the number, and blank fill the empty columns. Any other unique identifying number can be used instead of a Policy Number for privacy reasons.</td>
<td></td>
</tr>
</tbody>
</table>

*Commented [MA4]: For elements that may not be readily available, the phase in period identifies the year in which this element will be required.*
### Section 1. Basic Policy Information

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.

If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 4    | 30–32  | 3 | Segment Number | Includes all policy segment entry, entire segment number. For a single life policy, the base policy is to be put in the record with segment number ‘1.’ Subsequent policy segments are in separate records with information about that coverage and differing segment numbers.

For joint life policies, the base policy of the first life is to be put in a record with segment number ‘1,’ and the base policy of the second life is to be put in a separate record with segment number ‘2.’ Joint life policies with more than two lives are not to be submitted. Subsequent policy segments are in separate records with information about that coverage and differing segment numbers.

A policy segment is a layer of coverage that represents a unique combination of Items 3, 5, 6, and 16. Assign each policy segment a unique integer starting with ‘1’ for the base policy coverage. Use the same segment number for each policy segment in all Observation Years. Note that additional amounts of insurance should be reported in a separate policy segment, rather than added to the base coverage or reported in a new policy number.

For joint life policies, the base policy of the first life is to be put in the record with segment number ‘1,’ and the base policy of the second life is to be put in a separate record with segment number ‘2.’ Joint life policies with more than two lives are not to be submitted. Subsequent policy segments are in separate records with information about that coverage and differing segment numbers.

Policy segments with the same policy number are to be submitted for:
- Single life policies;
- Joint life policies;
- Term/paid up riders;
- Additional amounts of insurance including purchase through dividend options.

**Commented [MA4]:** For elements that may not be readily available, the phase in period identifies the year in which this element will be required.
### Section 1. Basic Policy Information

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.

If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>PROSPECTIVE RETROSPECTIVE PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>45</td>
<td>1</td>
<td>Segment Type</td>
<td>Base policy coverage: 01 = Base policy coverage 02 = Primary insured additional term rider 03 = Other insured permanent rider 034 = Other insured term rider 0405 = Accidental death and dismemberment rider 065 = Additional amounts of insurance purchased as the result of exercising a guaranteed insurability option 068 = Additional amounts of insurance purchased after issue 07 = Additional amounts of insurance purchased with dividends 079 = Other (life insurance coverage only)</td>
<td>Prospective 2023</td>
</tr>
<tr>
<td>1</td>
<td>45</td>
<td>1</td>
<td>Segment Type</td>
<td>Retrospective: 01 = Base policy coverage 02 = Primary insured additional term rider 03 = Other insured permanent rider 034 = Other insured term rider 0405 = Accidental death and dismemberment rider 065 = Additional amounts of insurance purchased as the result of exercising a guaranteed insurability option 068 = Additional amounts of insurance purchased after issue 07 = Additional amounts of insurance purchased with dividends 079 = Other (life insurance coverage only)</td>
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</tr>
<tr>
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<td>8</td>
<td>1</td>
<td>Type of Application</td>
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</tr>
<tr>
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<td>2</td>
<td>1</td>
<td>Applicant Type</td>
<td>0 = Unknown 1 = Individual Consumer 2 = Member of Employee Group (including worksite) 3 = Member of Association Group 4 = COLI 5 = BOLI 6 = Trust Owned 7 = Other</td>
<td>Prospective 2023</td>
</tr>
<tr>
<td>9</td>
<td>18:45</td>
<td>1</td>
<td>Application Signed Date</td>
<td>YYYYMMDD</td>
<td>Retrospective</td>
</tr>
<tr>
<td>10</td>
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<td>1</td>
<td>State of Issue</td>
<td>Use standard, two-letter state abbreviations (e.g., NY for New York)</td>
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<tr>
<td>38</td>
<td>39</td>
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<td>Participant Signed Date</td>
<td>Use standard, two-letter state abbreviations (e.g., NY for New York)</td>
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<tr>
<td>40</td>
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</tr>
</tbody>
</table>

Commented [MA4]: For elements that may not be readily available, the phase in period identifies the year in which this element will be required.

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### Section I: Basic Policy Information

- Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.
- If an item is unknown, leave blank unless otherwise specified.

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<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>PROSPECTIVE PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td>Gender</td>
<td></td>
<td>Prospective/Retrospective</td>
</tr>
<tr>
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<td>2-4</td>
<td>50</td>
<td></td>
<td>0 = Unknown or unable to subdivide</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 = Male</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 = Female</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 = Unisex – Unknown or unable to identify</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 = Unisex – Male</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 = Unisex – Female</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>5-11</td>
<td>40</td>
<td>Date of Birth</td>
<td>Enter the numeric date of birth in YYYYMMDD format</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>12-18</td>
<td>50</td>
<td>Age Basis</td>
<td>0 = Age Nearest Birthday</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 = Age Last Birthday</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 = Age Next birthday</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Date of Birth</td>
<td>Enter the numeric date of birth in YYYYMMDD format</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Issue Age</td>
<td>Enter the numeric date of birth in YYYYMMDD format</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Smoker Status (at issue)</td>
<td>Smoker status should be submitted where reliable.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0 = Unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 = No tobacco usage</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 = Nonsmoker</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 = Cigarette smoker</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 = Tobacco user</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preferred Class Structure Indicator</td>
<td>Preferred class structure means that, depending on the underwriting results, a policy could be issued in classes ranging from a best preferred class to a residual standard class.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0 = If no reliable information on multiple preferred and standard classes is available, or if the policy segment was issued substandard (Item 18 is 1 or 2), or if there were no multiple preferred and standard classes available for this policy segment or if preferred information is unknown.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 = If this policy was issued in one of the available multiple preferred and standard classes for this policy segment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Date of Birth</td>
<td>Enter the numeric date of birth in YYYYMMDD format</td>
<td></td>
</tr>
</tbody>
</table>

**Drafting Note:** Professional actuarial organization will need to develop either age next birthday mortality tables or procedure to adapt existing mortality tables to age next birthday basis.

**Commented [MA4]:** For elements that may not be readily available, the phase in period identifies the year in which this element will be required.

**Commented [MA5]:** Moved this item to plan table.
### Section 1: Basic Policy Information

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded. If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>PROSPECTIVE PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>123</td>
<td>123</td>
<td>1</td>
<td>Number of Classes in Nonsmoker Preferred Class Structure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>124</td>
<td>124</td>
<td>1</td>
<td>Preferred Class Structure Indicator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>125</td>
<td>125</td>
<td>1</td>
<td>Number of Classes in Standard Preferred Class Structure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For nonsmoker or no tobacco usage policies that could have been issued as one of multiple preferred and standard classes, enter the number of nonsmoker preferred and standard classes available at time of issue.

Commented [MA4]: For elements that may not be readily available, the phase in period identifies the year in which this element will be required.

Commented [MA6]: Moved this item to plan table.

Commented [MA7]: Moved this item to plan table.

Commented [MA8]: Moved this item to plan table.

Commented [MA9]: Moved this item to plan table.

Commented [MA10]: Moved this item to plan table.
## Section 1. Basic Policy Information

Round all dollar amounts in the table to the nearest dollar. All values should be prior to any reinsurance ceded. If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>PROSPECTIVE PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td></td>
<td>1</td>
<td>Nonsmoker Preferred Class</td>
<td>1 = Best preferred class&lt;br&gt;2 = Next Best preferred class after 1&lt;br&gt;3 = Next Best preferred class after 2&lt;br&gt;4 = Next Best preferred class after 3&lt;br&gt;5 = Next Best preferred class after 4&lt;br&gt;6 = Next Best preferred class after 5&lt;br&gt;7 = Next Best preferred class after 6&lt;br&gt;8 = Next Best preferred class after 7&lt;br&gt;9 = Next Best preferred class after 8</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td>1</td>
<td>Number of Classes in Nonsmoker Preferred Class Structure</td>
<td>Number of Classes in Nonsmoker Preferred Class Structure</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td>1</td>
<td>Smoker Preferred Class</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, enter 0. If Preferred Class Structure Indicator is 0 or unreliable, policy segment was issued substandard, or if Smoker Status is 0, enter 0. For smoker or tobacco user policies that could have been issued as one of multiple preferred and standard classes, enter the number of smoker preferred and standard classes available at time of issue.</td>
<td></td>
</tr>
</tbody>
</table>

Commented [MA4]: For elements that may not be readily available, the phase in period identifies the year in which this element will be required.

Commented [MA11]: Moved to Plan Table

Commented [MA12]: Moved this item to plan table

Commented [MA13]: Moved this item to plan table
## Section 1: Basic Policy Information

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded. If item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>PROSPECTIVE</th>
<th>RETROSPECTIVE</th>
<th>PHASE IN PERIOD</th>
</tr>
</thead>
</table>
| 16   | 19     | 1 | Smoker Preferred Class | For smoker policy segments that could have been issued as one of multiple preferred and standard classes:  
1 = Best preferred class  
2 = Next Best preferred class after 1  
3 = Next Best preferred class after 2  
4 = Next Best preferred class after 3  
5 = Next Best preferred class after 4  
6 = Next Best preferred class after 5  
7 = Next Best preferred class after 6  
8 = Next Best preferred class after 7  
9 = Next Best preferred class after 8  
Note: The policy segment with the highest Smoker Preferred Class number should have that number equal to the Number of Classes in Smoker Preferred Class Structure. | Commented (M44): For elements that may not be readily available, the phase-in period identifies the year in which this element will be required. | | |
Section 1. Basic Policy Information

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded. If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>64.05</td>
<td>2</td>
<td>Type of Underwriting Requirements</td>
<td>If underwriting requirement of ordinary business is reliably known, use code other than “99.” Ordinary business does not include separate lines of business, such as simplified issue/guaranteed issue, worksite, individually solicited group life, direct response, final expense, pre-need, home service and COLI/BOLI/CHOLI. If underwriting requirement of ordinary business is reliably known, use code other than “99.” Ordinary business does not include separate lines of business, such as simplified issue/guaranteed issue, worksite, individually solicited group life, direct response, final expense, pre-need, home service and COLI/BOLI/CHOLI.</td>
</tr>
<tr>
<td>18</td>
<td>66</td>
<td>1</td>
<td>Substandard Indicator</td>
<td>0 = Policy segment is not substandard 1 = Policy segment is substandard 2 = Policy segment is uninsurable</td>
</tr>
</tbody>
</table>

Note: All policy segments that are substandard need to be identified as substandard or uninsurable. Submission of substandard policies is optional. If feasible, identify substandard policy segments where temporary flat extra has ceased as substandard.
## Section I: Basic Policy Information

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded. If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>PROSPECTIVE</th>
<th>RETROSPECTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>15:77</td>
<td>1</td>
<td>Extra Mortality Table Rating</td>
<td>If Substandard Indicator, is 1, and the extra mortality percentage is known, then enter the mortality rating as a percentage of the standard mortality (e.g. if the risk is classified as exhibiting 150% of standard mortality, enter 150). If Substandard Indicator, is 1, and the extra mortality percentage is unknown, enter 000.</td>
<td>Retrospective</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>18</td>
<td>1</td>
<td>Type of Flat Extra Mortality</td>
<td>If Substandard Indicator, is 1, and the policy segment was issued with an extra flat mortality rate per 1000 of insurance amount and is currently in effect: enter the current permanent or temporary extra mortality per 1000 of insurance (e.g. if the risk is being charged an extra $4.50 per 1000 of insurance, enter 00450). If the flat extra rate is unknown, enter 00000.</td>
<td>Retrospective</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>90:83</td>
<td>1</td>
<td>Rated Issue Age</td>
<td>If Substandard Indicator, is 1, and the policy segment was issued at an age rate higher than to the actual issue age, and which is currently in effect: enter the rated issue age at which the policy was issued (e.g. if the actual issue age is 45 and the rates are based on issue age 50, enter 050). If the rates issue age is unknown, enter 000.</td>
<td>Retrospective</td>
<td></td>
</tr>
</tbody>
</table>

**Commented [MA4]:** For elements that may not be readily available, the phase in period identifies the year in which this element will be required.

**Commented [MA15]:** Did not include extensive list of plan descriptions.
<table>
<thead>
<tr>
<th>Base Plan Identifier</th>
<th>Ties to item #3 from 00 = If unable to distinguish among plan types listed below</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Term life</td>
</tr>
<tr>
<td>02</td>
<td>Whole life</td>
</tr>
<tr>
<td>03</td>
<td>Econolife (combination of permanent life and term life)</td>
</tr>
<tr>
<td>04</td>
<td>Excess interest whole life</td>
</tr>
<tr>
<td>05</td>
<td>Universal life</td>
</tr>
<tr>
<td>06</td>
<td>Extended term (nonforfeiture)</td>
</tr>
<tr>
<td>07</td>
<td>Reduced paid-up (nonforfeiture)</td>
</tr>
</tbody>
</table>

Exclude from contribution: spouse and children under family policies or riders. If Form for Additional Plan Codes was submitted for this policy, enter unique three-digit plan number(s) that differ from the plan numbers below:

<table>
<thead>
<tr>
<th>Base Plan Identifier</th>
<th>Ties to item #3 from 00 = If unable to distinguish among plan types listed below</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>Permanent plans</td>
</tr>
<tr>
<td>100</td>
<td>Joint life plan</td>
</tr>
</tbody>
</table>

Permanent Plans:
- 010 = Traditional fixed premium fixed benefit permanent plan
- 011 = Permanent life (traditional) with term
- 012 = Single premium whole life
- 013 = Econolife (permanent life with lower premiums in the early durations)
- 014 = Excess interest whole life
- 015 = First to die whole life plan
- 016 = Second to die whole life plan
- 017 = Joint whole life plan
- 018 = Permanent products with non-level death benefits
- 019 = Permanent products with non-level death benefits

Term Insurance Plans:
- 210 = Term (traditional level benefit and attained age premium)
- 211 = Term (level death benefit with guaranteed level premium for five years and guaranteed level term period for 10 years)
- 212 = Term (level death benefit with guaranteed level premium for five years and guaranteed level term period for 15 years)
- 213 = Term (level death benefit with guaranteed level premium for five years and guaranteed level term period for 20 years)
<table>
<thead>
<tr>
<th>Plan</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>214</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>215</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>022</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 10 years)</td>
</tr>
<tr>
<td>221</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 15 years)</td>
</tr>
<tr>
<td>222</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>223</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>224</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>023</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 15 years)</td>
</tr>
<tr>
<td>231</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>232</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>233</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>024</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>241</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>242</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>025</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>251</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>026</td>
<td>Term (level death benefit with guaranteed level premium for 30 years and anticipated level term period for 30 years)</td>
</tr>
</tbody>
</table>
027 = Term (level death benefit with guaranteed level premium period equal to anticipated level term period, where the period is other than five, 10, 15, 20, 25 or 30 years)

028 = Term (decreasing benefit)

040 = Select ultimate term (premium depends on issue age and duration)

041 = Return of Premium Term (level death benefit with guaranteed level premium for 15 years)

042 = Return of Premium Term (level death benefit with guaranteed level premium for 20 years)

043 = Return of Premium Term (level death benefit with guaranteed level premium for 25 years)

044 = Return of Premium Term (level death benefit with guaranteed level premium for 30 years)

045 = Return of Premium Term (level death benefit with guaranteed level premium for period other than 15, 20, 25 or 30 years)

046 = Economatic term

059 = Term plan, unable to classify

101 = First to die term plan (submit separate records for each life)

102 = Second to die term plan (submit separate records for each life)

103 = Joint term plan – unknown whether 101 or 102 (submit separate records for each life)

Universal Life Plans (Other than Variable), issued without a Secondary Guarantee:

061 = Single premium universal life

062 = Universal life (decreasing risk amount)

063 = Universal life (level risk amount)

064 = Universal life – unknown whether code 062 or 063

065 = First to die universal life plan (submit separate records for each life)

066 = Second to die universal life plan (submit separate records for each life)

067 = Joint life universal life plan – unknown whether code 065 or 066 (submit separate records for each life)

068 = Indexed universal life

Universal Life Plans (Other than Variable) with Secondary Guarantees:

071 = Single premium universal life with secondary guarantees

101 = First to die universal life plan without separate records

102 = Second to die universal life plan without separate records

103 = Joint life universal life plan without separate records

104 = Universal life plan – unknown whether 101 or 102 (submit separate records for each life)

Universal Life Plans (Other than Variable) with Secondary Guarantee:

071 = Single premium universal life with secondary guarantees

072 = Universal life plan without separate records

073 = Joint life universal life plan without separate records

074 = Indexed universal life

075 = Universal life plan – unknown whether 071 or 072 (submit separate records for each life)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>072</td>
<td>Universal life with secondary guarantees (decreasing risk amount)</td>
</tr>
<tr>
<td>073</td>
<td>Universal life with secondary guarantees (level risk amount)</td>
</tr>
<tr>
<td>074</td>
<td>Universal life with secondary guarantees – unknown whether code 072 or 073</td>
</tr>
<tr>
<td>075</td>
<td>First to die universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>076</td>
<td>Second to die universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>077</td>
<td>Joint life universal life plan with secondary guarantees – unknown whether code 075 or 076 (submit separate records for each life)</td>
</tr>
<tr>
<td>078</td>
<td>Indexed universal life with secondary guarantees</td>
</tr>
<tr>
<td>080</td>
<td>Variable life</td>
</tr>
<tr>
<td>081</td>
<td>Variable universal life (decreasing risk amount)</td>
</tr>
<tr>
<td>082</td>
<td>Variable universal life (level risk amount)</td>
</tr>
<tr>
<td>083</td>
<td>Variable universal life – unknown whether code 081 or 082</td>
</tr>
<tr>
<td>084</td>
<td>First to die variable universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>085</td>
<td>Second to die variable universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>086</td>
<td>Joint life variable universal life plan with secondary guarantees – unknown whether code 084 or 085 (submit separate records for each life)</td>
</tr>
<tr>
<td>090</td>
<td>Variable life with secondary guarantees</td>
</tr>
<tr>
<td>091</td>
<td>Variable universal life with secondary guarantees (decreasing risk amount)</td>
</tr>
<tr>
<td>092</td>
<td>Variable universal life with secondary guarantees (level risk amount)</td>
</tr>
<tr>
<td>093</td>
<td>Variable universal life with secondary guarantees – unknown whether code 091 or 092</td>
</tr>
<tr>
<td>094</td>
<td>First to die variable universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>095</td>
<td>Second to die variable universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>096</td>
<td>Joint life variable universal life plan with secondary guarantees – unknown whether code 094 or 095 (submit separate records for each life)</td>
</tr>
<tr>
<td>098</td>
<td>Extended term</td>
</tr>
<tr>
<td>099</td>
<td>Reduced paid-up</td>
</tr>
</tbody>
</table>

Variable Life Plans with Nonforfeiture:
- 600 | Nonforfeiture

Nonforfeiture:
- 601 | Extended term
- 602 | Reduced paid-up
### Section 1: Basic Policy Information

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.

If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>PROSPECTIVE PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>92/101</td>
<td>H</td>
<td>Plan Code</td>
<td>Company’s plan code used for this policy</td>
<td>Retrospective</td>
</tr>
<tr>
<td>29</td>
<td>93</td>
<td></td>
<td>Product Type</td>
<td>00 = If unable to distinguish among plan types listed below</td>
<td></td>
</tr>
<tr>
<td></td>
<td>102/103</td>
<td></td>
<td></td>
<td>01 = Term life</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>02 = Whole life</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>03 = Econolife (combination of permanent life and term life)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>04 = Excess interest whole life</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>05 = Universal life</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>06 = Extended term (nonforfeiture)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>07 = Reduced paid-up (nonforfeiture)</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>89</td>
<td></td>
<td>Insured Type</td>
<td>1 = Single life</td>
<td></td>
</tr>
<tr>
<td></td>
<td>90</td>
<td></td>
<td></td>
<td>2 = Second to die (submit separate segments for each life)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>91</td>
<td></td>
<td></td>
<td>3 = First to die (submit separate segments for each life)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>92</td>
<td></td>
<td></td>
<td>4 = Joint (unknown if first or second)</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>85</td>
<td></td>
<td>Premium Type</td>
<td>0 = If term policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>96</td>
<td></td>
<td></td>
<td>1 = Single pay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>105</td>
<td></td>
<td></td>
<td>2 = Fixed limited pay</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 = Fixed premium (level)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 = Fixed premium (increasing)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 = Fixed premium (decreasing)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6 = Flexible premium</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7 = Other</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>97</td>
<td></td>
<td>Death Benefit Option</td>
<td>0 = If not universal life policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>98</td>
<td></td>
<td></td>
<td>1 = A/1 (Level death benefit)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99</td>
<td></td>
<td></td>
<td>2 = B/2 (Increasing death benefit based on cash value)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 = C/3 (Increasing death benefit based on premium)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 = Other</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>100</td>
<td></td>
<td>Crediting Type</td>
<td>0 = If term policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 = Fixed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 = Indexed / Interest Sensitive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 = Variable</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 = Other</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>101</td>
<td></td>
<td>Participation Type</td>
<td>1 = Participating</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 = Non-participating</td>
<td></td>
</tr>
</tbody>
</table>

Commented [MA4]: For elements that may not be readily available, the phase in period identifies the year in which this element will be required.
### Section 1. Basic Policy Information

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded. If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>PROSPECTIVE PHASE IN PERIOD</th>
</tr>
</thead>
</table>
| 19.6 | 20     | 1 | Length of Surrender Charge Period | 0 = No surrender charge period  
1 = 0 to 9.99 years  
2 = 10 to 19.99 years  
3 = 20 to 29.99 years  
4 = 30 to 39.99 years  
5 = 40+ years | |
| 19.7 | 21     | 1 | Distribution Channel | 00 = Unknown  
01 = Career  
02 = Independent  
03 = Bank/wirehouse/broker  
04 = Website  
05 = Direct Mail / Email  
06 = Print Media  
07 = TV / Radio  
08 = Telephone  
09 = IMO (Independent Marketing Organization)  
10 = Financial Planner  
11 = Kiosk  
12 = Other/unknown | |
| 19.8 | 22     | 1 | Life Insurance Test | 1 = Cash value accumulation test  
2 = Guideline premium test | |
| 19.9 | 23     | 1 | Premium Ratio | TBD | |
| 20   | 24     | 1 | In-force Indicator | 0 = If the policy segment was not in force at the end of the calendar year of observation  
1 = If the policy segment was in force at the end of the calendar year of observation | |
| 21   | 25     | 1 | Face Amount of Insurance at Issue | |
### Section 1: Basic Policy Information

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded. If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>PROSPECTIVE</th>
<th>RETROSPECTIVE</th>
<th>PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>114-124</td>
<td>126-147</td>
<td>Face Amount of Insurance at the Beginning of the Observation Year</td>
<td>The face amount of the policy segment at the beginning of the observation year regardless of whether or not the policy was issued during the observation year. If returns of premium are included, the Face Amount at the Beginning of the Observation Year is considered a liability. If policy provides payment of cash value in addition to face amount, include face amount and do not include cash value. Exclude extra amounts attributable to 7702 corridors. If the policy was issued during the observation year, the Face Amount at the Beginning of the Observation Year should be blank.</td>
<td>Retrospective</td>
<td>Phase in period identifies the year in which this element will be required.</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>123-134</td>
<td>148-159</td>
<td>Face Amount of Insurance at the End of the Observation Year/Actual Termination Date</td>
<td>The face amount of the policy segment at the end of the observation year regardless of whether or not the policy was issued during the observation year. If returns of premium are included, the Face Amount at the End of the Observation Year/Actual Termination Date is considered a liability. If policy provides payment of cash value in addition to face amount, include face amount, and do not include cash value. Exclude extra amounts attributable to 7702 corridors. If In-force Indicator is 0, enter face amount of the policy segment at the time of termination, if available; otherwise, leave blank.</td>
<td>Retrospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>160-171</td>
<td>12</td>
<td>Ultimate Face Amount</td>
<td>Face Amount at maturity. Enter 999999999999 if not known at issue. Leave blank if using units.</td>
<td>Retrospective</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section 1: Basic Policy Information

If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>PROSPECTIVE</th>
<th>RETROSPECTIVE</th>
<th>PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>172-180</td>
<td>9</td>
<td>Number of Units</td>
<td>For policies that have a constant number of units for all policy durations but vary the dollar value of the unit over different policy durations, fill out the number of units. Leave blank if using amounts. The number of units is the ultimate face amount divided by 1000, rounded to the nearest integer.</td>
<td>Retrospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>181-189</td>
<td>9</td>
<td>Death Claim Units</td>
<td>If Inforce Indicator is 1 or amounts are used, leave blank. This number of units is to represent the number of units that were paid for the death claim. If Inforce Indicator is 0 and Cause of Termination is not '04', then leave blank.</td>
<td>Retrospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>202-203</td>
<td>3</td>
<td>Cause of Death Code Type</td>
<td>Identify the classification method of diagnosis for the death claim.</td>
<td>Prospective</td>
<td>2021</td>
<td></td>
</tr>
</tbody>
</table>

**Commented [MA4]:** For elements that may not be readily available, the phase in period identifies the year in which this element will be required.
### Section 1: Basic Policy Information

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded. If an item is unknown, leave blank unless otherwise specified.

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<th>DESCRIPTION</th>
<th>PROSPECTIVE PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>204-207</td>
<td>8</td>
<td>Primary Cause of Death</td>
<td>Enter the Primary Cause of Death Code using the type indicated in Cause of Death Code Type. If unknown, enter '0000000'. If not a death, leave blank. Enter the ICD 9/10 diagnosis code for the primary cause of death or enter the SOA's 1980 cause of death codes. If ICD9 code, insert the three-digit code (e.g. - if ICD9 code = 010 (Primary Tuberculosis infections), enter &quot;010&quot;). Do not include supplementary digits 4 nor 5 in the code. For e800-e999, use the letter and 3 digit number, e.g. for e806-Other specified railway accident, enter &quot;e806&quot;. Note: the base 800-999 codes (those without a letter classification) are morbidity codes, not mortality codes. If ICD10 code, insert the letter and first two digits (e.g. - if ICD10 code = A00 (Cholera), insert &quot;A00&quot;). Do not include any additional supplementary digits in the code. If SOA 1980 codes are used, insert the three digit SOA class code (e.g. for 07 Septicemia, insert &quot;070&quot;). Leave blank if unknown or if termination is other than by death.</td>
<td>Prospective 2021</td>
</tr>
<tr>
<td>46</td>
<td>208-211</td>
<td>8</td>
<td>Secondary Cause of Death</td>
<td>Enter the Secondary Cause of Death Code using the type indicated in Cause of Death Code Type. If unknown or no secondary cause of death, enter '0000000'. If not a death, leave blank. Enter the ICD 9/10 diagnosis code for the secondary cause of death or enter the SOA's 1980 cause of death codes. If ICD9 code, insert the letter (if applicable) and the three-digit code (e.g. - if ICD9 code = 010 (Primary Tuberculosis infections), enter &quot;0010&quot;). Do not include supplementary digits 4 nor 5 in the code. For e800-e999, use the 3 digit number, e.g. for e806-Other specified railway accident, enter &quot;e806&quot;. Note: the base 800-999 codes (those without a letter classification) are morbidity codes, not mortality codes. If ICD10 code, insert the letter and first two digits (e.g. - if ICD10 code = A00 (Cholera), insert &quot;A00&quot;). Do not include any additional supplementary digits in the code. If SOA 1980 codes are used, insert the three digit SOA class code (e.g. for 07 Septicemia, insert &quot;070&quot;). Leave blank if the secondary cause of death is unknown or if termination is other than by death.</td>
<td>Prospective 2021</td>
</tr>
<tr>
<td>43</td>
<td>104-105</td>
<td>10</td>
<td>Termination Reported Date</td>
<td>If In-force Indicator is 1, leave blank. Enter in the format YYYYMMDD the eight-digit calendar date that the termination was reported.</td>
<td></td>
</tr>
</tbody>
</table>

Commented [MA4]: For elements that may not be readily available, the phase in period identifies the year in which this element will be required.
### Section 1. Basic Policy Information

Due to delays in obtaining the initial input data, the rules in the Attachments should be implemented by the phase-in periods indicated. Any item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>PROSPECTIVE PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>155-156</td>
<td>284-285</td>
<td>48</td>
<td>Actual Termination Date</td>
<td>If In-force Indicator is 1, leave blank. Enter in the format YYYYMMDD the eight-digit calendar date when the termination occurred. If termination is due to death (Cause of Termination is 04), enter actual date of death. If termination is lapse due to non-payment of premium (Cause of Termination is 01 or 02 or 14), enter the last day the premium was paid.</td>
</tr>
<tr>
<td>27</td>
<td>163-164</td>
<td>229-230</td>
<td>49</td>
<td>Cause of Termination</td>
<td>If In-force Indicator is 1, leave blank. 00 = Termination type unknown or unable to subdivide among 01, 02, 03, 07, 09, 10, 11, 13 01 = Reduced paid-up 02 = Extended term 03 = Voluntary; unable to subdivide among 01, 02, 07, 09, 10, 11 or 13 04 = Death 07 = 1035 exchange 09 = Term conversion – unknown whether attained age or original age 10 = attained age term conversion 11 = Original age term conversion 12 = Coverage expired or contract reached end of the mortality table 13 = Surrendered for full cash value 14 = Lapse (other than to Reduced Paid Up or Extended Term) 15 = Termination via payment of a discounted face amount while still alive, pursuant to an accelerated death benefit provision</td>
</tr>
</tbody>
</table>

Commented [MA4]: For elements that may not be readily available, the phase in period identifies the year in which this element will be required.
### Section 1: Basic Policy Information

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded. If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>10</td>
<td>Annualized Premium at Issue</td>
<td>For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, plan, enter the annualized premium set at issue. Except for level term segments specified above, leave blank for non-base segments. For the base segments for ULSG, and Variable Life with Secondary Guarantees (VLSG) with plan codes 071 through 078 or 090 through 096 of Item 19, plan, enter the annualized billed premium set at issue. Round to the nearest dollar. If unknown, leave blank. For Segment 01 through 03 (Item 5) level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, plan, enter the annualized premium set at issue. For all other segments, leave blank unless otherwise specified. For the base segments for ULSG, and Variable Life with Secondary Guarantees (VLSG) with plan codes 071 through 078 or 090 through 096 of Item 19, plan, enter the annualized billed premium set at issue. Round to the nearest dollar. If unknown, leave blank.</td>
</tr>
</tbody>
</table>

*Commented [MA4]: For elements that may not be readily available, the phase in period identifies the year in which this element will be required.*

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### Section 1: Basic Policy Information

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded. If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
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<th>L</th>
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<th>DESCRIPTION</th>
<th>PROSPECTIVE</th>
<th>RETROSPECTIVE</th>
<th>PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>X</td>
<td>10</td>
<td>Annualized Premium at the Beginning of Observation Year</td>
<td>For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, enter the annualized premium for the policy year that includes the beginning of the observation year. Except for level term segments specified above, leave blank for non-base segments. For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, enter the annualized billed premium for the policy year that includes the beginning of the observation year. Except for level term segments specified above, leave blank for non-base segments. Round to the nearest dollar. For policies issued in the observation year, leave blank. If unknown, leave blank.</td>
<td>Commented [MA4]: For elements that may not be readily available, the phase in period identifies the year in which this element will be required.</td>
<td></td>
<td>175-184</td>
</tr>
</tbody>
</table>

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For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, for each segment that has Item 20, with the In-force Indicator = 1, enter the annualized premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized premium that would have been paid at the end of the observation year. If the end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26).

Except for level term segments specified above, leave blank for non-base segments.

For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, use the annualized billed premium. For base segments that have Item 20, with the In-force Indicator = 1, enter the annualized billed premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized billed premium that would have been paid at the end of the observation year. If the end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26).

Round to the nearest dollar.
If unknown, leave blank.

For Segment Types 01 through 03 (Item 5) level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, for each segment that has Item 20, with the In-force Indicator = 1, enter the annualized premium for the policy year that includes the end of the observation year.

For Segment Types 01 through 03 (Item 5) where the In-force Indicator = 0, enter the annualized premium that would have been paid at the end of the observation year. If end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26).

Except for level term segments specified above, leave blank for non-base segments.

For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, use the annualized billed premium. For base segments that have Item 20, with the In-force Indicator = 1, enter the annualized billed premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized billed premium that would have been paid at the end of the observation year. If the end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26).

Round to the nearest dollar.
If unknown, leave blank.
<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
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<th>DESCRIPTION</th>
<th>PROSPECTIVE</th>
<th>RETROSPECTIVE</th>
</tr>
</thead>
</table>
| 44   | 60-606 | 200–206 | $2.1-4.5 \% | Premium Mode | 01 = Annual  
02 = Semiannual  
03 = Quarterly  
04 = Monthly Bill Sent  
05 = Monthly Automatic Payment  
06 = Semi-monthly  
07 = Biweekly  
08 = Weekly  
09 = Single Premium  
10 = Other/Unknown | Retrospective |  
Commented [MA4]: For elements that may not be readily available, the phase-in period identifies the year in which this element will be required. |
| 45   | 602    |  | Latest Payment Type | If policy is terminated, then enter the last payment type used prior to termination.  
0 = Unknown  
1 = Direct  
2 = Payroll Deduction / Group  
3 = Credit Card / Debit Card  
4 = EFT / Pre-Authorized check  
5 = Coupon  
6 = Other  
7 = Unable to Determine | Retrospective |  
Commented [MA4]: For elements that may not be readily available, the phase-in period identifies the year in which this element will be required. |
| 53   | 602    |  | Cumulative Premium Collected as of the Beginning of the Observation Year | For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: If not ULSG or VLSG, leave blank.  
1) For non-base segments, leave blank.  
2) For base segments, enter the cumulative premium collected since issue, as of the beginning of the observation year. Round to the nearest dollar.  
If unknown, leave blank.  
For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:  
1) For non-base segments, leave blank.  
2) For base segments, enter the cumulative premium collected since issue, as of the beginning of the observation year. Round to the nearest dollar.  
For policies issued in the observation year, leave blank.  
If unknown, leave blank. |
### Section I. Basic Policy Information

Due to pending lawsuits in the nature of design, data about the following must be reported per prior year's Underwriting year.

#### DATA ELEMENT DESCRIPTION

<table>
<thead>
<tr>
<th>ITEM</th>
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<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td>207-216, 273-282</td>
<td>10</td>
<td>Cumulative Premium</td>
<td>Collected as of the End of Observation Year if available. Otherwise Cumulative Premium Collected as of Actual Termination Date (Item 26). Round to the nearest dollar. If unknown, leave blank. For ULSG, and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: 1) For non-base segments, leave blank. 2) For base segments in force at the end of the observation year, enter the cumulative premium collected as of the end of the observation year. 3) For base segments terminated during the observation year, enter the cumulative premium collected since issue, or as of the Actual Termination Date (Item 26). Round to the nearest dollar. If unknown, leave blank.</td>
</tr>
<tr>
<td>57</td>
<td>283</td>
<td>1</td>
<td>Policy On Premium Waiver</td>
<td>0 = Unknown 1 = Policy not converted, not on waiver 2 = Policy not converted but on waiver 3 = Policy converted, then on waiver 4 = Policy on waiver then converted</td>
</tr>
<tr>
<td>58</td>
<td>284</td>
<td>1</td>
<td>Term Conversion Type</td>
<td>If policy was issued as a result of a term conversion, enter the type of term conversion: 0 = Unknown 1 = Original Age Term Conversion 2 = Attained Age Term Conversion 3 = Unknown whether Original Age or Attained Age Term Conversion 4 = Not a Term Conversion</td>
</tr>
<tr>
<td>59</td>
<td>285-292</td>
<td>8</td>
<td>Original Issue Date</td>
<td>If Type of Term Conversion is 1; enter the issue date of the original policy in YYYYMMDD format. If the issue date of the original policy is unknown, please leave blank. Otherwise, Leave blank</td>
</tr>
</tbody>
</table>

Commented [MA4]: For elements that may not be readily available, the phase in period identifies the year in which this element will be required.
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<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>06</td>
<td>1</td>
<td>Type of Underwriting Requirements</td>
<td>If underwriting requirement of ordinary business is reliably known, use code other than “99.” Ordinary business does not include separate lines of business, such as simplified issue/guaranteed issue, worksite, individually solicited group life, direct response, final expense, pre-need, home service and COLI/BOLI/CHOLI. If underwriting requirement of ordinary business is reliably known, use code other than “99.” Ordinary business does not include separate lines of business, such as simplified issue/guaranteed issue, worksite, individually solicited group life, direct response, final expense, pre-need, home service and COLI/BOLI/CHOLI.</td>
</tr>
</tbody>
</table>

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<tr>
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<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>05:03</td>
<td>9</td>
<td>Underwriting Specification Identifier</td>
<td>Identifier that ties to UW Specification File Item 3</td>
</tr>
</tbody>
</table>

Commented [MA17]: For elements that may not be readily available, the phase in period identifies the year in which this element will be required

Commented [MA18]: Changed location
### Section 2. Underwriting Information

For non-base segments, leave blank.

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.

If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
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<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 65   | 007    | 1 | Do you have a reflexive aspect to your application? | 0 = Unknown  
1 = No  
2 = Yes  
Reflexive questions are questions that are asked depending on the response to a previous question. For example, if the applicant answers yes to a specific condition question, then reflexive questions would gather additional information about the condition.

Prospective 2021 |
| 66   | 008    | 1 | Was there an underwriter review? | 0 = Unknown  
Y = Yes  
N = No  
Round to the nearest dollar.

Prospective 2023 |
| 67   | 009    | 1 | After the policy is issued, is monitoring employed? | 0 = Unknown  
1 = No or None  
2 = Yes, Prescription Data  
3 = Yes, Attending Physician Statement  
4 = MIB  
5 = Multiple  
6 = Unknown, Leave Blank

Prospective 2024 |
| 68   | 010    | 1 | Was the application designed with Sentinel Value or Behavioral Economic considerations? | 0 = Unknown  
1 = Yes  
2 = No  
Sentinel Value involves asking specific questions in order to prompt the applicant to divulge information that they might not otherwise divulge or to discourage them from proceeding with the application because of the information divulged.  
Behavioral Economics is the study of how cognitive, emotional, and social factors affect decision-making. In life insurance, the structure of the application, order of the questions and product design may all be developed with the thought of influencing the truthfulness of the applicant or policyholder. Round to the nearest dollar.

Prospective 2021 |
| 69   | 011    | 1 | Was there a senior underwriting questionnaire or protocol done? | 0 = Unknown  
1 = No  
2 = Yes

Prospective 2021 |
| 70   | 012    | 1 | Field Underwriting (Impairment or Rx Knockouts) | 0 = Unknown  
1 = No  
2 = Yes  
Round to the nearest dollar.

Prospective 2021 |

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<tr>
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<th>PROSPECTIVE/RETROSPECTIVE PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>71</td>
<td>313</td>
<td>Predictive Analytics for Marketing Selection (Lead Generation)</td>
<td>Prospective 2021</td>
</tr>
<tr>
<td>72</td>
<td>314</td>
<td>Predictive Analytics for Underwriting Triage or Risk Classification</td>
<td>Prospective 2021</td>
</tr>
<tr>
<td>73</td>
<td>315</td>
<td>Attending Physician Statement</td>
<td>Prospective 2021</td>
</tr>
<tr>
<td>74</td>
<td>316</td>
<td>Para-Medical Exam</td>
<td>Prospective 2021</td>
</tr>
<tr>
<td>75</td>
<td>317</td>
<td>Physician Exam</td>
<td>Prospective 2021</td>
</tr>
<tr>
<td>76</td>
<td>318</td>
<td>Electronic Health Records</td>
<td>Prospective 2021</td>
</tr>
<tr>
<td>77</td>
<td>319</td>
<td>Personal History Interview</td>
<td>Prospective 2021</td>
</tr>
<tr>
<td>78</td>
<td>320</td>
<td>Blood Sample</td>
<td>Prospective 2023</td>
</tr>
<tr>
<td>79</td>
<td>321</td>
<td>Urine / HGS specimen</td>
<td>Prospective 2023</td>
</tr>
</tbody>
</table>

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<th>DESCRIPTION</th>
<th>PROSPECTIVE / RETROSPECTIVE</th>
<th>PHASE IN PERIOD</th>
</tr>
</thead>
</table>
| 80   | 322    | 1 | Saliva / Oral fluid specimen | 0 = Unknown  
1 = No  
2 = Yes  
3 = Waived | Prospective 2023 |
| 81   | 323    | 1 | Stress Test | 0 = Unknown  
1 = No  
2 = Yes - treadmill test  
3 = Yes - chemical stressers  
4 = Waived | Prospective 2023 |
| 82   | 324    | 1 | MIB Requested | 0 = Unknown  
1 = No  
2 = Yes  
3 = Yes IAI  
4 = Yes both  
5 = Requested but not used | Prospective 2021 |
| 83   | 325    | 1 | Prescription History Data Requested | 0 = Unknown  
1 = No  
2 = Yes  
3 = Not used | Prospective 2021 |
| 84   | 326    | 1 | Prescription History Data Received | 0 = Unknown  
1 = No  
2 = Hit with drugs  
3 = Hit with no drugs  
4 = Not used | Prospective 2021 |
| 85   | 327    | 1 | Prescription Rating Provided Automatically | 0 = Unknown  
1 = No  
2 = Numerical Score  
3 = Severity Group  
4 = Both  
5 = Not used | Prospective 2021 |
| 86   | 328    | 1 | Personal History - Cancer | 0 = Unknown  
Y = Yes  
N = No | Prospective 2023 |
| 87   | 329-331 | 3 | Personal History - Cancer - Age at Diagnosis | Number | Prospective 2023 |
| 88   | 332    | 1 | Personal History - Cerebrovascular (stroke, arteria sclerotic vascular disease) | 0 = Unknown  
Y = Yes  
N = No | Prospective 2023 |
| 89   | 333-335 | 3 | Personal History - Cerebrovascular - Age at Diagnosis | Number | Prospective 2023 |

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<th>PROSPECTIVE PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>M6</td>
<td>1</td>
<td>Personal History – Coronary (heart attack, hypertensive heart disease, atherosclerotic vascular disease)</td>
<td>0 = Unknown, Y = Yes, N = No</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>91</td>
<td>M7/339</td>
<td>3</td>
<td>Personal History – Mental / Nervous</td>
<td>Number</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>92</td>
<td>M4</td>
<td>1</td>
<td>Personal History – Diabetes</td>
<td>0 = Unknown, Y = Yes, N = No</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>93</td>
<td>M4/341</td>
<td>3</td>
<td>Personal History – Alcohol Abuse</td>
<td>Number</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>94</td>
<td>M45/347</td>
<td>3</td>
<td>Personal History – Drug Abuse other than Marijuana</td>
<td>Number</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>95</td>
<td>M58</td>
<td>3</td>
<td>Personal History – Drug Abuse other than Marijuana</td>
<td>0 = Unknown, Y = Yes, N = No</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>96</td>
<td>M49/351</td>
<td>3</td>
<td>Personal History – Drug Abuse other than Marijuana</td>
<td>Number</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>97</td>
<td>M52</td>
<td>3</td>
<td>Personal History – Drug Abuse other than Marijuana</td>
<td>0 = Unknown, Y = Yes, N = No</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>98</td>
<td>M53/355</td>
<td>3</td>
<td>Personal History – Drug Abuse other than Marijuana</td>
<td>Number</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>99</td>
<td>M56</td>
<td>3</td>
<td>Personal History – Drug Abuse other than Marijuana</td>
<td>0 = Unknown, Y = Yes, N = No</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>100</td>
<td>M57/359</td>
<td>3</td>
<td>Personal History – Drug Abuse other than Marijuana</td>
<td>Number</td>
<td>Prospective 2025</td>
</tr>
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</thead>
</table>
| 102  | 660-364| 4 | Smoking status source | 0 = Unknown  
1 = App  
2 = E-Health Records  
3 = Paramed  
4 = APS  
5 = Other  
Enter all options that apply. (e.g. if both App and Paramed, then enter 13) | Prospective 2025 |
| 103  | 665-370| 6 | Blood Pressure source | 0 = Unknown  
1 = Not used  
2 = App self reported  
3 = E-Health Records  
4 = Paramed  
5 = APS  
6 = Other  
Enter all that apply (e.g. if App, Paramed, and APS, then enter 245) | Prospective 2025 |
| 104  | 771-373| 3 | Diastolic Blood Pressure | Numerical Value  
999 = Not collected | Prospective 2025 |
| 105  | 774-376| 3 | Systolic Blood Pressure | Numerical Value  
999 = Not collected | Prospective 2025 |
| 106  | 777    | 3 | Blood Pressure Treatment | 0 = Unknown  
1 = Not Treated  
2 = Treated  
3 = Not collected | Prospective 2025 |
| 107  | 778-382| 5 | Source of Height and Weight | 0 = Unknown  
1 = Self Reported  
2 = Independently Taken  
3 = E-Health Records  
4 = Paramed  
5 = APS  
6 = Other  
Enter all that apply (e.g. if both self reported and Paramed, then enter 14) | Prospective 2025 |
| 108  | 883-385| 3 | Height in inches | Numerical Value as an integer  
999 = Not collected | Prospective 2025 |
| 109  | 886-388| 3 | Weight in pounds | Numerical Value as an integer  
999 = Not collected | Prospective 2025 |
| 110  | 889-393| 5 | Cholesterol Source | 0 = Unknown  
1 = App / Self Reported  
2 = E-Health Records  
3 = Paramed  
4 = APS  
5 = Other  
Enter all options that apply. (e.g. if both App and Paramed, then enter 13) | Prospective 2025 |
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<th>PROSPECTIVE PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>111</td>
<td>394-396</td>
<td>1</td>
<td>Cholesterol Total</td>
<td>Numerical Value as an integer 999 = Not collected</td>
<td>Prospective 2023</td>
</tr>
<tr>
<td>112</td>
<td>395-399</td>
<td>1</td>
<td>HDL</td>
<td>Numerical Value as an integer 999 = Not collected</td>
<td>Prospective 2023</td>
</tr>
<tr>
<td>113</td>
<td>400</td>
<td>1</td>
<td>Financial Data (Income and Assets information on the Application)</td>
<td>0 = Unknown 1 = No 2 = Yes</td>
<td>Prospective 2021</td>
</tr>
<tr>
<td>114</td>
<td>401</td>
<td>1</td>
<td>Credit Data</td>
<td>0 = Unknown 1 = No 2 = Yes</td>
<td>Prospective 2021</td>
</tr>
<tr>
<td>115</td>
<td>402</td>
<td>1</td>
<td>Credit Behavior Mortality Risk Score (not FICO Credit Score)</td>
<td>0 = Unknown 1 = No 2 = Yes</td>
<td>Prospective 2021</td>
</tr>
<tr>
<td>116</td>
<td>403</td>
<td>1</td>
<td>Motor Vehicle Records Requested</td>
<td>0 = Unknown 1 = No 2 = Yes 3 = Yes &amp; used as part of a scoring system 4 = Waived 5 = Not used</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>117</td>
<td>404</td>
<td>1</td>
<td>Driving Record - Moving Violations</td>
<td>0 = Unknown Y = Yes N = No</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>118</td>
<td>405-407</td>
<td>1</td>
<td>Driving Record - Specific Violations</td>
<td>0 = Unknown 1 = Driving Under the Influence (DUI) 2 = Reckless Driving (RD) 3 = Driving License Suspended 4 = None of the above Enter all that apply (e.g. if DUI and License Suspended, enter 13)</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>119</td>
<td>408</td>
<td>1</td>
<td>Wearable Technology</td>
<td>0 = Unknown 1 = No 2 = Yes, as part of underwriting 3 = Yes, enforce engagement 4 = Both 2 and 3</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>120</td>
<td>409</td>
<td>1</td>
<td>Other New Technology or Data Considered</td>
<td>0 = Unknown Y = Yes N = No</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>121</td>
<td>410</td>
<td>1</td>
<td>Occupation</td>
<td>0 = Unknown 1 = No 2 = Yes: Information collected and rated as a result 3 = Yes: Information collected but not used 4 = Yes, Reflexive Question Only 5 = Actively at work question only</td>
<td>Prospective 2025</td>
</tr>
</tbody>
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<th>RETROSPECTIVE</th>
<th>PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>122</td>
<td>411</td>
<td>1</td>
<td>Avocation</td>
<td>0 = Unknown 1 = No 2 = Yes: Information collected and rated as a result 3 = Yes: Information collected but not used 4 = Yes, Reflexive Question Only</td>
<td>Prospective 2023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>123</td>
<td>412</td>
<td>1</td>
<td>Driving Record</td>
<td>0 = Unknown 1 = No 2 = Yes: Information collected and rated as a result 3 = Yes: Information collected but not used 4 = Yes, Reflexive Question Only</td>
<td>Prospective 2023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>124</td>
<td>413</td>
<td>1</td>
<td>Aviation</td>
<td>0 = Unknown 1 = No 2 = Yes: Information collected and rated as a result 3 = Yes: Information collected but not used</td>
<td>Prospective 2023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>125</td>
<td>414</td>
<td>1</td>
<td>Citizenship</td>
<td>0 = Unknown 1 = No 2 = Yes: Information collected and rated as a result 3 = Yes: Information collected but not used</td>
<td>Prospective 2023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>126</td>
<td>415</td>
<td>1</td>
<td>Foreign Travel</td>
<td>0 = Unknown 1 = No 2 = Yes: Information collected and rated as a result 3 = Yes: Information collected but not used</td>
<td>Prospective 2023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>127</td>
<td>416</td>
<td>1</td>
<td>Residency</td>
<td>0 = Unknown 1 = No 2 = Yes: Information collected and rated as a result 3 = Yes: Information collected but not used</td>
<td>Prospective 2023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>128</td>
<td>417:419</td>
<td>3</td>
<td>Family History Cancer</td>
<td>F = Father M = Mother S = Sibling blank if none Enter all that apply (e.g. if both Mother and Sibling, then enter MS)</td>
<td>Prospective 2023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>129</td>
<td>420-422</td>
<td>3</td>
<td>Family History Cancer Youngest Age at Diagnosis for Parent</td>
<td>Enter the youngest age at diagnosis for either parent identified in item 128 Blank if none</td>
<td>Prospective 2023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>130</td>
<td>423-425</td>
<td>3</td>
<td>Family History Cancer Youngest Age at Death for Parent</td>
<td>Enter the youngest age at death for either parent identified in item 128 Blank if none</td>
<td>Prospective 2023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>131</td>
<td>426-428</td>
<td>3</td>
<td>Family History Cancer Youngest Age at Diagnosis for Sibling</td>
<td>Enter the youngest age at diagnosis for sibling(s) identified in item 128 Blank if none</td>
<td>Prospective 2023</td>
<td></td>
<td></td>
</tr>
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<th>RETROSPECTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>132</td>
<td>429-431</td>
<td>1</td>
<td>Family History - Cancer - Youngest Age at Death for Sibling</td>
<td>Enter the youngest age at death for sibling(s) identified in item 128. Blank if none</td>
<td>Prospective 2025</td>
<td></td>
</tr>
</tbody>
</table>
| 133  | 432-434| 1 | Family History - Cerebrovascular (stroke, arteria sclerotic vascular disease) | F = Father  
M = Mother  
S = Sibling  
Blank if none  
Enter all that apply (e.g. if both Mother and Sibling, then enter MS) | Prospective 2025 |               |
| 134  | 435-437| 1 | Family History - Cerebrovascular - Youngest Age at Diagnosis for Parent | Enter the youngest age at diagnosis for either parent identified in item 133. Blank if none | Prospective 2025 |               |
| 135  | 438-440| 1 | Family History - Cerebrovascular - Youngest Age at Death for Parent | Enter the youngest age at death for either parent identified in item 133. Blank if none | Prospective 2025 |               |
| 136  | 441-443| 1 | Family History - Cerebrovascular - Youngest Age at Diagnosis for Sibling | Enter the youngest age at diagnosis for sibling(s) identified in item 133. Blank if none | Prospective 2025 |               |
| 137  | 444-446| 1 | Family History - Cerebrovascular - Youngest Age at Death for Sibling | Enter the youngest age at death for sibling(s) identified in item 133. Blank if none | Prospective 2025 |               |
| 138  | 447-449| 1 | Family History - Coronary (heart attack, hypertensive heart disease, arteria sclerotic vascular disease) | F = Father  
M = Mother  
S = Sibling  
Blank if none  
Enter all that apply (e.g. if both Mother and Sibling, then enter MS) | Prospective 2025 |               |
| 139  | 450-452| 1 | Family History - Coronary - Youngest Age at Diagnosis for Parent | Enter the youngest age at diagnosis for either parent identified in item 138. Blank if none | Prospective 2025 |               |
| 140  | 453-455| 1 | Family History - Coronary - Youngest Age at Death for Parent | Enter the youngest age at death for either parent identified in item 138. Blank if none | Prospective 2025 |               |
| 141  | 456-458| 1 | Family History - Coronary - Youngest Age at Diagnosis for Sibling | Enter the youngest age at diagnosis for sibling(s) identified in item 138. Blank if none | Prospective 2025 |               |

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<tbody>
<tr>
<td>142</td>
<td>459-461</td>
<td>3</td>
<td>Family History Coronary Youngest Age at Death for Sibling</td>
<td>Enter the youngest age at death for sibling(s) identified in item 138. Blank if none</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>143</td>
<td>462-464</td>
<td>3</td>
<td>Family History Mental / Nervous F = Father M = Mother S = Sibling blank if none</td>
<td>Enter all that apply (e.g. if both Mother and Sibling, then enter MS)</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>144</td>
<td>465-467</td>
<td>3</td>
<td>Family History Mental / Nervous Youngest Age at Diagnosis for Parent</td>
<td>Enter the youngest age at diagnosis for either parent identified in item 143. Blank if none</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>145</td>
<td>468-470</td>
<td>3</td>
<td>Family History Mental / Nervous Youngest Age at Death for Parent</td>
<td>Enter the youngest age at death for either parent identified in item 143. Blank if none</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>146</td>
<td>471-473</td>
<td>3</td>
<td>Family History Mental / Nervous Youngest Age at Diagnosis for Sibling</td>
<td>Enter the youngest age at diagnosis for sibling(s) identified in item 143. Blank if none</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>147</td>
<td>474-476</td>
<td>3</td>
<td>Family History Mental / Nervous Youngest Age at Death for Sibling</td>
<td>Enter the youngest age at death for sibling(s) identified in item 143. Blank if none</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>148</td>
<td>477-479</td>
<td>3</td>
<td>Family History Diabetes F = Father M = Mother S = Sibling blank if none</td>
<td>Enter all that apply (e.g. if both Mother and Sibling, then enter MS)</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>149</td>
<td>480-482</td>
<td>3</td>
<td>Family History Diabetes Youngest Age at Diagnosis for Parent</td>
<td>Enter the youngest age at diagnosis for either parent identified in item 148. Blank if none</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>150</td>
<td>483-485</td>
<td>3</td>
<td>Family History Diabetes Youngest Age at Death for Parent</td>
<td>Enter the youngest age at death for either parent identified in item 148. Blank if none</td>
<td>Prospective 2025</td>
</tr>
<tr>
<td>151</td>
<td>486-488</td>
<td>3</td>
<td>Family History Diabetes Youngest Age at Diagnosis for Sibling</td>
<td>Enter the youngest age at diagnosis for sibling(s) identified in item 148. Blank if none</td>
<td>Prospective 2025</td>
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<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>PROSPECTIVE RETROSPECTIVE PHASE IN PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>152</td>
<td>689-49</td>
<td>1</td>
<td>Youngest Age at Death for Sibling</td>
<td>Enter the youngest age at death for sibling(s) identified in item 148. Blank if none</td>
<td>Prospective 2025</td>
</tr>
</tbody>
</table>

Commented [MA17]: For elements that may not be readily available, the phase in period identifies the year in which this element will be required.
### Section 23. Secondary Guarantee Policy Information

For non-UL SG or non-VLSG products, leave blank.

For non-base segments, leave blank.

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.

If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>44</td>
<td>153</td>
<td>Length of Secondary Guarantee (ULSG/VLSG) Premium Type</td>
<td>1 = 0 to 4.99 years  2 = 5 to 9.99 years  3 = 10 to 19.99 years  4 = 20+ years For non-base segments, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: 00 = Unknown 01 = Single premium 02 = ULSG/VLSG Whole life level premium 03 = Lower premium (term like) 04 = Other</td>
</tr>
<tr>
<td>54</td>
<td>65</td>
<td>154</td>
<td>Type of Secondary Guarantee</td>
<td>01 = Both Cumulative Premium without Interest and Shadow Account 02 = Both Cumulative Premium with Interest and Shadow Account 03 = Other, not involving either Cumulative Premium or Shadow Account</td>
</tr>
</tbody>
</table>
Section 23. Secondary Guarantee Policy Information

For non-ULSG or non-VLSG products, leave blank. For non-base segments, leave blank.

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance crediting. If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>220-229</td>
<td>495-504</td>
<td>10</td>
<td>Cumulative Minimum Premium as of the Beginning of Observation Year</td>
<td>If not ULSG or VLSG leave blank. If not ULSG or VLSG, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank. If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank. Leave non-base segments, blank. For base segments: Enter the cumulative minimum premiums, including applicable interest, for all policy years up to the beginning of the observation year. Round to the nearest dollar. If unknown, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: If Item 35, Type of Secondary Guarantee (Item 15445) is blank, 00, 11, 12, 13 or 23, leave blank. If Item 35, Type of Secondary Guarantee (Item 15445) is 01, 02, 03, 04, 05, through 06, 21 or 22: Leave non-base segments, blank. For base segments: Enter the cumulative minimum premiums, including applicable interest, for all policy years up to the beginning of the observation year. Round to the nearest dollar. If unknown, leave blank. For policies issued in the observation year, leave blank. For unknown, leave blank.</td>
</tr>
</tbody>
</table>
### Section 23. Secondary Guarantee Policy Information

For non-ULSG or non-VLSG products, leave blank.
For non-base segments, leave blank.
Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.
If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>42</td>
<td>10</td>
<td>Cumulative</td>
<td>Minimum</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Premium as of</td>
<td>the</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>End of</td>
<td>Observation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Year/Actual</td>
<td>Termination Date</td>
</tr>
</tbody>
</table>

For non-ULSG or non-VLSG, leave blank.
For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan:
If Item 35, Type of Secondary Guarantee (Item 15445) is blank, 00, 11, 12, 13 or 23, leave blank.
If Item 35, Type of Secondary Guarantee (Item 15445) is 01, 02, 03, 04, 05, 06, 21 or 22:
1) For non-base segments, leave blank.
2) For base segments in force at the end of the observation year, enter the cumulative minimum premiums, including applicable interest, up to the end of the observation year.
3) For base segments terminated during the observation year, enter the cumulative minimum premiums, including applicable interest, up to the Actual Termination Date (Item 4836).
Round to the nearest dollar.
If unknown, leave blank.

If not ULSG or VLSG, leave blank.
If Item 35, Type of Secondary Guarantee (Item 15445) is blank, 00, 11, 12, 13 or 23, leave blank.
If Item 35, Type of Secondary Guarantee (Item 15445) is 01, 02, 03, 04, 05, through 06, 21 or 22:
1) For non-base segments, leave blank.
2) For base segments in force at the end of the observation year, enter the cumulative minimum premiums, including applicable interest, up to the end of the observation year.
3) For base segments terminated during the observation year, enter the cumulative minimum premiums, including applicable interest, up to the Actual Termination Date (Item 8546).
Round to the nearest dollar.
If unknown, leave blank.
### Section 23. Secondary Guarantee Policy Information

For non-ULSG or non-VLSG products, leave blank.
For non-base segments, leave blank.
Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.

If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td>48</td>
<td>515-524</td>
<td>10 Shadow Account Amount at the Beginning of Observation Year</td>
<td>If an item is unknown, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: If Item 35, Type of Secondary Guarantee (Item 15442) is blank, 00, 01, 02, 03, 04, 05, 06, or 23, leave blank. If Item 35, Type of Secondary Guarantee (Item 15442) is 11, 12, 13, 21, or 22: 1) Leave non-base segments blank. 2) For base segments: Enter the total amount of the Shadow Account at the beginning of the observation year. The Shadow Account can be positive, zero, or negative. Round to the nearest dollar. If unknown, leave blank.</td>
</tr>
</tbody>
</table>
### Section 23, Secondary Guarantee Policy Information

For non-ULSG or non-VLSG products, leave blank.

For non-base segments, leave blank.

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.

If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>158</td>
<td>250-259</td>
<td>525-534</td>
<td>Shadow Account Amount at the End of Observation Year/Actual Termination Date</td>
<td>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: If Item 35, Type of Secondary Guarantee (Item 15445) is blank, 00, 01, 02, 03, 04, 05, 06, or 23 leave blank. If Item 35, Type of Secondary Guarantee (Item 15445 is 11, 12, 13, 21 or 22: For non-base segments, leave blank. For base segments inforce at the end of the observation year, enter the total amount of the Shadow Account at the end of the observation year. The Shadow Account can be positive, zero or negative. For base segments terminated during the observation year, enter the total amount of the Shadow Account as of the Actual Termination Date (Item 4836). The Shadow Account can be positive, zero or negative. Round to the nearest dollar. Leave blank.</td>
</tr>
</tbody>
</table>
Section 23. Secondary Guarantee Policy Information

For non-ULSG or non-VLSG products, leave blank.
For non-base segments, leave blank.
Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.
If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>159</td>
<td>535-544</td>
<td>10</td>
<td>Account Value at the Beginning of Observation Year</td>
<td>For non-base segments, leave blank. For non-ULSG or non-VLSG products, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, enter the policy Account Value (gross of any loan) at the Beginning of the Observation Year. The policy Account Value is the net account value (gross of any loan) at the Beginning of the Observation Year. The policy Account Value can be positive, zero or negative. Rounded to the nearest dollar. Leave blank if not ULSG or VLSG. For policies issued in the observation year, leave blank. If unknown, leave blank.</td>
</tr>
</tbody>
</table>
Section 23. Secondary Guarantee Policy Information

For non-ULSG or non-VLSG products, leave blank.
For non-base segments, leave blank.
Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.
If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>250-255</td>
<td>545-554</td>
<td>Account Value at the End of Observation Year/Actual Termination Date</td>
</tr>
</tbody>
</table>

For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:
1) If policy is in force at the end of observation year, enter the policy Account Value (gross of any loan) at the end of the Observation Year. The policy Account Value can be positive, zero or negative.
2) If policy terminated during the observation year, enter the policy Account Value (gross of any loan) as of the Actual Termination Date (Item 48). The policy Account Value can be positive, zero or negative.
Round to the nearest dollar. If unknown, leave blank.
### Section 23, Secondary Guarantee Policy Information

For non-UL SG or non-VLSG products, leave blank.

For non-base segments, leave blank.

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.

If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 280 | 280-289 | 555-564 | 10 | Amount of Surrender Charge at the Beginning of Observation Year | For non-base segments, leave blank.

For ULSG or VLSG, leave blank.

For ULSG and VLSG policies with plan codes 071 through 096 of Item 19, enter the dollar Amount of the Surrender Charge as of the Beginning of the Observation Year, rounded to the nearest dollar.

For policies issued in the observation year, leave blank. If unknown, leave blank.

For ULSG and VLSG policies with plan codes 071 through 096 of Item 19, enter the dollar Amount of the Surrender Charge as of the Beginning of the Observation Year, rounded to the nearest dollar.

For policies issued in the observation year, leave blank. If unknown, leave blank.
### Section 23. Secondary Guarantee Policy Information

For non-ULSG or non-VLSG products, leave blank.

For non-base segments, leave blank.

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.

If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>54</td>
<td>52</td>
<td>565-574</td>
<td>Amount of Surrender Charge at the End of Observation Year/Actual Termination Date</td>
</tr>
</tbody>
</table>

1. If policy is in force at the end of the observation year, enter the dollar amount of the Surrender Charge at the end of the Observation Year.
2. If policy terminated during the observation year, enter the dollar amount of the Surrender Charge as of the Actual Termination Date (Item 48). Round to the nearest dollar. If unknown, leave blank.

For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:

If policy is in force at the end of the observation year, enter the dollar amount of the Surrender Charge at the end of the Observation Year.

If policy terminated during the observation year, enter the dollar amount of the Surrender Charge as of the Actual Termination Date (Item 48). Round to the nearest dollar. If unknown, leave blank.
Section 23. Secondary Guarantee Policy Information

For non-ULSG or non-VLSG products, leave blank.

For non-base segments, leave blank.

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.

If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>500-304</td>
<td></td>
<td>Operative Secondary Guarantee at the Beginning of Observation Year</td>
<td></td>
</tr>
<tr>
<td>163</td>
<td>575-576</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The company defines whether a secondary guarantee is in effect for a policy with a secondary guarantee at the beginning of the Observation Year. The company defines whether a secondary guarantee is in effect for a policy with secondary guarantees at the beginning of the Observation Year.

- Item 35, Type of Secondary Guarantee is blank: Leave blank.
- Item 35, Type of Secondary Guarantee is other than 00 through 23: Leave blank.
- Item 35, Type of Secondary Guarantee is 00: Leave blank.
- Item 35, Type of Secondary Guarantee is 01: Leave blank.
- Item 35, Type of Secondary Guarantee is 02: Leave blank.
- Item 35, Type of Secondary Guarantee is 03: Leave blank.

- Item 35, Type of Secondary Guarantee is 00 through 23: Leave blank.
- Item 35, Type of Secondary Guarantee is 00: Leave blank.
- Item 35, Type of Secondary Guarantee is 01: Leave blank.
- Item 35, Type of Secondary Guarantee is 02: Leave blank.
- Item 35, Type of Secondary Guarantee is 03: Leave blank.
Section 23. Secondary Guarantee Policy Information
For non-ULSG or non-VLSG products, leave blank.
For non-base segments, leave blank.
Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.
If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>164</td>
<td>55</td>
<td></td>
<td>302-303</td>
<td>Operative Secondary Guarantee at the End of Observation Year/Actual Termination Date</td>
</tr>
<tr>
<td></td>
<td>577</td>
<td></td>
<td>578</td>
<td></td>
</tr>
</tbody>
</table>

The company defines whether a secondary guarantee is in effect for a policy with a secondary guarantee at the end of the Observation Year/Actual Termination Date. The company defines whether a secondary guarantee is in effect for a policy with a secondary guarantee at the end of the Observation Year/Actual Termination Date.

For non-base segments, leave blank.
For base segments in force at the end of observation year, enter the appropriate value below as of the end of observation year or as of the Actual Termination Date (Item 4836):

00 = If unknown whether the secondary guarantee is in effect
01 = If secondary guarantee is not in effect
02 = If secondary guarantee is in effect
03 = If all secondary guarantees have expired

For base segments terminated during the observation year, enter the appropriate value below as of the Actual Termination Date (Item 26):

00 = If unknown whether the secondary guarantee is in effect
01 = If secondary guarantee is not in effect
02 = If secondary guarantee is in effect
03 = If all secondary guarantees have expired

For non-base segments, leave blank.
### Section 23. Secondary Guarantee Policy Information

For non-ULSG or non-VLSG products, leave blank.

For non-base segments, leave blank.

Round all dollar amounts to the nearest dollar. All values should be prior to any reinsurance ceded.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>275-276</td>
<td>2</td>
<td>State of Domicile</td>
<td>Use standard, two-letter state abbreviations codes (e.g., FL for Florida) for the state of the policy owner's domicile. If outside of the U.S., leave blank.</td>
</tr>
</tbody>
</table>

### Section 26. State of Domicile

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>275-276</td>
<td>2</td>
<td>State of Domicile</td>
<td>Use the standard, two-letter state abbreviations codes (e.g., FL for Florida) for the state of the policy owner's current state of domicile. If unknown or outside of the U.S., leave blank.</td>
</tr>
</tbody>
</table>

### Section 27. Term Policy Information

For non-term policies, leave blank.

If an item is unknown, leave blank.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td>#</td>
<td>1</td>
<td>Death Benefit</td>
<td>Initial Term Period: 1 = Level, 2 = Increasing, 3 = Decreasing</td>
</tr>
<tr>
<td>48</td>
<td>#</td>
<td>1</td>
<td>Death Benefit After Initial Term Period: 1 = Level, 2 = Increasing, 3 = Decreasing</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>#</td>
<td>1</td>
<td>Death Benefit Payout: 1 = Lump sum, 2 = Income term – level payment, 3 = Income term – increasing payment</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>#</td>
<td>2</td>
<td>Guaranteed Level Premium Period: 01 = 1 year/ART, 05 = 5 years, 10 = 10 years, 15 = 15 years, 20 = 20 years, 25 = 25 years, 30 = 30 years, 00 = Other</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>#</td>
<td>2</td>
<td>Anticipated Level Premium Period: 01 = 1 year/ART, 05 = 5 years, 10 = 10 years, 15 = 15 years, 20 = 20 years, 25 = 25 years, 30 = 30 years, 00 = Other</td>
<td></td>
</tr>
</tbody>
</table>

Commented [MA19]: Moved to item 8

Commented [LH20]: For discussion: should Section 4 be left blank for non-base segments?
### Section 4. Term Policy Information
For non-term policies, leave blank.
If an item is unknown, leave blank.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 52   | 1      |   | Post Level Premium Period | 1 = No post level premium period  
                  |   |   |          | 2 = Attained age premium – guaranteed only  
                  |   |   |          | 3 = Attained age premium – indeterminate  
                  |   |   |          | 4 = Select and ultimate |

### Section 45 Rider Information
For non-base segments, leave blank.
If an item is unknown, leave blank.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 53   | 154    |   | Chronic Illness Rider | Does this policy contain this rider?  
                  |   |   |          | 0 = No  
                  |   |   |          | 1 = Yes (no separate charge)  
                  |   |   |          | 2 = Yes (separate charge)  
                  |   |   |          | 3 = Not offered  
                  |   |   |          | 4 = Not included (no separate charge)  
                  |   |   |          | 5 = Selected (separate charge)  
                  |   |   |          | 6 = Offered but not selected (separate charge) |
| 54   | 155    |   | Critical Illness Rider | Does this policy contain this rider?  
                  |   |   |          | 0 = No  
                  |   |   |          | 1 = Yes (no separate charge)  
                  |   |   |          | 2 = Yes (separate charge)  
                  |   |   |          | 3 = Not offered  
                  |   |   |          | 4 = Not included (no separate charge)  
                  |   |   |          | 5 = Selected (separate charge)  
                  |   |   |          | 6 = Offered but not selected (separate charge) |
| 55   | 156    |   | Long-Term Care Rider | Does this policy contain this rider?  
                  |   |   |          | 0 = No  
                  |   |   |          | 1 = Yes (no separate charge)  
                  |   |   |          | 2 = Yes (separate charge)  
                  |   |   |          | 3 = Not offered  
                  |   |   |          | 4 = Not included (no separate charge)  
                  |   |   |          | 5 = Selected (separate charge)  
                  |   |   |          | 6 = Offered but not selected (separate charge) |
| 56   | 157    |   | Guaranteed Insurability Rider | Does this policy contain this rider?  
                  |   |   |          | 0 = No  
                  |   |   |          | 1 = Yes (no separate charge)  
                  |   |   |          | 2 = Yes (separate charge)  
                  |   |   |          | 3 = Not offered  
                  |   |   |          | 4 = Not included (no separate charge)  
                  |   |   |          | 5 = Selected (separate charge)  
                  |   |   |          | 6 = Offered but not selected (separate charge) |
### Rider Information

For non-base segments, leave blank.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>57</td>
<td>60</td>
<td>169</td>
<td>Return of Premium Rider</td>
<td>Does this policy contain this rider?</td>
</tr>
<tr>
<td>58</td>
<td>61</td>
<td>169</td>
<td>Disability Rider</td>
<td>Does this policy contain this rider?</td>
</tr>
<tr>
<td>59</td>
<td>62</td>
<td>169</td>
<td>Liquidity Rider</td>
<td>Does this policy contain this rider?</td>
</tr>
<tr>
<td>60</td>
<td>63</td>
<td>170</td>
<td>Terminal Illness Rider</td>
<td>Does this policy contain this rider?</td>
</tr>
</tbody>
</table>

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## Appendix 2: Plan Design Data Elements and Format

### Section 1. Basic Plan Information

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1–5</td>
<td>NAIC Company Code</td>
<td>Your NAIC Company Code</td>
</tr>
<tr>
<td>2</td>
<td>6–9</td>
<td>Observation Year</td>
<td>Enter Calendar Year of Observation</td>
</tr>
<tr>
<td>3</td>
<td>10–19</td>
<td>Data Plan Identifier</td>
<td>Unique identifier for each plan. May be sequential numbering or unique identifier used within the company. This field is used to tie a record in the policy file to this plan file.</td>
</tr>
<tr>
<td>4</td>
<td>20–29</td>
<td>Policy Form Number</td>
<td>If multiple policy forms are used for this plan, then enter the most commonly used form.</td>
</tr>
<tr>
<td>5</td>
<td>30–39</td>
<td>Application Form Number</td>
<td>If multiple application forms are used for this plan, then enter the most commonly used form.</td>
</tr>
<tr>
<td>6</td>
<td>40</td>
<td>Pre-Need (as defined in VM02)</td>
<td>0 = Unknown 1 = Not Pre-Need Policy 2 = Pre-Need Policy</td>
</tr>
<tr>
<td>7</td>
<td>41</td>
<td>Death Benefit Pattern</td>
<td>0 = Unknown 1 = Level (includes increases due to corridor) 2 = Modified Death Benefit 3 = Increasing 4 = Decreasing 5 = Flexible 6 = Other</td>
</tr>
<tr>
<td>8</td>
<td>42-43</td>
<td>Death Benefit Pattern Years</td>
<td>Number of years of grading before Death Benefit Pattern becomes level. If Death Benefit does not become level then leave blank. If Death Benefit not Increasing or Decreasing then leave blank.</td>
</tr>
<tr>
<td>9</td>
<td>44-45</td>
<td>Premium Pattern</td>
<td>00 = Unknown 01 = Single Premium 02 = Level Modal Premium payable for the life of the policy 03 = Graded Premium payable for the life of the policy 04 = Level Premium payable for the life of the policy 05 = Renewable Term based on Issue Age 06 = Renewable Term based on Issue Age and Excess Premiums 07 = Limited Pay Premium by number of years 08 = Paid up at a Specified Age 09 = Flexible 10 = RPU 11 = ETI 12 = Other</td>
</tr>
</tbody>
</table>

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## Section 1. Risk Plan Information

<table>
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<th>ITEM</th>
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<td>10</td>
<td>46-47</td>
<td>Premium Pattern</td>
<td>Enter the number of years that will be used to describe the premium pattern.</td>
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<td></td>
<td>2</td>
<td>Premium Pattern is to be used for band renewal term.</td>
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<td>Preferred class structure means that, depending on the underwriting results, a policy could be issued in classes ranging from a best preferred class to a residual standard class.</td>
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<tr>
<td>11</td>
<td>48</td>
<td>Are applicants underwritten based on the same requirements?</td>
<td>0 = Requirements vary by Issue Age or Coverage Amount</td>
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<tr>
<td></td>
<td></td>
<td>1</td>
<td>Additional Requirements ordered for Cause Only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>Requirements do not vary</td>
</tr>
<tr>
<td>12</td>
<td>49-50</td>
<td>Smoker Period Definition</td>
<td>Number of years to qualify for non-smoker/non-tobacco</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Smoker Period Definition</td>
</tr>
<tr>
<td></td>
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<td>Smoker Period Definition</td>
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## Section 2. Risk Class Structure

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<td>15</td>
<td>53</td>
<td>Preferred Class Structure Indicator</td>
<td>Preferred class structure means that, depending on the underwriting results, a policy could be issued in classes ranging from a best preferred class to a residual standard class.</td>
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<td></td>
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</tbody>
</table>

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### Section 2. Risk Class Structure

If an item is unknown, leave blank unless otherwise specified.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
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</thead>
<tbody>
<tr>
<td>16</td>
<td>54-55</td>
<td>Number of Classes</td>
<td>Nonsmoker Preferred Class Structure</td>
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<tr>
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<td></td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank.</td>
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<tr>
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<td></td>
<td></td>
<td>For nonsmoker or no tobacco usage policies that could have been issued as one of multiple preferred and standard classes, enter the number of nonsmoker preferred and standard classes available at time of issue.</td>
</tr>
<tr>
<td>17</td>
<td>56-57</td>
<td>Number of Classes</td>
<td>Smoker Preferred Class Structure</td>
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<td></td>
<td></td>
<td></td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank.</td>
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<tr>
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<td></td>
<td>For smoker or tobacco user policies that could have been issued as one of multiple preferred and standard classes, enter the number of smoker preferred and standard classes available at time of issue.</td>
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</table>

### Section 3. Term Policy Information

For non-term products, leave blank. For items, if unknown, leave blank.

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<th>DESCRIPTION</th>
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<tr>
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<td>58</td>
<td>Death Benefit</td>
<td>Initial Term Period</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>1 = Level</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 = Increasing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 = Decreasing</td>
</tr>
<tr>
<td>19</td>
<td>59</td>
<td>Death Benefit</td>
<td>After Initial Term Period</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 = Level</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 = Increasing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 = Decreasing</td>
</tr>
<tr>
<td>20</td>
<td>60</td>
<td>Death Benefit</td>
<td>Payout</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 = Lump sum</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 = Income term – level payment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 = Income term – increasing payment</td>
</tr>
<tr>
<td>21</td>
<td>61-62</td>
<td>Guaranteed Level Premium Period</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>01 = 1 year/ART</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>05 = 5 years</td>
</tr>
<tr>
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<td>10 = 10 years</td>
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<td>30 = 30 years</td>
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<td></td>
<td></td>
<td>00 = Other</td>
</tr>
<tr>
<td>22</td>
<td>63-64</td>
<td>Anticipated Level Premium Period</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>01 = 1 year/ART</td>
</tr>
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<td></td>
<td>05 = 5 years</td>
</tr>
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<td>25 = 25 years</td>
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<tr>
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<td></td>
<td></td>
<td>30 = 30 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>00 = Other</td>
</tr>
</tbody>
</table>

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# Appendix 3: Underwriting Specifications Data Elements and Format

This will be submitted as a separate file.  
There will be a separate record for each combination of coverage band and age band within each Specification Identified.  
Items with asterisks represent key fields which define a unique record.  
Round all dollar amounts to the nearest dollar.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1-5</td>
<td>NAIC Company Code</td>
<td>Your NAIC Company Code</td>
</tr>
<tr>
<td>2</td>
<td>6-9</td>
<td>Observation Year</td>
<td>Enter Calendar Year of Observation</td>
</tr>
<tr>
<td>3</td>
<td>10-18</td>
<td>Underwriting Specification Identifier</td>
<td>Sequential number or company defined identifier</td>
</tr>
<tr>
<td>4</td>
<td>19-26</td>
<td>Effective Date of Underwriting Specification</td>
<td>Date this specification was first used (format YYYYMMDD)</td>
</tr>
<tr>
<td>5</td>
<td>27-38</td>
<td>Minimum Face Amount</td>
<td>Minimum Face Amount allowed</td>
</tr>
<tr>
<td>6</td>
<td>39-41</td>
<td>Minimum Issue Age</td>
<td>Minimum Issue Age allowed</td>
</tr>
<tr>
<td>7</td>
<td>42-43</td>
<td>Number of Coverage Bands</td>
<td>Total number of Coverage Bands</td>
</tr>
<tr>
<td>8</td>
<td>44-45</td>
<td>Number of Age Bands</td>
<td>Total number of Age Bands</td>
</tr>
<tr>
<td>9</td>
<td>46-47</td>
<td>Coverage Band Number</td>
<td>Specific Coverage Band for this Record</td>
</tr>
<tr>
<td>10</td>
<td>48-59</td>
<td>Maximum Face Amount this Coverage Band</td>
<td>Number</td>
</tr>
<tr>
<td>11</td>
<td>60-61</td>
<td>Age Band Number</td>
<td>Specific Age Band for this Record</td>
</tr>
<tr>
<td>12</td>
<td>62-64</td>
<td>Maximum Age this Age Band</td>
<td>Number</td>
</tr>
</tbody>
</table>
| 13   | 65     | Attending Physician Statement | Is this item required for this Coverage and Age Group?  
1 = Yes  
2 = No |
| 14   | 66     | Para-Medical Exam | Is this item required for this Coverage and Age Group?  
1 = Yes  
2 = No |
| 15   | 67     | Physician Exam | Is this item required for this Coverage and Age Group?  
1 = Yes  
2 = No |
| 16   | 68     | Electronic Health Records | Is this item required for this Coverage and Age Group?  
1 = Yes  
2 = No |
| 17   | 69     | Personal History Interview | Is this item required for this Coverage and Age Group?  
1 = Yes  
2 = No |
This will be submitted as a separate file.

There will be a separate record for each combination of coverage band and age band within each Specification Identifier.

Items with asterisks represent key fields which define a unique record.

Round all dollar amounts to the nearest dollar.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
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<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>70</td>
<td>Blood Sample</td>
<td>Is this item required for this Coverage and Age Group? &lt;br&gt; 1 = Yes &lt;br&gt; 2 = No</td>
</tr>
<tr>
<td>19</td>
<td>71</td>
<td>Urine / HOS specimen</td>
<td>Is this item required for this Coverage and Age Group? &lt;br&gt; 1 = Yes &lt;br&gt; 2 = No</td>
</tr>
<tr>
<td>20</td>
<td>72</td>
<td>Saliva / Oral fluid specimen</td>
<td>Is this item required for this Coverage and Age Group? &lt;br&gt; 1 = Yes &lt;br&gt; 2 = No</td>
</tr>
<tr>
<td>21</td>
<td>73</td>
<td>Stress Test</td>
<td>Is this item required for this Coverage and Age Group? &lt;br&gt; 1 = Yes &lt;br&gt; 2 = No</td>
</tr>
<tr>
<td>22</td>
<td>74</td>
<td>MIB</td>
<td>Is this item required for this Coverage and Age Group? &lt;br&gt; 1 = Yes &lt;br&gt; 2 = No</td>
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<td>23</td>
<td>75</td>
<td>Prescription History</td>
<td>Is this item required for this Coverage and Age Group? &lt;br&gt; 1 = Yes &lt;br&gt; 2 = No</td>
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<tr>
<td>24</td>
<td>76</td>
<td>Motor Vehicle Records</td>
<td>Is this item required for this Coverage and Age Group? &lt;br&gt; 1 = Yes &lt;br&gt; 2 = No</td>
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</table>
HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

<table>
<thead>
<tr>
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<th>Page</th>
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<tbody>
<tr>
<td>Health Insurance and Managed Care (B) Committee Dec. 8, 2019, Minutes</td>
<td>7-2</td>
</tr>
<tr>
<td>Health Insurance and Managed Care (B) Committee Oct. 24, 2019, Minutes (Attachment One)</td>
<td>7-5</td>
</tr>
<tr>
<td>Health Insurance and Managed Care (B) Committee 2020 Proposed Charges (Attachment One-A)</td>
<td>7-6</td>
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<tr>
<td>Consumer Information (B) Subgroup Nov. 18, 2019, Minutes (Attachment Two)</td>
<td>7-7</td>
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<tr>
<td>Consumer Information (B) Subgroup Oct. 21, 2019, Minutes (Attachment Three)</td>
<td>7-9</td>
</tr>
<tr>
<td>Frequently Asked Questions (FAQ) About Health Care Reform (Attachment Three-A)</td>
<td>7-11</td>
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<td>Consumer Information (B) Subgroup Oct. 7, 2019, Minutes (Attachment Four)</td>
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<tr>
<td>Health Innovations (B) Working Group Dec. 7, 2019, Minutes (Attachment Five)</td>
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<td>Health Innovations (B) Working Group Oct. 28, 2019, Minutes (Attachment Five-A)</td>
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Health Insurance and Managed Care (B) Committee
Austin, Texas
December 8, 2019

The Health Insurance and Managed Care (B) Committee met in Austin, TX, Dec. 8, 2019. The following Committee members participated: Jessica Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); Dean L. Cameron (ID); Vicki Schmidt (KS); Nancy G. Atkins represented by John Melvin (KY); Steve Kelley (MN); Mike Chaney represented by Bob Williams (MS); Jon Godfread (ND); John Elias represented by Maureen Belanger (NH); Linda A. Lacewell represented by Tom Dudek (OK); Andrew Stolfi (OR); Hodgen Mainda (TN); Scott A. White represented by Julie Blauvelt (VA); and Mike Kreidler and Jane Beyer (WA). Also participating were: Steve Ostlund (AL); Ryan James (AR); Fleur McKendell and Leslie Ledogar (DE); Doug Ommen and Andria Seip (IA); Alex Peck (IN); Frank Opelka (LA); Kevin Dyke (MI); Paige Duhamel (NM); Glen Muready (OK); Marie Ganim (RI); Nancy Clark (TX); Todd E. Kiser and Tanji Northrup (UT); and Nathan Houdek and Jennifer Stegall (WI).

1. **Adopted its Oct. 24 and Summer National Meeting Minutes**

The Committee met Oct. 24 and Aug. 4. During its Oct. 24 meeting, the Committee took the following action: 1) adopted the Health Actuarial (B) Task Force’s 2020 proposed charges, the Regulatory Framework (B) Task Force’s 2020 proposed charges, and the Senior Issues (B) Task Force’s 2020 proposed charges; and 2) adopted its 2020 proposed charges.

Director Wing-Heier made a motion, seconded by Commissioner Godfread, to adopt the Committee’s Oct. 24 (Attachment One) and Aug. 4 (see NAIC Proceedings – Summer 2019, Health Insurance and Managed Care (B) Committee) minutes. The motion passed unanimously.

2. **Adopted its Subgroup, Working Group and Task Force Reports**

Commissioner Conway made a motion, seconded by Commissioner Kreidler, to adopt the following reports: the Consumer Information (B) Subgroup, including its Nov. 18 (Attachment Two), Oct. 21 (Attachment Three) and Oct. 7 (Attachment Four) minutes; the Health Innovations (B) Working Group (Attachment Five); the Health Actuarial (B) Task Force; the Long-Term Care Insurance (E/B) Task Force; the Regulatory Framework (B) Task Force; and the Senior Issues (B) Task Force. The motion passed unanimously.

3. **Heard an Update from the CCIIO**

Randy Pate (federal Center for Consumer Information and Insurance Oversight—CCIIO) updated the Committee on the CCIIO’s regulatory activities related to the federal Affordable Care Act (ACA) and other activities of interest to the Committee. He provided a snapshot of the current open enrollment period to date, including application and enrollment numbers. He highlighted the effect of the ACA Section 1332 waivers in reducing premium costs. He said that to date, the CCIIO has approved 13 waivers. Most of the approved waivers were for establishing a reinsurance program. He also highlighted the steps the Trump Administration has taken to improve price transparency in healthcare, which is one of the Trump Administration’s key priorities, including the publication of a proposed rule on Nov. 15 to require issuers to provide information to consumers on projected out-of-pocket (OOP) costs and make price information available to third-party vendors. Mr. Pate also discussed the CCIIO’s recently released Risk Adjustment Data Verification (RAD-V) white paper. The RAD-V white paper lays out options for potential modifications to several aspects of the U.S Department of Health and Human Services (HHS)-RADV methodology. Mr. Pate urged state insurance regulators to submit comments on the RAD-V white paper.

4. **Heard a Presentation on “Overcharged: Why Americans Pay Too Much for Health Care”**

Charles Silver (University of Texas at Austin & CATO Institute), co-author of the book “Overcharged: Why Americans Pay Too Much for Health Care,” discussed the problems in the U.S. healthcare system, which have contributed to high health care costs. He said these problems include: 1) fraud, waste and abuse; 2) uncontrolable spending; 3) opaque prices; 4) surprise bills; 5) quality that is highly variable and often mediocre; and 6) absurd prices for prescription drugs. He suggested several potential solutions to address these problems, such as: 1) eliminating tax exemptions and coverage for mandates; 2) promoting competition and encouraging medical tourism; 3) letting the insurance-driven spending cycle burn itself out; and 4) turning Medicare, Medicaid and other programs into cash-transfer programs along the lines of social security and the earned income tax credit.
Professor Silver described the problems in the U.S. health care system and its high and increasing health care costs as a vicious cycle with its excessive reliance on third-party payment. He said coverage of health care costs stimulates demand for more and more expensive medical treatments. This heightened demand drives up prices and encourages the proliferation of services. He said with these rising prices and expanded health care needs, consumers become scared and demand more protection. Insurers and government agencies respond to this panic by offering more comprehensive coverage, circling back to the beginning of the problem.

Professor Silver said the solution to ending this vicious cycle is to let it burn out. He said that as spending increases, insurance becomes more expensive, which leads to more uninsured. As people go without insurance or carry higher deductible and copays, the army of self-paying consumers grows. He said the retail sector responds to this increase in demand by offering options for obtaining medical care that is cheaper and more convenient. He discussed a current example of this retail revolution, the Surgery Center of Oklahoma.

Commissioner Stolfi asked Professor Silver about the consequences of letting the system burn itself out, particularly with respect to the poor. Professor Silver said he believes consumers should use health insurance to insure against catastrophic events like other types of insurances. He said his idea for creating cash-transfer programs would address the needs of the poor. Commissioner Conway questioned one aspect of Professor Silver’s theory of letting the system burn itself out with respect to consumers paying more in deductibles and copays leading to lower health care prices in light of the growth of high deductible health plans (HDHPs). Professor Silver said it takes time for the transition. He cited the example of CVS halting the sale of tobacco products and establishing walk-in health care clinics. He acknowledged the difficulty of such a change with respect to catastrophic health care services.

5. Heard a Panel Presentation on State Surprise Billing Laws

Ms. Beyer provided an overview of Washington’s Balance Billing Protection Act (BBPA). She explained that as of Jan. 1, 2020, in Washington, surprise/balance billing is prohibited for: 1) all emergency services at in-network and out-of-network (OON) hospitals; and 2) non-emergency surgical or ancillary services provided by an OON provider at an in-network hospital or ambulatory surgical center. She discussed the scope of the BBPA, including how it applies to emergency services received out-of-state. She discussed the BBPA’s application, including a provision that permits self-funded plans to opt-in to the BBPA’s balance billing prohibition, consumer protections, and arbitration provisions. She said that self-funded plans that want to opt-in can use a simple on-line “opt-in” process to do so. She said the Washington Department of Insurance (DOI) will maintain a list of self-funded plans choosing to opt-in.

Ms. Beyer discussed the BBPA’s OON payment provision. She said the BBPA provides that the OON provider be paid a “commercially reasonable amount based on payment for the same or similar services provided in a similar geographic area.” If the provider and health carrier cannot agree on this amount, after a 30-day informal negotiation period, they can proceed to arbitration. Ms. Beyer explained that to inform negotiations and arbitration, providers, carriers and arbitrators have access to a data set from the state’s all payer claims database (APCD). She also described the BBPA’s transparency and enforcement provisions.

Ms. Taylor said Texas’ surprise billing law is similar in many ways to Washington’s BBPA. She said Texas’ law is also effective Jan. 1, 2020. The Texas law’s application to insured plans and state employee plans is similar to Washington’s law, except Texas’ law does not include provisions permitting self-funded plans to opt-in. Ms. Taylor said Texas’ law is unique in that it includes both an arbitration process and a mediation process. She said Texas’ arbitration process must conclude by day 51. Its mediation process may last up to 120 days. Ms. Taylor said the OON provider payment is based on 80% of billed charges and geographic area.

Commissioner Altman asked what advice Ms. Beyer and Ms. Taylor would provide to the states considering such legislation. Ms. Beyer said she believes that in order to get such legislation enacted, it must strike a balance where stakeholders are not completely happy with the legislation, but they can live with it. Ms. Taylor agreed. Commissioner Godfread asked what services are not included in the scope of either law. Ms. Beyer said air ambulance and ground ambulance services are not included in the scope of Washington’s law. Ms. Taylor said Texas’ law is similar. Ms. Duhamel discussed New Mexico’s surprise bill law and its challenge with setting the OON payment benchmark. She agreed with Washington and Texas that one key to getting such legislation enacted was involving stakeholders throughout the process. Commissioner Mulready discussed Oklahoma’s struggle with such legislation concerning the lack of authority the DOI has over certain health care providers. Ms. Beyer said Washington worked through this issue and ultimately worked out an agreement to work collaboratively with its Department of Health (DOH) concerning any provider enforcement issues.
6. **Heard an Update on Legal Action Surrounding the ACA**

William Schiffbauer (Law Office of William G. Schiffbauer) gave an update from his presentation at the Spring National Meeting on the four major cases involving the ACA: 1) *Texas v. United States of America, et al.*, which challenges the constitutionality of the ACA’s individual mandate and its potential impact on other key ACA provisions; 2) *State of New York v. U.S. Department of Labor*, which challenges the legality of the federal association health plan (AHP) regulation; 3) *Association of Community Affiliated Plans, et al. v. U.S. Department of Treasury, et al.*, which challenges the legality of the federal short-term, limited-duration (STLD) plan regulation; and 4) *Maine Community Health Options v. United States*, which challenges the legality of the federal government withholding full risk corridor payment amounts to participants.

Mr. Schiffbauer provided an overview of the timeline, current status, and main arguments for each of the cases. The *Texas v. United States of America, et al.* case is pending in the U.S. Court of Appeals for the Fifth Circuit. The *State of New York v. U.S. Department of Labor* and *Association of Community Affiliated Plans, et al. v. U.S. Department of Treasury, et al.*, cases are both pending in the U.S. Court of Appeals for the Washington, DC Circuit. The *Maine Community Health Options v. United States* case is pending before the U.S. Supreme Court. Oral arguments in this case are scheduled before the U.S. Supreme Court Dec. 10.

Mr. Schiffbauer explained that if these cases are not already before the U.S. Supreme Court, no matter the outcome at the U.S. Court of Appeals level, it is anticipated that the parties in these cases will file a Petition for Certiorari to the U.S. Supreme Court. He summarized the cases as follows: 1) the Fifth Circuit Court of Appeals decision in *Texas v. United States of America, et al.* is expected before the end of the year, most likely following the end of the current open enrollment period ending Dec. 15. A U.S. Supreme Court opinion would be issued on or before July 31, 2020; 2) the District of Columbia Court’s opinion in *State of New York v. U.S. Department of Labor* is expected in by December 2019 or January 2020. A U.S. Supreme Court opinion would be issued on or before July 31, 2020; 3) The District of Columbia Court will hold oral arguments in the *Association of Community Affiliated Plans, et al. v. U.S. Department of Treasury, et al.* case in March or April 2020. The court would issue an opinion in May or June 2020. It is unlikely that the U.S. Supreme Court would issue an opinion on or before July 31, 2020; and 4) The U.S. Supreme Count is likely to issue an opinion in the *Maine Community Health Options v. United States* on or before July 31, 2020.

7. **Heard a Federal Legislative Update**

Joe Touschner (NAIC) provided a federal legislative update on Congressional activity of interest to the Committee. He discussed the current status of surprise billing legislation, explaining that it appears that a bi-cameral agreement has been reached. He said he would provide more details on this agreement to the Committee and other state insurance regulators after the Fall National Meeting. He said the NAIC received a letter from the federal Centers for Medicare & Medicaid Services (CMS) Administrator seeking recommendations for creating interstate compacts for the sale of health insurance across state lines, as required by ACA section 1333 and in compliance with an Executive Order. He said the Government Relations (EX) Leadership Council considered a letter responding to the request Dec. 4. He also said there is strong bipartisan support for further delaying the health insurance tax (HIT), which was not paid in 2019. He said the difficulty that the U.S. Congress (Congress) is facing is how to pay for it. The HIT brings in over $16 billion a year. Mr. Touschner said delaying the HIT could be part of an end-of-the-year budget deal.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
Health Insurance and Managed Care (B) Committee
Conference Call
October 24, 2019

The Health Insurance and Managed Care (B) Committee met via conference call Oct. 24, 2019. The following Committee members participated: Jessica Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair, represented by Sarah Bailey (AK); Michael Conway (CO); Dean L. Cameron represented by Weston Trexler (ID); Vicki Schmidt represented by Julie Holmes (KS); Nancy G. Atkins (KY); Steve Kelley represented by Grace Arnold (MN); Jon Godfread (ND); Andrew Stolfi (OR); Hodgen Mainda (TN); Scott A. White (VA); and Mike Kreidler represented by Molly Nollette (WA). Also participating was: Kevin Dyke (MI).

1. **Adopted the Health Actuarial (B) Task Force’s 2020 Proposed Charges**

Mr. Dyke provided a brief overview of the Health Actuarial Task Force’s 2020 proposed charges. He said the Task Force’s proposed charges are similar to its 2019 charges. The Task Force will continue to focus on issues related to the federal Affordable Care Act (ACA) and long-term care insurance.

Commissioner Conway made a motion, seconded by Ms. Arnold, to adopt the Task Force’s 2020 proposed charges (see NAIC Proceedings – Fall 2019, Health Actuarial (B) Task Force, Attachment One-A). The motion passed unanimously.

2. **Adopted the Regulatory Framework (B) Task Force’s 2020 Proposed Charges**

Commissioner Conway said the Regulatory Framework’s 2020 proposed changes are straightforward, with only one completion date changed from 2019 to 2020. He said the Accident and Sickness Insurance Minimum Standards (B) Subgroup’s charge to revise the Accident and Sickness Insurance Minimum Standards Model Act (#170) was removed, as that work has been completed (including changing the title to the Supplementary and Short-Term Health Insurance Minimum Standards Model Act).

Ms. Nollette made a motion, seconded by Mr. Trexler, to adopt the Task Force’s 2020 proposed charges (see NAIC Proceedings – Fall 2019, Regulatory Framework (B) Task Force, Attachment One-A). The motion passed unanimously.

3. **Adopted the Senior Issues (B) Task Force’s 2020 Proposed Charges**

David Torian (NAIC) said the Senior Issues (B) Task Force’s 2020 proposed charges are basically the same as its 2019 charges, except for the following changes: Charge 2 and Charge 3 have been deleted because the subgroup and working group, respectively, have completed their work; and Charge 1F has been revised to add the Limited Long-Term Care Insurance Model Act (#642) and the Limited Long-Term Care Insurance Model Regulation (#643).

Commissioner Atkins made a motion, seconded by Commissioner Godfread, to adopt the Task Force’s 2020 proposed charges (see NAIC Proceedings – Fall 2019, Senior Issues (B) Task Force, Attachment One-A). The motion passed unanimously.

4. **Adopted its 2020 Proposed Charges**

Commissioner Altman stated that, prior to the call, NAIC staff distributed the Committee’s 2020 proposed charges and posted them on the Committee’s website, but—similar to many of the task force charges—there are not significant changes. The Committee will continue much of the important work that is already ongoing.

Commissioner Conway made a motion, seconded by Commissioner Stolfi, to adopt the Committee’s 2020 proposed charges (Attachment One-A). The motion passed unanimously.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

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

Conference Call

November 18, 2019

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Nov. 18, 2019. The following Subgroup members participated: Angela Nelson, Chair, Jessica Schrimpf, Carrie Couch, Danielle McAfee-Thoenen and Camille Anderson-Weddle (MO); Michelle Baldock (IL); Alex Peck and Jenifer Groth (IN); Joy Hatchette (MD); Melinda Domzalski-Hansen (MN); Cuc Nguyen (OK); Katie Dzurec, David Buono and Elizabeth Hart (PA); Jill Kruger, Candy Holbrook and Gretchen Brodkorb (SD); Heidi Clausen and Jaakob Sundberg (UT); and Jennifer Stegall, Eric Corman, Julie Walsh, Mary Kay Rodriguez, Rebecca Rebolz and Sue Ezalarab (WI). Also participating were: Jacob Lauten and Chelsey Maller (AK); Julia Yee (CA); John Reilly (FL); Teresa Winer (GA); Cynthia Banks Radke and Sonya Sellmeyer (IA); Emily DeLaGarza (MI); Pam Koenig and Michelle Scaccia (MT); Jessica Baker, Monica Bryant and Patricia Trujillo (NM); Jana Jarrett (OH); Libby Camp Elliott and Markus Wilcox (TX); Yolanda Tennyson (VA); Dena Wildman, Ellen Potter and Vanessa George (WV); and Denise Burke (WY).

1. Discussed a Consumer Guide on Using Health Insurance

Ms. Nelson brought up the consumer guide, Using Your Health Coverage. She said that it had been sent to Brenda J. Cude (University of Georgia) to review for readability. She said that Ms. Cude had some questions overall and encouraged greater consistency in use of terms. Ms. Nelson said that the draft uses the terms “health insurance,” “health plan,” “coverage,” and others and asked how the Subgroup would like to align these references.

The Subgroup discussed choosing one term and adding a definition of it early in the document. Harry Ting (Chester County Department of Aging Services - Apprise Program) said that the document references Medicare in some places and that “health plan” would be a better fit than “carrier” in the Medicare context. The Subgroup discussed the use of “health plan” further.

Ms. Hatchette said that one concern is that the broader the application, the longer the document, and the fewer people who will read it. Ms. Cude said that all these terms could be used, but the document should stick with consistent phrasing. She said that the conversation was helpful and that she would need to review the document again.

2. Discussed a Consumer Guide on Claims Issues

Ms. Nelson brought up the next item on the Subgroup’s work plan, a consumer guide related to claims. She said that this piece has a great deal of potential benefit for consumers. She said that many states have consumer information on appeals and grievances, but she would like to take a step back to the beginning of the process and provide better information on explanations of benefits (EOBs).

Ms. Nelson asked who the target audience for the guide should be. She asked whether the Subgroup had concerns with writing it in a broad-based way that applies to all private health coverage. Ms. Domzalski-Hansen asked whether it would cover Medicare, and Ms. Nelson responded that it should be focused on private coverage, not Medicare or Medicaid plans. The two discussed whether the document should include information on which government agency consumers should contact with a complaint, depending on the type of plan they have. Ms. Nelson said it should describe common elements in EOBs and present whom to call, but also help consumers be advocates for themselves.

Ms. Hatchette said that one concern is that the broader the application, the longer the document, and the fewer people who will read it. She said this piece could be something distributed in doctors’ offices, but if it is a multi-page document, that is difficult. Ms. Nelson said the Subgroup could consider a longer piece that consists of multiple one-pagers that could be used individually.

Ms. Nelson asked what topics should be covered in the guide. She mentioned several potential topics, including EOBs, claims denials, prior authorization, prescription drug exceptions, medical necessity determinations, mental health parity, provider access and external appeals. Ms. Baldock suggested focusing on appeals, complaints and external reviews, and the Subgroup
discussed how to keep the document readable with a large number of potential topics. Mr. Ting suggested prioritizing the ones that come up the most often or are most important for consumers. Ms. Nelson stressed the importance of explaining EOBs.

Ms. Nelson asked about documents that could serve as models for the consumer guide. Ms. Hatchette said she likes a publication from Georgians for a Healthy Future, but it is still too long. Mr. Ting agreed that many existing pieces are too long and suggested that the guide include sample letters for different appeals. Ms. Cude questioned whether the guide should be split into multiple documents, and Ms. Nelson said it was an option and, in any case, the guide should be streamlined and easily digestible.

Ms. Nelson asked that the Subgroup send ideas for topics to cover in response to an initial list she would send.

Having no further business, the Consumer Information (B) Subgroup adjourned.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Oct. 21, 2019. The following Subgroup members participated: Angela Nelson, Chair, and Jessica Schrimpf (MO); William Rodgers (AL); Weston Trexler (ID); Michelle Baldock and David Osborn (IL); Alex Peck (IN); Joy Hatchette and Mary Kwei (MD); Melinda Domzalski-Hansen (MN); Martin Swanson (NE); Cuc Nguyen (OK); Elizabeth Hart and Katie Dzurec (PA); Gretchen Brodkorb (SD); Heidi Clausen, Tanji Northrup and Jaakob Sundberg (UT); Todd Dixon (WA); Jennifer Stegall, Rebecca Rebolz and Julie Walsh (WI). Also participating were: Chelsey Maller (AK); Gerard O’Sullivan (CT); Fleur McKendell (DE); John Reilly (FL); Cynthia Banks Radke and Sonya Sellmeyer (IA); Emily DeLaGarza and Renee Campbell (MI); Bob Williams (MS); Pam Koenig (MT); Jana Jarrett (OH); Vickie Trice (TN); Angela Herron, Scott Helmcamp, Rachel Bowden and Marcus Wilcox (TX); and Yolanda Tennyson (VA); Joylynn Fix (WV); and Tana Howard (WY).

1. Discussed the Updated the Health Insurance Shopping Tool

Ms. Nelson provided an overview of the revisions the NAIC’s Communications Division made to the Health Insurance Shopping Tool adopted by the Subgroup in 2018. She said that it looks better than before. In response to questions, she said that the text had not changed but the layout did. She said the states can use it to assist consumers. Subgroup members also inquired whether states are permitted to add their own branding so that the document shows both state and NAIC logos and whether an editable version would be available.

Joe Touschner (NAIC) responded that he would bring these questions to the Communications Division and get back to the Subgroup.


Ms. Nelson brought up the consumer guide, Using Your Health Coverage. She reminded the Subgroup that it is intended for consumers enrolled in different kinds of coverage, including insurance in the individual market, as well as employer-sponsored coverage. She provided an overview of the updates to the table of contents, and the Subgroup had no further edits.

Ms. Nelson said that Ms. Baldock and Candy Gallaher (America’s Health Insurance Plans—AHIP) collaborated on edits to the “Life Changes” section and asked them to review them. Ms. Gallaher said that they added subheadings and noted that open enrollment period and special enrollment period were not listed in the glossary, which they recommended be added.

The Subgroup discussed whether and how to reference transitions to Medicare. Ms. Gallaher noted that a note early in the document says that the guide is not applicable to Medicare, but that Medicare can be a more affordable option for eligible individuals than marketplace plans. She suggested that the guide recommend exploring Medicare options. Anna Howard (American Cancer Society Cancer Answer Network—ACS CAN) suggested a direction to contact a State Health Insurance Assistance Program (SHIP) with Medicare questions.

The Subgroup discussed how to deal with short-term health plans, which do not provide a Summary of Benefits and Coverage (SBC). Some suggested making reference to comprehensive coverage, which would exclude short-term plans. Others observed that existing language notes that the guides does not cover supplemental plans. Ms. Nelson said that the average consumer may not know what these terms mean. The Subgroup discussed adding text in the “Getting to Know Your Health Plan” section that urges consumers to identify the type of plan they are enrolled in and potentially saying that those in comprehensive coverage will receive an SBC. Some Subgroup members suggested a direction to check the policy.

Ms. Nelson asked whether the consumer guide is ready for a review for readability by Brenda J. Cude (University of Georgia). Ms. Cude said she is happy to review the document.

Ms. Nelson said the goal is to complete the guide by Jan. 1, 2020, and then move on to a guide to help consumers deal with claims denials. She said that the Subgroup can still make edits after Ms. Cude’s review.
3. **Adopted Revisions to the FAQ Document**

Ms. Nelson told the Subgroup that the “Frequently Asked Questions About Health Care Reform” (FAQ document) is for consumer services staff in state insurance departments to use when assisting consumers. She said the questions on the individual mandate and anti-discrimination provisions had been updated based on input from Subgroup members.

Ms. Dzurec made a motion, seconded by Mr. Swanson, to adopt the revised FAQ document (Attachment Three-A). The motion passed.

Ms. Nelson asked that the FAQ be posted to the Subgroup web page on the NAIC website and sent to the NAIC’s Health Reform email list.

Having no further business, the Consumer Information (B) Subgroup adjourned.
FREQUENTLY ASKED QUESTIONS ABOUT HEALTH CARE REFORM

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Q 38: What is a health reimbursement arrangement?

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ACA REQUIREMENT TO HAVE BASIC HEALTH CARE COVERAGE (INDIVIDUAL MANDATE)

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Q 73: Will an insurance agent or broker show consumers all of the plan choices available through the [insert name of state exchange]?

Q 74: Will consumers have to share their personal information, including their tax returns, with an agent or broker, navigator, in-person assistance personnel, or certified application counselor?

Q 75: Will consumers have to share their account username and password with an insurance agent or broker, navigator, in-person assister, or certified application counselor?

Q 76: What help should an insurance agent or broker, navigator, in-person assister, or certified application counselor give consumers if they or their dependents are eligible for Medicaid or CHIP?
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COSTS AND ASSISTANCE WITH COSTS

Q 78: Is there cost-sharing for contraceptives?

Q 79: How much do plans offered through the [insert name of state exchange] cost?

Q 80: Do plans offered through the [insert name of state exchange] have large out-of-pocket costs?

Q 81: Where can consumers inquire to learn if they’re eligible for help paying premiums or for Medicaid?

Q 82: Is there help for consumers who can’t afford coverage?

Q 83: Who’s eligible for premium tax credits and cost-sharing reductions?

Q 84: How do premium tax credits to buy coverage through the [insert name of state exchange] work?

Q 85: Is an individual who is a victim of domestic abuse and separated (but not divorced) from his or her spouse eligible for subsidies on the exchange?

Q 86: If a consumer is eligible for subsidy assistance, is there a grace period before a company can terminate the consumer for non-payment of premiums?

Q 87: What should consumers do if they find themselves enrolled in both Medicaid/CHIP and exchange coverage with premium tax credits?

QUESTIONS ABOUT OTHER TYPES OF COVERAGE

Q 88: What is available in the market outside the [insert name of state exchange]?

Q 89: What are short-term plans?

Q 90: If consumers already have coverage, may they buy separate policies for their children?

ACA MEDICARE-RELATED QUESTIONS

Q 91: Who should consumers contact with questions about Medicare, Medicare Supplement insurance, or Medicare Advantage plans?

Q 92: Are people who pay premiums for Medicare Part A able to enroll through the [insert name of exchange]?

Q 93: If individuals become eligible for Medicare and are already in a QHP, can they stay in their plan instead of enrolling in Medicare?

Q 94: If individuals become eligible for Medicare and are already in a QHP, can they stay in their plan?

Q 95: Is there anything consumers and their dependents who are already on Medicare and have employer-based coverage need to do because of the ACA?

Q 96: Is there anything consumers and their dependents who are already on Medicare and have retiree coverage from an employer need to do because of the ACA?

Q 97: Will consumers with Medicare Supplement insurance be affected by the ACA?

Q 98: How will consumers’ Medicare prescription drug “donut hole” be affected?

Q 99: What about LTC insurance policies?

ACA MEDICAID-RELATED QUESTIONS

Q 100: Where can consumers find more information about Medicaid?

Q 101: Did consumers’ eligibility for Medicaid changed under the ACA?

Q 102: What is the expanded Medicaid eligibility under the ACA?
Q 103: What is the federal poverty level (FPL), and why is it important in the context of health care coverage? .......... 
Q 104: What benefits will be available for adults newly eligible for Medicaid? ............................................................ 
Q 105: Are undocumented immigrants eligible for Medicaid? ....................................................................................... 
Q 106: How do consumers apply for Medicaid? ............................................................................................................. 
Q 107: Will consumers still need to submit documents to prove their income? ................................................................. 

COMMON CONCERNS ABOUT HOW THE ACA AFFECTS CONSUMERS .............................................................................. 
Q 108: Does the ACA eliminate private health insurance? .............................................................................................. 
Q 109: Does the ACA include rules about insurance premiums? ....................................................................................... 
Q 110: Does the ACA address discrimination? ................................................................................................................... 
Q 111: What are the income tax implications of the ACA? ................................................................................................. 
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Q 113: What does the health plan “accreditation status” information on the exchange Web page mean? ......................... 
Q 114: What does the health plan “consumer experience” information on the [insert name of state exchange] Web page mean? 
Q 115: What appeal rights do consumers have? ................................................................................................................ 
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Q 117: If consumers apply for coverage in the market outside the [insert name of state exchange], what are the rules regarding open and special enrollment? .......................................................... 

QUESTIONS INVOLVING SPECIAL CIRCUMSTANCES AND POPULATIONS ........................................................................ 
Q 118: What is available for consumers with chronic conditions? Does the ACA help them get better coverage? .... 
Q 119: What options are there for consumers with children who aren’t citizens or legal residents? ............................. 
Q 120: Are immigrants not legally present eligible for coverage through the [insert name of state exchange] or for premium tax credits? ........................................................................................................ 
Q 121: Are incarcerated people eligible for coverage through the [insert name of state exchange] or for premium tax credits? 
Q 122: Are tribal members eligible for coverage through the [insert name of state exchange] or for premium tax credits? 

QUESTIONS ABOUT MLR .................................................................................................................................................. 
Q 123: What is the Medical Loss Ratio (MLR) requirement? .............................................................................................. 
Q 124: What is an MLR Rebate? ........................................................................................................................................ 
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QUESTIONS ABOUT WHETHER A PLAN IS LEGITIMATE ...................................................................................................... 
Q 126: Why is this a time to be especially on guard against health insurance fraud? .......................................................... 
Q 127: Can consumers get help from their current insurance agent or insurance company to buy health insurance coverage through the [insert name of state exchange]? .................................................................... 
Q 128: If consumers don’t have a relationship with an insurance agent or company, where should they go for help?.
Q 129: If someone comes to consumers’ homes, calls consumers out of the blue, or sends emails to offer consumers health insurance coverage for a terrific premium, how will consumers know whether the person and the health insurance coverage are legitimate?

PURPOSE

This document is designed for state insurance departments to use as they give answers to frequently asked questions (FAQ) and guide consumers about their health care choices. This document reflects regulations and guidance received from the federal government as of October 2019 and is subject to change.

This document isn’t intended to be given directly to consumers. States will need to modify this document to include state-specific information and terminology. Drafting notes indicate where states may choose to add additional clarity on state policies. While some sections may be useful for direct-to-consumer communications, the document’s primary purpose is to give insurance department staff accurate and understandable information to use when they respond to consumer questions about healthcare reform.

Note that the federal Affordable Care Act (ACA) and related regulations refer to “exchanges” that operate in the states, while federal guidance documents refer to these exchanges as “marketplaces.” This document uses the term “exchanges.” However, some states may decide to follow federal guidance and use the term “marketplaces.”

Note, also, that states will need to modify this FAQ if the state has combined the exchange for individuals and families with the Small Business Health Options Program (SHOP) exchange.

HEALTH CARE REFORM OVERVIEW

Health care has changed in many ways as a result of the passage and implementation of the Patient Protection and Affordable Care Act, Public Law 111-148 (PPACA), and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152. These two laws are collectively known as the ACA.

Q 1: When did the ACA take effect?

The ACA was enacted March 23, 2010.

Q 2: What changes have taken place?

Several changes took place before Jan. 1, 2014:

- Lifetime and annual dollar limits on essential health benefits (EHB) are not allowed. Annual dollar limits on EHB were also phased out by Jan. 1, 2014.
- Consumers are guaranteed certain appeal rights.
- Nearly all adult children up to age 26 are eligible to remain on a parent’s health insurance policy, regardless of the child’s marital status, financial dependency, enrollment in school or place of residence.
- Insurers must cover certain preventive services without cost sharing. (See Question 25.)
- Medical loss ratio (MLR) standards limit how much of premium dollars insurers can spend on administrative expenses.
- Many insurers must use a standardized Summary of Benefits and Coverage (SBC), which makes it easier to compare plans.
- Small businesses that provide health care for employees can apply for a tax credit.
- Persons with Medicare prescription drug coverage receive a rebate to help cover the cost of the “donut hole.” For 2020, consumers no longer face a donut hole.
Several major changes became effective for non-grandfathered individual and small group plans sold or renewed on or after Jan. 1, 2014:

- Plans must include new consumer protections. Health insurers can’t deny or refuse to renew coverage because of a pre-existing medical condition. They also can’t charge a higher premium due to a person’s gender or health condition.
- Insurers must cover routine medical costs if a person participates in a clinical trial for cancer or other life-threatening diseases.
- Many, though not all, insurance plans must cover a minimum set of EHB and can’t put annual dollar limits on these benefits.
- Individuals and families with incomes below 400% of the federal poverty level may qualify for financial assistance when they shop in the health insurance exchanges.
- In the small group market, from the period November 15 to December 15 each year, small employers can purchase coverage for their workers for the following year without having to meet minimum participation or minimum contribution requirements.

Note: Plans sold before March 23, 2010, that have had no significant changes are considered “grandfathered” and aren’t required to comply with many of these requirements. (See Question 31 on grandfathering.) Additionally, plans sold before Jan. 1, 2014, may—if allowed by the state—continue to be renewed through policy years beginning on or before Oct. 1, 2020, without coming into compliance with certain reforms. (See Question 32 on transition policy.)

Q 3: Where can a person find more information about the ACA, including detailed timeline information?

For more general and detailed information about the ACA and its key provisions, visit the federal government’s website at www.healthcare.gov, or call 1-800-318-2596 (TTY: 1-855-889-4325).

For information about implementation of the ACA in [insert name of state], contact [insert name of state exchange] at [email address] or [xxx-xxx-xxxx].

There are also several other helpful sites and resources for more information about the ACA, including: Kaiser Family Foundation (www.kff.org/health-reform/); Commonwealth Fund (https://www.commonwealthfund.org/health-care-coverage-and-access); The Robert Wood Johnson Foundation (www.rwjf.org), the Georgetown Center on Health Insurance Reforms (http://chir.georgetown.edu/projects-pubs); and the Center on Budget and Policy Priorities (www.healthreformbeyondthebasics.org).

Q 4: Do the consumer protections of the ACA apply to all health coverage?

No, not all health coverage is required to comply with all of the protections included in the ACA. The ACA largely established new protections in the individual and small group markets, which includes policies sold through the exchanges in every state. Health coverage sold outside of the individual or small group markets, or that is not considered insurance may not be required to comply with some or any of these protections.

Consumers may have questions about several types of coverage other than the qualified health plans sold through exchanges.

- Short-term, limited duration insurance. Several protections applicable in the individual market do not apply; however, state law or regulation may add some protections. Because the ACA does not apply, these plans may:
  - deny coverage or increase premium due to health status,
  - exclude essential health benefits,
  - refuse renewal,
  - limit coverage for pre-existing conditions,
  - establish annual or lifetime benefit maximums,
  - not establish an out-of-pocket maximum, or
  - exceed medical loss ratio standards without rebating premium.
• Association health plans. Depending on the structure of the association and state law, consumer protections applicable to individual, small group, or large group market plans may apply.
• Health care sharing ministry. These coverage arrangements are not considered to be insurance, so the requirements and protections described in this FAQ do not apply.
• Fixed indemnity insurance. The requirements and protections described in this FAQ generally do not apply.

Drafting note: States may want to add more details about state-level protections that apply to the coverage types mentioned in the bullets.

EXCHANGE BASICS

Q 5: What is the [insert name of state health insurance exchange]? (For questions about the [insert name of state SHOP exchange], see Questions 40-44, 46-50, and 69-72).

The [insert name of state exchange] is the name of [insert name of state]’s health insurance exchange. The ACA created health insurance exchanges as places where individuals, families, and small employers can compare private health insurance plans and shop for coverage. Exchanges also provide access to a tax credit to help lower- and middle-income individuals pay for coverage. (See Questions 81-84.) Through exchanges, individuals may also qualify for help to lower their out-of-pocket costs (deductibles, coinsurance or copayments) when they receive health care services. Insurers may sell plans through the exchange, as well as in the market outside the exchange. Premium tax credits and cost-sharing reductions aren’t available for plans sold outside the exchange.

Drafting Note: States that have no market outside the exchange should modify the previous paragraph accordingly. States should note, however, that some individuals such as incarcerated individuals and immigrants not legally present cannot be denied coverage on the basis of health status even though they will not be able to buy coverage through the exchange. (See Questions 118-119.)

To learn more, or to apply for coverage through the [insert name of state exchange], individuals and families should visit the website for the [insert name of state exchange] at [insert link to state exchange website]. For more general information about health insurance exchanges, visit the federal government’s website at https://www.healthcare.gov/what-is-the-health-insurance-marketplace.

Q 6: Are there different types of health insurance exchanges?

While the basic features of exchanges are the same in all of the states, the ACA allows for differences in who operates them. Some exchange operation options include the federal government operating the exchange, the state operating the exchange, and a partnership between the federal and state governments working together to operate the exchange. Please contact [insert state consumer affairs contact information] to learn how your state’s exchange is operated.

Q 7: What is a CO-OP plan?

CO-OP stands for Consumer Operated and Oriented Plan, which is a type of health insurer created under the ACA. The ACA gave low interest loans to private organizations to create a new type of nonprofit insurer designed to increase the plan choices available through the state exchanges. Any profits earned by CO-OPS must be applied to either lower premiums or expand benefits for customers. The federal Center for Insurance Information and Insurance Oversight (CCIIO) in the U.S. Department of Health and Human Services (HHS) maintains oversight of the CO-OPS. CO-OPS also must be governed by their members (or customers) and are required to offer plans through their respective states’ exchanges.

In [insert name of state], the [insert name of CO-OP] is the CO-OP available through the [insert name of state exchange]. If a CO-OP in the state is no longer available or enrollment has been capped, consumers can explore other coverage options through the exchange during the open enrollment period (or may be eligible for a special enrollment period (SEP) if their CO-OP coverage ends outside of the open enrollment period).

To find out more about the CO-OP program, please visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Consumer-Operated-and-Oriented-Plan-Program.html.
Drafting Note: States should modify or eliminate this question if there aren’t any CO-OPs in the state, if the CO-OP is no longer available, or enrollment has been capped.

**Q 8: If consumers live in one state but work in another, to which state’s exchange should they apply?**
Consumers who don’t have access to coverage through their employer (or their spouse’s employer) should apply for coverage in the state where they live.

**Q 9: Who can buy a plan through the [insert name of state exchange]?**
In [insert name of state], any individual or family who wants may buy coverage through the [insert name of state exchange]. The only people who can’t are those who are not lawfully present in the U.S. (see Questions 119-120), incarcerated individuals (other than pending disposition of charges) (see Question 121), and generally, people on Medicare (see Question 94).

Small employers (employers with fewer than [XX] employees) may buy health insurance for their employees through the [insert name of state SHOP exchange]. (For more information about the [insert name of state SHOP exchange], see Questions 40-44, 46-50, and 69-72).

Drafting note: States should insert the appropriate number in place of XX above, taking into account the specific rules for SHOP participation.

**Q 10: When are consumers able to enroll in plans through the [insert name of state exchange]?**
Consumers may enroll during the annual open enrollment period or when they qualify for a special enrollment period. In [insert name of state], open enrollment in [insert name of state exchange] for 2020 coverage for individuals and families begins [Nov. 1, 2019], and continues through [Dec. 15, 2019].

Coverage effective dates depend on the date of enrollment and are contingent on consumers paying the first month’s premium directly to the insurance company. [Enrollment during Open Enrollment becomes effective on January 1, 2020.] Enrollment during a special enrollment period will be effective on either the first day of the following month—if a consumer enrolls by the 15th of the month—or the first day of the second following month, if a consumer enrolls after the 15th of the month.

During open enrollment, consumers may change plans, change insurance companies, or stay with the plan they have, if it’s still available. Current enrollees will also receive a new eligibility determination to determine if they will receive more or less financial help in the form of premium tax credits or cost-sharing reductions. If a consumer does not actively select a new plan and is eligible for auto-renewal, he or she will be automatically re-enrolled into the closest comparable plan for 2020. So, if a consumer wants to make changes to their coverage effective on Jan. 1, he or she must choose a plan by Dec. 15.

**Q 11: What if a consumer wants to enroll or change plans outside of the open enrollment period?**
Consumers may be eligible to enroll in coverage at times other than during the open enrollment period. There are special enrollment periods (SEPs) for individuals or families if they experience certain events. Some examples of events that trigger an SEP include: 1) loss of minimum essential coverage for an individual or their dependent; 2) gaining or becoming a dependent (such as marriage or the birth/adoption of a baby); and 3) being enrolled in a plan through the exchange without tax credits and then becoming newly eligible for tax credits. (See Question 83.) The federal website https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ lists possible options for consumers to obtain coverage outside an open enrollment period. Consumers generally have 60 days from the date of the event that triggered an SEP to enroll in coverage. Additional information on SEP rules is available at http://www.healthreformbeyondthebasics.org/wp-content/uploads/2015/06/SEP-Reference-Chart.pdf.

Consumers can apply for coverage through [insert name of state exchange] any time during the year, regardless of whether it’s an enrollment period. The [insert name of state exchange] will process the application and tell the consumer whether or not he or she can enroll or must wait until an enrollment period. Contact the [insert name of state exchange] at [insert website] or [insert phone number] for information about whether a consumer might be eligible to enroll in coverage through
the [insert name of state exchange] during an SEP. People who are eligible for Medicaid and the Children’s Health Insurance Program (CHIP) can apply and enroll in [insert name of state Medicaid agency] at any time.

Q 12: How can a consumer prepare to enroll in a plan through the [insert name of state exchange]?

The federal website https://www.healthcare.gov/apply-and-enroll/get-ready-to-apply/ has suggestions for things consumers should be thinking about to prepare to enroll in a plan through the exchange. The [insert name of state department of insurance] website at [insert website] has helpful information for consumers who are thinking about enrolling in a plan through the [insert name of state exchange]. Consumers can also make an appointment with a navigator, certified application counselor, insurance agent or broker, or other assister to help prepare for enrollment and compare plans. To find those that can assist consumers, go to Find Local Help at: https://localhelp.healthcare.gov/.

Consumers can start gathering basic information about household income, such as their most recent tax return if they filed one, or other income information. A full list of required documents is available at https://marketplace.cms.gov/outreach-and-education/marketplace-application-checklist.pdf. Many people will qualify for financial help to make insurance affordable, and consumers will need income information to find out how much help they are eligible for. Consumers can find more information about how to save money on coverage at https://www.healthcare.gov/lower-costs/.

SHOPPING FOR HEALTH INSURANCE: WHAT IS COVERED?

Q 13: What types of plans are available through the [insert name of state exchange]?

Health plans sold through the [insert name of state exchange] are required to meet comprehensive standards for items and services that must be covered. (See Question 16.) To help consumers compare costs, plans available through the [insert name of state exchange] are organized in four tiers, or four levels, that estimate the generosity of the plans’ coverage:

- **Bronze level** – The plan must cover about 60% of expected costs across a standard population. This is the lowest level of coverage.
- **Silver level** – The plan must cover about 70% of expected costs across a standard population.
- **Gold level** – The plan must cover about 80% of expected costs across a standard population.
- **Platinum level** – The plan must cover about 90% of expected costs across a standard population. This is the highest level of coverage.

In addition, catastrophic plans cover the same services, but its coverage will be slightly less generous than the bronze level plans. A catastrophic plan may be a less expensive option for those who are eligible: Only individuals under age 30 and individuals who cannot afford other coverage are allowed to buy catastrophic plans. If consumers have their plan cancelled and can’t afford replacement coverage, they may apply for a hardship exemption and buy a catastrophic plan. Premium tax credits and cost-sharing reductions aren’t available for catastrophic plans. Also, catastrophic plans cannot be used with health savings accounts (HSAs).

Stand-alone dental plans are available through the [insert name of state exchange]. (See Question 25.)

Q 14: How do the tiers (bronze, silver, gold, and platinum) help consumers compare plans?

The tiers are a way to categorize plans based on “actuarial value.” Plans within each tier have a similar actuarial value, even if they cover different benefits or have different types of cost-sharing. While all plans in a tier must cover EHB (see Question 17), the details of their coverage (such as how many physical therapy visits are covered or which prescription drugs are covered) may be different. Not all plans in the same tier have the same benefits or cost-sharing requirements. Some plans may offer benefits in addition to the EHB.

The metal levels indicate only the level of cost-sharing required by the plan. They do not provide consumers an indication of the plans’ provider network size, quality, or any other aspect of coverage.
**Q 15: What is actuarial value?**

Actuarial value represents how much of a standard population’s medical spending the health insurance plans in a given metal level would cover. Percentages (60% for bronze, 70% for silver, 80% for gold, and 90% for platinum) represent the approximate actuarial value of plans at each level. A higher percentage means the plan covers more of a standard population’s costs (and the population pays less out-of-pocket). A lower percentage means the plan covers less (and the population pays more). The actuarial value calculation focuses mainly on cost-sharing charges so that a bronze plan generally would have higher enrollee cost-sharing amounts compared to a gold plan. There also may be differences in how benefits are covered, such as differences in the prescription drugs that are covered or how many physical therapy visits the plan covers. The law requires all the metal level plans and catastrophic plans to cover a set of EHB.

Actuarial value is calculated for a standard population and doesn’t mean that the plan will pay that percentage of any given person’s actual costs. For instance, a silver tier plan will pay more than 70% of covered medical expenses for some people and less than 70% for other people.

Actuarial value doesn’t give other information about a plan that may be important to a particular person or affect their costs. It doesn’t tell you how broad or narrow a plan’s provider network is, the quality of the provider network, about the plan’s customer service and support, how broad or narrow the drug formulary is, or the premium levels. All of this information is important for consumers to consider when they choose a plan.

See [https://www.healthcare.gov/choose-a-plan/](https://www.healthcare.gov/choose-a-plan/) for more consumer information about choosing a plan.

**Q 16: What services/benefits must plans cover? What are essential health benefits?**

Many plans sold in the individual and small group market, including all of those sold through the [insert name of state exchange] and [insert name of state SHOP exchange] must cover, at a minimum, a comprehensive set of benefits known as essential health benefits (EHB). These EHB include the following:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, including chronic disease management
- Pediatric services, including oral and vision care

“Grandfathered,” “transitional,” and “short-term” plans in the individual and small group markets aren’t required to include EHB. For more information on these plans, see Questions 30-31.

For more detailed information about essential health benefits in [insert name of state] and other states, visit [https://www.cms.gov/cciio/resources/data-resources/ehb.html#ehb](https://www.cms.gov/cciio/resources/data-resources/ehb.html#ehb).

**Q 17: What insurance companies will offer coverage through the [Insert name of state exchange]? How can consumers get a list of companies and plans available?**

There are listings of the health plans available through the [insert name of state exchange] on its website: [Insert links to state exchange website]. People without access to the Internet can call the customer service line for the [insert name of state exchange] at [insert phone number] or get help from an agent, broker, or other type of assister. (See Question 62.)
Q 18: How can a consumer find out the details about what a particular plan covers?

All individual and small group plans offered after Jan. 1, 2014, will cover EHB (see Question 16), except grandfathered, transitional, and short-term plans. (See Questions 30-31 and 89.)

To learn if a specific benefit is covered, and at what level, check a plan’s Summary of Benefits and Coverage (SBC). An SBC is a uniform document that includes details about what a plan does and doesn’t cover. It also includes information about what kinds of costs a consumer can expect to pay out-of-pocket, such as copayments, coinsurance, and deductibles. An insurance company must provide an SBC for all health plans except for short term and limited benefit plans. It gives information in the same way for every plan to make it easier to compare plans. The SBC forms are available on the federal government’s website at www.healthcare.gov, the [insert name of state exchange] website at [insert link], the insurance company’s website, or from an agent or broker for plans offered in the market outside the exchange.

It should be noted that the SBC provides a summary of the benefits. More detailed information is available through the insurer or an insurance agent or broker, and each SBC must include a link to a copy of the actual individual coverage policy or group certificate of coverage that will provide more detailed information.

The [insert name of state exchange] website at [insert link] includes information about what each plan covers and links to the insurer’s plan brochures.


Q 19: How can consumers compare benefits and understand what a plan covers?

In addition to getting an SBC (see Question 18), consumers can get information about the health plan options available in their state online at the [insert name of state exchange] website at [insert link], through the [insert name of state exchange]'s toll-free telephone number, or from agents, brokers, navigators or consumer assisters. To find those that can assist you in your area, you can go to “Find Local Help” at https://localhelp.healthcare.gov/.

Q 20: How can consumers see and compare premiums for plans?

The [insert name of state exchange] is set up to let consumers compare policies on the basis of premiums, provider network, actuarial value, and other factors. In addition to premium costs, consumers should look at all the benefits and cost-sharing provisions when choosing a plan because plans with the lowest premium often have the highest out-of-pocket costs.

Consumers can get information to compare premiums from the [insert name of state exchange] website at [insert link] or call center at [insert phone number]. Also, navigators, certified application counselors, insurance agents or brokers, or other assisters should be able to help consumers compare plans.

Drafting Note: States that allow stand-alone vision plans to be sold through the exchange should modify this answer to include stand-alone vision plans.

Q 21: Can a person or a health insurance issuer take benefits out of a plan? What if a consumer doesn’t need all of the benefits in a plan?

No. Neither consumers nor health insurance issuers can take benefits out of a plan. At a minimum, every health plan on the [insert name of state exchange] must provide coverage for all of the essential health benefits the ACA requires. (See Question 16.) Even though a person may not need every benefit in a plan, plans must cover all of the essential benefits to share risk across a broad pool of consumers and be sure all benefits are available for everyone. This also helps to protect people from risks they can’t always predict across their lifetimes.

There may be short-term plans or limited benefit plans available that do not cover all of the essential health benefits.
**Drafting Note:** States with an individual mandate may want to add: Consumers who don’t have a plan that provides minimum essential coverage may have to pay a penalty when they file their state income taxes. The federal penalty was reduced to $0 starting with tax year 2019. (See Question 57.)

**Q 22: Can consumers’ health conditions affect what coverage they are able to get?**

No. Under the ACA, health insurance companies no longer can leave coverage out of a plan based on a person’s health condition, a practice that used to be known as a “pre-existing condition exclusion.” Nor can they charge a higher premium because of a person’s health condition. These protections apply whether a person buys an individual market plan through the exchange or outside the exchange; it does not apply to short term or limited benefit plans.

**Q 23: Can an insurance company charge tobacco users more than non-tobacco users?**

Under the ACA, health insurance companies in the individual and small group markets can charge consumers who use tobacco products a higher premium. People who use tobacco may be charged up to [insert state-specific tobacco surcharge – no higher than 50%] more than people who don’t use tobacco. Consumers in group plans may not have to pay this extra charge if they complete a tobacco cessation program and cannot be charged more unless they are provided an opportunity to complete a tobacco cessation program. This does not apply to coverage that is not considered individual coverage, including short-term plans.

**Drafting Note:** States that don’t allow the tobacco surcharge should replace the previous paragraph with the following one: In [insert name of state], health insurance companies can’t charge consumers a higher premium for being a tobacco user.

**Q 24: What are preventive benefits and how are they covered?**

Preventive benefits are designed to keep people healthy by providing screening for early detection of certain health conditions or to help prevent illnesses. The ACA requires that individual market and non-grandfathered group health plans cover many preventive services with no out-of-pocket costs (meaning no deductibles, co-payments and coinsurance) for all new plans sold after Sept. 23, 2010. Some of these covered preventive services are:

- Colorectal cancer screenings, including polyp removal for individuals over age 50
- Immunizations and vaccines for adults and children
- Counseling to help adults stop smoking
- Well-woman check-ups, as well as mammograms and cervical cancer screenings
- Well-baby and well-child exams for children

Unless an insurer doesn’t have an in-network provider to do a particular preventive service, plans can charge for these preventive services when done by an out-of-network provider.

For more detailed information about covered preventive services, visit the federal government’s website at https://www.healthcare.gov/what-are-my-preventive-care-benefits.

**Q 25: Are dental or vision benefits available through the [insert name of state exchange]?**

The ACA requires plans sold through the [insert name of state exchange] to include vision coverage for children, so children’s vision benefits are included in plans through the [insert name of state exchange]. Dental benefits are treated differently. The ACA lets insurance companies offer health plans through the [insert name of state exchange] that don’t include children’s dental benefits as long as the [insert name of state exchange] offers a stand-alone dental plan that includes a pediatric dental benefit.

Plans aren’t required to include dental or vision coverage for adults, but a plan can choose to include these benefits as part of its coverage. Check a plan’s SBC to learn if the plan includes dental or vision coverage for adults.

Some insurance companies may offer stand-alone dental plans through the [insert name of state exchange]. Check the [insert name of state exchange] website at [insert link] for more information.
Check the federal website at www.healthcare.gov for more information about dental benefits.

**Drafting Note:** States where consumers may buy dental coverage without purchasing health coverage should add a sentence as appropriate to explain.

**Drafting Note:** States that allow people with Medicare to buy dental plans through the exchange should include this information in this answer.

**Drafting Note:** States that allow stand-alone vision plans to be sold through the exchange should modify the answer to this question as appropriate.

**Q 26: How does a consumer find out what drugs a plan covers?**

Health insurers keep lists of which drugs are covered and which are covered at the lowest cost for each of their plans. These lists are called formularies. Drug cost-sharing is often “tiered”—that is, consumers pay less for a generic drug, more for a brand name drug and sometimes even more for a nonpreferred brand name drug. Consumers should review the formularies in any plan they are considering to be sure the plan meets their prescription drug needs and to know what cost sharing is required for any given drug. For plans that use formularies, the SBC includes an Internet address to obtain information about the plan’s drug coverage. Consumers also can call health insurers for information.

Formulary information is also available on [insert name of state exchange] website. If a consumer enrolls in coverage and needs access to a drug not on the plan’s formulary, the enrollee may be able to use the drug exceptions process to request and gain access to the needed drug.

**Drafting Note:** States should include their rules regarding whether the insurance company can change the formulary or tiering after the consumer has bought the plan.

**Q 27: What are out-of-network services, and do consumers have any coverage for them?**

Services are considered out-of-network if they’re from a doctor, hospital, or other provider that doesn’t have a contractual relationship with a particular health plan. Not all plans cover out-of-network services, but when they do, a consumer’s share of the cost is usually a lot higher than for an in-network service. (See Question 24 regarding preventive services and Question 29 regarding emergency services.) Consumers should find out whether a provider is in-network before they receive services. Consumers also should find out if their regular or desired health care providers are in-network before they buy a plan. Additionally, different plans offered by the same insurer may have different provider networks, so consumers should be careful to look at the network for their specific plan.

Although the ACA limits how much money a person is required to spend each year on his or her family’s health care, health insurers are permitted, although not required by federal law, to count the cost of out-of-network services toward these limits.

A plan’s SBC will include information about coverage for out-of-network services and an Internet address to see the plan’s provider network.

**Q 28: How do consumers determine if their doctor or dentist is in the network?**

The [insert name of state exchange] website (at [insert website]) lets consumers look up whether their doctor is in the plan network. For plans with a provider network, the SBC includes an Internet address to get a list of network providers. Because plan networks may change regularly, consumers also should check with the doctor or dentist before they schedule an appointment to learn if the provider is still in the plan’s network.

**Q 29: Do consumers have access to emergency care out-of-network?**

Yes. The ACA requires many health plans that provide benefits for emergency services to cover them regardless of whether the provider is in or out of the network. Under the ACA, health plans aren’t allowed to charge a higher copayment or coinsurance for out-of-network services received in an emergency. In addition, [insert name of state] prohibits balance billing for emergency care received out-of-network, meaning only in-network rates will apply for all emergency care.
Drafting Note: States that allow health care providers to balance bill for emergency care received out-of-network should replace the previous paragraph with the following:

Yes. The ACA requires many health plans that provide benefits for emergency services to cover them whether the provider is in or out of the network. While health plans aren’t allowed to charge a higher copayment or coinsurance for out-of-network services received in an emergency, [Insert state name] allows health care providers to bill consumers for the difference between the cost of emergency care received out-of-network and the amount the plan allows. For more information about [insert name of state]’s rules on balance billing, please contact [insert specific state contact information]. Under federal law, to limit amounts of balance billing for out-of-network emergency services, insurers must calculate amounts they pay for such services in such a way that yields the highest payment of the following three amounts:

(A) The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee

(B) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee.

(C) The amount that would be paid under Medicare Parts A or B for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee.

Q 30: What is a “grandfathered” health plan?

A grandfathered health plan is a plan that has existed continuously since before March 23, 2010, and that has not made certain significant changes in the plan. Grandfathered plans aren’t subject to many of the ACA requirements, such as the requirement that plans cover EHB (see Question 16), but they are considered to provide minimum essential coverage under the ACA. (See Question 57.)

Grandfathered plans that make certain changes, such as major increases in their cost-sharing (such as coinsurance, deductibles, copayments) or eliminating benefits to diagnose or treat a particular condition, may lose grandfathered status and then would have to follow the applicable ACA requirements. Employer-sponsored plans that significantly increase the employee share of the premium also could lose grandfathered status.

In the individual market, a consumer cannot enroll in a grandfathered plan with a new enrollment. However, consumers who are already enrolled in an individual market plan as of March 23, 2010, can renew their coverage in that grandfathered plan.

A plan must indicate in the plan materials if it’s a grandfathered plan. Also, consumers can check with their insurance company or employer to determine if their plan is grandfathered.

Q 31: Can consumers keep an existing plan that isn’t grandfathered, but which doesn’t comply with the ACA reforms (known as transitional plans or “grandmothered” plans)?

It depends. In November 2013, CMS announced a transitional policy that would permit insurers, if allowed by the state, to extend policyholders’ 2013 coverage for up to several additional years even if the plan did not comply with certain ACA reforms. These transitional plans can no longer be sold to new customers (after Jan. 1, 2014), and aren’t eligible for subsidies. Insurers that provide transitional plans will provide notice to affected individuals and small businesses. Check with your insurance carrier to see if it will be renewing these plans and what changes, if any, it will be making to the plans.

Drafting Note: States that did not adopt this policy, applied it only in certain markets (i.e., in the small group market but not the individual market), or that have already phased out transition plans would need to edit this answer accordingly or perhaps delete it entirely.
EMPLOYER-SPONSORED COVERAGE

Q 32: Is employer-based coverage required to cover dependents (spouses and children)?

Under the ACA, if an employer with 50 or more employees doesn’t offer coverage that meets minimum standards to employees and their dependents, and employees access premium tax credits through the exchange, the employer may have to pay a tax penalty. (See Questions 53-54.) However, for purposes of this penalty, the IRS has interpreted the phrase “and their dependents” to mean children under age 26 but not spouses. For more information, see https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions. Small employers with fewer than 50 employees that don’t offer coverage to employees or their dependents are not subject to any tax penalties, but may qualify for a tax credit if they choose to do so. (See Question 55.)

Also, if employer-based coverage includes children, the ACA requires the employer to let children up to age 26 stay on their parents’ policy. Adult children up to age 26 can stay on their parents’ policy whether or not they live in their parents’ home, are married, or the parents no longer claim them as a dependent on their tax return. The employee can be required to pay for this coverage, however.

Q 33: What can a consumer do when employer-based health coverage ends?

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal health law since 1986, when employees and their dependents lose employer-based coverage, they are still eligible to stay on their employer’s group health plan, even though that coverage would otherwise end. COBRA doesn’t apply to employers with fewer than 20 employees [insert state mini-COBRA law information if applicable].

However, COBRA coverage can be expensive because the former employer isn’t required to pay any part of the premium. Those who have lost employer-based health coverage may be eligible to access advance premium tax credits to buy a more affordable individual or family policy through the [insert name of state exchange] (see Question 83-84) even if the loss of coverage occurs outside of the open enrollment period. Consumers enrolled in COBRA cannot qualify for advance premium tax credits. Dropping COBRA coverage outside of an open enrollment period will not qualify as a special enrollment opportunity.

Q 34: Must a consumer exhaust all available COBRA coverage before buying coverage through the exchange with subsidies?

No. COBRA allows group health plan participants and beneficiaries to continue coverage under their group health plan for a limited period of time after certain events cause a loss of coverage, such as voluntary or involuntary job loss, reduction in the number of hours worked, transition between jobs, death, and divorce. If an individual loses eligibility for minimum essential coverage, including employment-based coverage, he or she will be eligible for a special enrollment period (SEP) during which he or she can buy coverage on the [insert name of state exchange] or in the individual market outside of it. At this time, the individual may also apply for advance premium tax credits and cost-sharing reductions through [insert name of state exchange] to see if he or she is eligible to receive them. However, if an individual has already enrolled in COBRA coverage, he or she must wait until the next open enrollment period or until that COBRA coverage has been exhausted before enrolling in an individual market plan.

Q 35: If a consumer has access to employer-based coverage, can an employer make the consumer wait before becoming eligible for benefits?

Yes. Employers may require a waiting period before individuals become eligible for benefits. Under the ACA, this waiting period can’t be longer than 90 days. Employers also may impose an additional one-month orientation period before the waiting period begins. For more information, consumers should contact their employer’s human resources department.
Q 36: Can a consumer with access to employer-based coverage get a tax credit to buy a plan through the [insert name of state exchange]?

A consumer who has access to employer-based coverage is free to buy a plan through the [insert name of state exchange], but tax credits to buy the coverage are available only if the employer’s plan isn’t affordable or doesn’t provide minimum value. (See Question 83.) If a consumer has access to employer-sponsored coverage that is affordable and provides minimum value, the consumer will not be able to get tax credits and cost-sharing reductions.

Coverage isn’t affordable if the cost of employee-only coverage under the lowest cost employer plan is more than 9.78% of the employee’s annual household income in 2020. The plan doesn’t provide minimum value if it pays for less than 60% of medical costs that the plan covers, or if it fails to provide substantial coverage of inpatient hospital or physician services. The HHS and IRS have developed a minimum value calculator at www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm.

Consumers can find out if an employer plan meets minimum value by looking at the SBC or by requesting that the employer fill out an Employer Coverage Tool. This form provides information that will help the consumer answer application questions correctly at the [insert name of state exchange]. The Employer Coverage Tool can be found at https://www.healthcare.gov/downloads/employer-coverage-tool.pdf.

There’s more information on [insert name of state exchange]’s website and on these IRS websites:

www.irs.gov/Affordable-Care-Act/Individuals-and-Families/The-Premium-Tax-Credit


Q 37: If a consumer is offered employer-based coverage that would cover a spouse or dependents, can that consumer’s spouse or children get a tax credit to buy coverage through the exchange?

It depends on whether the employer-based coverage is affordable and meets minimum value. If the premiums for employee-only coverage in the lowest cost plan are less than 9.78% of household income and the coverage provides minimum value, then no one in the family who is eligible for the plan is eligible for premium tax credits. This may be the case even when it would be unaffordable for a spouse or children to enroll in the plan, based on the cost of family coverage. Depending on state eligibility rules, the children may be eligible for Medicaid or CHIP coverage. (See Question 99.) Contact the [insert name of state exchange] to learn more.

Q 38: What is a health reimbursement arrangement?

Under a health reimbursement arrangement (HRA), an employer may offer employees tax-free funds to be used to purchase health coverage. Under an integrated HRA, an employer may offer funds instead of a group health plan to some or all employees. The employees use the funds to purchase individual market health plans for themselves and their families. Under an excepted benefits HRA, an employer may offer funds alongside a group health plan. The employees and their families may use the HRA funds to purchase coverage other than comprehensive health coverage, such as dental coverage, vision coverage, or short-term, limited duration insurance.

Q 39: If a consumer is offered a health reimbursement arrangement, can that consumer get a tax credit to buy coverage through the exchange?

It depends on the amount of the HRA offered by the employer. If the employer offers enough money through an HRA to make an exchange plan affordable for an employee, neither the employee nor family are eligible for a premium tax credit. If the size of the HRA does not make coverage affordable, the employee and family may still receive a premium tax credit. If the HRA is a qualified small employer HRA (QSEHRA), the amount of the tax credit is reduced by the amount of the QSEHRA.

The [state exchange name] may not take a consumer’s HRA into account when calculating how much premium tax credit the consumer is eligible for. In that case, the consumer may want to apply less than the full amount of the credit they are
awarded when paying for their premiums every month. This can help avoid the need to pay back some of the credit when the consumer files his or her federal income tax return.

Q 40: What is the [insert name of state SHOP exchange]?

Under the ACA, states or the federal government may create Small Business Health Options Program (SHOP) exchanges, where small employers who want to offer coverage to their employees can shop for plans. In [insert name of state], the SHOP exchange is called the [insert name of state SHOP exchange]. The SHOP can allow a small employer to offer a range of small group plans to their workers. Eligible employers can apply for the Small Business Health Care Tax Credit if they offer coverage through the SHOP and meet certain other criteria. The SHOP has no minimum contribution requirements for employers, but, some states may impose a contribution requirement in addition to a minimum participation rate. Employers who are interested in applying for the Small Business Health Care Tax Credit, however, must contribute at least 50% to their employees’ premium costs in order to be eligible for the credit. Just as with the regular small group market, employers that sign up for coverage during the small group open enrollment period that runs from Nov. 15 to Dec. 15 will face no minimum participation requirements. Coverage would then be effective for workers beginning Jan. 1.

The ACA calls for “employee choice” in the SHOP exchanges. Under this provision, small employers may choose to give their employees a choice of health plans from multiple insurers across all metal levels on the SHOP exchange. In some states, employers may also choose to offer coverage by one insurance company. Whether offering employee choice or not, in most states, employers will work with their SHOP registered agent or broker, or insurance company or companies to obtain application, enrollment and billing information.

There’s more information about the [insert name of state SHOP exchange] at [insert link to state SHOP exchange website]. There are resources for information about small employer issues and the ACA on the following websites:

http://healthcare.gov/small-businesses

U.S. Department of Labor Patient Protection and Affordable Care Act information

Affordable Care Act Tax Provisions

Q 41: Is there a cost to participate in [insert name of state SHOP exchange]?

There’s no fee for small employers or their employees to enroll in SHOP coverage. Some employers may be eligible for the Small Business Health Care Tax Credit, which can be worth up to 50% of the employer’s premium contribution.

Q 42: Can insurers charge more (or less) for policies sold through [insert name of state SHOP exchange]?

No. Insurers must charge the same for similar plans whether they’re sold through the [insert name of state SHOP exchange] or in the market outside of the [insert name of state SHOP exchange].

Q 43: What happens if an employer’s staff increases to more than 50 employees in the year after the employer bought coverage through the SHOP?

The small employer still will be eligible to buy health insurance through the [insert name of state SHOP exchange] through the end of their plan year because the employer had 1-50 employees at the time they bought coverage through [insert name of state SHOP exchange].

Drafting Note: States should modify this paragraph in accordance with the state definition of small employer.
Q 44: How are small employers defined?

Generally, small employers who are eligible to get coverage in the small group market or in the SHOP are those with 50 or fewer employees, though the definition may vary by state.

Drafting Note: States should modify this paragraph in accordance with the state definition of small employer.

Q 45: How do employers with full-time and part-time employees know whether they’re required to pay a penalty if they don’t offer health insurance to their workers?

All employers will want to assess whether they’ll be considered to have at least 50 full-time equivalent employees. Penalties will be assessed (starting Jan. 1, 2016), against employers with at least 50 full-time equivalent employees who 1) do not offer health coverage that meets minimum standards, 2) have an employee who gets coverage through the exchange, and 3) have an employee who gets the premium tax credit. (See Questions 53-54.)


Q 46: Are health insurers required to sell their plans through the federal SHOP exchange?

It’s expected that only some insurers currently offering small group health insurance plans will choose to sell their plans through [insert name of state SHOP exchange]. If they choose to, they must at least offer one plan in the silver metal tier and one in the gold. (See Question 15.) They may offer plans in the other metal tiers, but they might choose to offer those plans only in the market outside the [insert name of state exchange]. That’s another reason to compare exchange plans with those in the market outside the exchange. It’s important for small employers to understand all of their options. Small employers may work with SHOP registered agents or brokers for information about the small group insurance options in their state.

Q 47: Are small employers required to buy a health plan for their employees through [insert name of state SHOP exchange]?

No. Small employers may buy health insurance for employees through the [insert name of state SHOP exchange] or in the market outside the exchange. However, to be eligible for the Small Business Health Care Tax Credit (see Question 55), in most cases the coverage must be bought through the SHOP exchange. It will be important for small employers to understand and compare all options available to them. State licensed health insurance agents and brokers, including SHOP registered agents and brokers, are available to help small employers compare options and determine which plan best meets their needs.

More information on the Small Business Health Care Tax Credit

Drafting Note: States that require small employers to buy health insurance for their employees through the exchange should modify this answer as appropriate.

Q 48: Will consumers be better off with individual coverage through the [insert name of state exchange] rather than small employer coverage?

Maybe. It depends on many variables, such as the employees’ out-of-pocket expenses under the small group plan offered, the consumers’ personal circumstances, and the premiums of the plans available through the exchange. Employees, their spouses, and dependents offered coverage through an employer are usually not eligible for premium tax credits, so small employer-sponsored coverage could cost less than individual coverage through the federal exchange.

Rates are available for plans offered through the [insert name of state exchange] and for plans in the market outside the [insert name of state exchange] so employers and employees can compare their options.
Q 49: Are there participation rates that insurers can require employers to meet to be eligible to buy small group coverage through the [insert name of state SHOP exchange] or in the market outside the [insert name of state SHOP exchange]?

As a result of the ACA, insurers offering coverage in the small group market cannot deny coverage to a small employer based on failure to meet minimum participation requirements, provided that the employer seeks coverage during the small group open enrollment period that runs from Nov. 15 to Dec. 15 each year. Outside of that time period, insurers in the small group market may impose participation requirements through the [insert name of state exchange] or outside the [insert name of state exchange] consistent with [insert name of state] law.

[Insert name of state] law doesn’t allow a small employer insurer to impose more stringent requirements than the following:

- [insert participation limits consistent with state law]

**Drafting Note:** States with state-based exchanges may impose minimum participation rates as a condition of participation in a state SHOP exchange. In states with a federally-facilitated exchange, the SHOP has a default minimum participation rate of 70% for qualified health plans (QHPs) and the minimum participation rate will be adjusted higher or lower depending on state law or general insurer practice. For more information, see this link: https://marketplace.cms.gov/outreach-and-education/shop-minimum-participation-rates.pdf

Q 50: Can small employers who are the sole employees of their business buy small group coverage either through the [insert name of state SHOP exchange] or the outside market?

Neither federal nor state law lets insurers sell small group health insurance plans to self-employed individuals with no common law employees through the SHOP.

Contact the [insert name of state exchange] at [insert link] or [phone number], or a licensed agent or broker for help.

Q 51: How does rating work in the small group market?

Under the ACA, there is adjusted community rating in the small group market. This means that the rates each employer pays for health insurance depends on the claims experience of the insurer’s entire small group market in [insert name of state], rather than the claims experience of that employer’s small group.

The ACA offers states the option to combine the individual and small group markets. By combining the markets, risk gets pooled among a larger number of policyholders. A larger risk pool increases rate stability; however, initially premiums for individuals are likely to be lower on average, while premiums for small employers are likely to be higher.

Q 52: Do small employers that don’t offer health care insurance coverage to their employees, have to pay a tax penalty?

No. Small employers who want to provide coverage may be eligible for the Small Business Health Care Tax Credit to help make insurance more affordable.

If the employer does offer coverage, however, the coverage must meet the ACA’s minimum standards for small group insurance plans, as well as specific requirements that apply to the small group market, such as coverage of EHB and the prohibition on discrimination based on health status.

In [insert name of state], the [insert name of state SHOP exchange] is a place where small employers who want to offer coverage to their employees can shop. There’s more information about the [insert name of state SHOP exchange] at [insert link to state SHOP exchange website].
Q 53: Do large employers have to offer health care insurance coverage to their employees? What about seasonal employees?

Under the ACA, if a large employer doesn’t offer affordable coverage that provides minimum value to full-time employees (and their dependents1), and an employee gets a premium tax credit, the employer has to pay a penalty. For employer-based coverage to be considered affordable in 2020, the premiums for the plan’s employee-only option must be less than 9.78% of his or her 2020 annual household income.

To offer minimum value, the plan must pay at least 60% of the medical costs for services the plan covers and include substantial coverage of inpatient hospital and physician services. The HHS and IRS have developed a minimum value calculator at www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm.

Large employers for this purpose are employers with 50 or more full-time employees, including full-time equivalent (FTE) employees. Full-time employees are employees with 30 hours or more of service in a week. The number of FTE employees is determined by adding the number of hours of service in a month for all part-time workers and dividing by 120 hours per month.

Penalties were assessed starting Jan. 1, 2016, against employers with 50 or more FTE employees not offering health coverage if an employee gets the premium tax credit.

Employers with a large seasonal workforce (such as agricultural workers hired for the harvest season or retail clerks hired for the holiday season) are given leeway under the ACA not to count seasonal employees to decide if they meet the definition of a large employer. If the employer has more than 50 full-time or FTE employees during 120 or fewer days per year, the employer doesn’t have to count those employees for those months.


This question does not take into account all possible situations. Employers should consult a tax professional for assistance with their particular situation.

Q 54: What are the penalties if large employers don’t provide coverage?

Large employers may have to pay a tax penalty if they don’t offer affordable coverage that provides minimum value for at least 95% of their full-time employees and their dependents, or all but five full-time employees, whichever is greater, and at least one of their employees gets premium tax credits through the [insert name of state exchange]. The penalty was imposed starting Jan. 1, 2016, for coverage not offered in 2015.

The penalty for a large employer that doesn’t offer coverage to full-time employees and their dependents is $2,320 multiplied by the number of full-time employees, if at least one full-time employee has received a premium tax credit. The first 30 employees are exempted in the count to calculate the penalty.

Similarly, the penalty for a large employer that offers coverage that isn’t affordable or doesn’t give minimum value is $3,480 multiplied by the number of full-time employees who receive premium tax credits. (The maximum penalty may not be greater than $2,320 multiplied by the total number of all full-time employees.)

Medicaid-eligible employees can’t get premium tax credits, so employers will not face penalties for employees who receive Medicaid coverage or for employees’ children who receive CHIP coverage.

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**Q 55: How do small employers find out if they’re eligible for the Small Business Health Care Tax Credit?**

Employers who buy coverage for their employees through the [insert name of state SHOP exchange] may be eligible for the Small Business Health Care Tax Credit. To qualify, the employer must: 1) have fewer than 25 full-time equivalent employees; 2) pay employees an average annual wage that’s less than $50,000; and 3) pay at least half of the insurance premiums.

The tax credit operates on a sliding scale, with a maximum credit of 50% of the employer’s share of the premium costs and is only available to small employers buying health insurance through [insert name of state SHOP exchange]. The tax credit may be worth up to 50% of an employer’s contribution toward employees’ premium costs (up to 35% for tax-exempt employers).

Contact the [insert name of state SHOP exchange] at [insert link] or [insert phone number] for more information. A competent tax advisor also should be able to advise a small employer. There’s more information on the IRS website at www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-Questions-and-Answers:-Calculating-the-Credit.

**Q 56: What ACA requirements apply to large employers?**

Several ACA requirements apply to non-grandfathered health plans that large employers offer on either an insured or self-insured basis. The requirements include limits on out-of-pocket expenditures and waiting periods, no annual or lifetime dollar limits on coverage of EHB or cost-sharing for preventive services, the requirement that coverage be offered to adult children up to age 26, and the requirement of access to internal and external appeals. Also, as noted in Question 53 and Question 82, large employers are required to offer affordable and adequate coverage, or face a tax penalty.

**Q 57: What is the individual responsibility requirement, and does it mean consumers must buy coverage through the [insert name of state exchange]?**

Under the ACA, consumers and their dependent children are required to have “minimum essential coverage” unless they qualify for an exemption. This requirement is known as “individual shared responsibility” or the “individual mandate.”

However, beginning in 2019, the penalty for going without coverage is reduced to $0. Therefore, those without coverage will have to pay out-of-pocket for any health care expenses they incur, but they will not pay an additional tax penalty.

This link to the IRS website has more information: www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage.

Coverage purchased through an exchange counts as minimum essential coverage, and so do other types of coverage. Employer-sponsored coverage, grandfathered plans, Medicare, Medicaid, and CHIP are all minimum essential coverage. Short-term health plans, fixed indemnity insurance, and coverage through a health care sharing ministry are not minimum essential coverage.

Check the website at www.healthcare.gov/fees/fee-for-not-being-covered/ for more information.

**Q 58: Without a tax penalty, is having minimum essential coverage important?**

After 2018, the tax penalty for not having Minimum Essential Coverage becomes $0. There’s more information on the penalty at www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/.

Individuals without minimum essential coverage are ineligible for one type of Special Enrollment Period (SEP). Those who are enrolled in MEC that ends are eligible for an SEP that allows them to enroll in individual market coverage, including exchange coverage. Those who are enrolled in coverage that is not MEC do not qualify for this SEP. Therefore, if their coverage ends, they need to wait until the next Open Enrollment Period or until they qualify for another SEP to enroll. Individuals cannot be eligible for premium tax credits until they are enrolled in an exchange plan. More information on SEP rules is available at http://www.healthreformbeyondthebasics.org/wp-content/uploads/2015/06/SEP-Reference-Chart.pdf.
And of course, having coverage offers consumers some protection against high health costs, even if there is no tax penalty for going without coverage.

**Drafting Note:** States with their own penalties for lacking MEC should include that information.

**ENROLLING IN HEALTH CARE COVERAGE: WHERE CAN CONSUMERS GET HELP?**

**Q 59: Where do consumers go for help to choose and enroll in a plan?**

Consumers should make a list of questions before they shop for a health plan. Consumers should gather information about household income and set a budget for health insurance. Consumers should find out if they can stay with their current doctors and pharmacy, and understand how insurance works—including understanding deductibles, out-of-pocket maximums, and co-payments.

There are several resources from the Kaiser Family Foundation, Consumer Reports, the NAIC, HHS and U.S. Department of Labor (DOL) to help consumers understand how insurance works, the different insurance options, and what to consider when buying coverage.

A standard form called the Summary of Benefits and Coverage, or SBC, and the companion set of uniform definitions, also is available for many health insurance plans. This information can help consumers compare different insurance options. (See Question 18.) Consumers can get the form and definitions through the [insert name of state exchange] at [insert link to state exchange webpage], or ask the plan for it. The [insert name of state exchange] also can direct consumers to more information and resources about the options that are available.

If a consumer is eligible to buy coverage through the [insert name of state exchange], he or she can enroll through the [insert name of state exchange] website at [insert link], by phone at [insert phone number], or in person through [insert links and contact information].

Also, there are four types of individuals trained to help consumers make decisions about health coverage:

- **A. Insurance agents or brokers**

  Health insurance agents and brokers sell insurance coverage from one or more insurance companies. Health insurance agents and brokers are licensed by [insert name of state] and receive continuing education related to their job. They can help educate consumers about health insurance policies, help consumers apply for coverage, and advise consumers about the type of health insurance coverage that best suits them and their family. Agents and brokers can sell consumers insurance plans in the market outside the exchange, as they always have.

  Agents and brokers who want to sell policies through the [insert name of state exchange] have extra training from the HHS or the state-based exchange. They have passed a test at the end of their training to sell insurance policies through the [insert name of state exchange]. [Insert name of state] requires agents and brokers to have extra state-specific training before they sell through the [insert name of state exchange]. A list of agents and brokers authorized to sell through the [insert name of state exchange] is available on the [insert name of state exchange] website at [insert link]. Consumers may want to talk with more than one agent or broker before they decide which plan to buy. (See Question 66.)

  **Drafting Note:** States where there may not be a list of agents and brokers on the exchange may want to modify the answer accordingly.

- **B. Navigators**

  Navigators are individuals trained to help consumers understand the insurance policies available through the [insert name of state exchange] and answer consumer questions about the [insert name of state exchange]. They also can answer questions about insurance affordability programs, including Medicaid and CHIP. Navigators also can help educate consumers about their health insurance policy options and help them apply for coverage. Navigators get grants from the [insert name of state exchange] to receive training on how to help consumers. After training, they must pass a test and be
certified by [insert name of state exchange]. In [insert name of state], navigators also must have extra state-specific training before they can help consumers. Consumers can contact navigators at [insert state contact information]. (See Question 67.)

**Drafting Note:** States where the HHS will be doing training and certification should modify the preceding paragraph accordingly. The HHS will certify navigators in the federally facilitated exchanges.

**C. In-person assistance personnel**

In-person assistance personnel generally do the same things as navigators. In-person assistance personnel have received and successfully completed comprehensive training. They also can help educate consumers about health insurance policies and help them apply for coverage. [Insert name of state] has set up an in-person assistance program. Consumers can contact in-person assistance personnel at [insert contact information].

**Drafting Note:** States should delete this section if they do not have in-person assistance personnel.

**D. Certified application counselors**

Certified application counselors provide enrollment assistance to consumers. Certified application counselors receive and successfully complete comprehensive training. They, too, can help educate consumers about health insurance plans and help them complete an application for coverage. In [insert name of state], examples of application counselors include staff at [insert name of local community health centers or hospitals or consumer nonprofit organizations].

**Drafting Note:** States will need to customize this section depending on what type of exchange they have and what kinds of individuals will be assisting consumers. More customization may be necessary if the state has any licensure or certification requirements.

**Q 60: May consumers directly enroll for coverage through insurers?**

Yes. Consumers may buy coverage directly from an insurance company. However, consumers should make sure that the coverage they buy is offered through the [insert state name of state exchange] and that the insurer has an agreement to do direct enrollment through the [insert name of state exchange] so they can get any tax credits or cost-sharing reductions to which they are entitled.

Consumers enrolling directly through the insurance company portal may not see all plans available through the [insert name of state exchange].

**Drafting Note:** States that do not allow insurers to enroll consumers directly into plans through the exchange should change this answer accordingly.

**Q 61: How are people who help consumers enroll in health coverage paid?**

Insurance agents and brokers may have an agreement that the insurance company will pay them if they enroll consumers in a health insurance policy consistent with state law. The state-based exchange may set rules about paying health insurance agents and brokers from the exchange or directly from insurance companies. In [insert name of state], the agent or broker will be paid an amount agreed to by the health insurance agent or broker and the company.

In [insert name of state], navigators will get funding from [insert funding source]. They don’t get enrollment-based reimbursement from insurance companies and aren’t allowed to charge a fee.

In-person assistance personnel will be paid by [insert funding source]. They don’t get enrollment-based reimbursement from insurance companies and aren’t allowed to charge a fee.

Certified application counselors will not be paid through the [insert name of state exchange]. They don’t get enrollment-based reimbursement from insurance companies and aren’t allowed to charge a fee. They may, however, receive federal funding through other grant programs, or Medicaid, or from another source.
Q 62: How can consumers find an insurance agent or broker to help them enroll in a plan?

In [insert state name], the [insert name of state health insurance exchange] website at [insert web address] lists insurance agents and brokers authorized to enroll individuals, families, and small businesses in coverage through the [insert name of state exchange]. Consumers can contact the [insert state Insurance Department] for a list of licensed health insurance agents and brokers in their area. Some agents and brokers don’t contract with all health plans, so consumers must make sure they know the full list of plans that are available to them before they ask an agent or broker for help. Also, health insurance agents and brokers may or may not be able to help individuals complete the enrollment process for Medicaid or CHIP after they get an eligibility decision.

Drafting Note: States should modify this answer consistent with the information available in the state. In the federally-facilitated exchanges, such a listing will not be available for agents assisting consumers with individual QHPs. It has not been decided whether such a listing will be available for the federally facilitated SHOP exchange.

Q 63: What are the qualifications required for health insurance agents and brokers to participate in the [insert name of state exchange]?

In [insert name of state], health insurance agents and brokers are regulated by the [insert name of state department of insurance]. Agents and brokers receive training from the [insert name of state exchange or the HHS]. The insurance companies must appoint the insurance agents and brokers who sell their plans through the [insert name of state exchange]. An agent or broker selling plans through the [insert name of state exchange] must provide information on all plans that are offered on the [insert name of state exchange], even if the agent or broker isn’t authorized to sell some of those plans.

Drafting Note: States that aren’t requiring agents and brokers to be appointed to all the insurance companies selling through the exchange or that aren’t requiring agents to provide information about all plans available through the exchange should modify the previous paragraph accordingly.

Q 64: Where should consumers go with a problem enrolling in a plan through the [insert name of state exchange]?

The [insert name of state exchange] should be able to help consumers with any problems. In particular, [insert name of state exchange] operates a call center to help answer consumer questions. The number for the call center is [insert number] and is available on the [insert name of state exchange] website at [insert link]. Insurance agents and brokers, navigators, in-person assistance personnel, and certified application counselors also should be able to help. (See Question 59.) Consumers can also contact the [insert name of state insurance department] at [insert phone number] to file a complaint or report a concern about a negative experience with an insurance company, agent and broker, navigator, in-person assister, or certified application counselor during and after the enrollment process.

Q 65: Do consumers have to re-enroll annually?

Eligibility for premium assistance and enrollment in a health plan will be decided annually using updated income, family size, and tax information (when authorized). Each year, before the open enrollment period, the [insert name of state exchange] will check income data and send a notice to consumers who are determined eligible for enrollment in a plan through the [insert name of state exchange]. This notice explains the consumer’s eligibility for the upcoming year and tells the consumer to let the [insert name of state exchange] know of any changes. After this, there will be an annual open enrollment period for consumers to change plans or insurance companies if they want to.

All consumers are encouraged to go to the exchange to review all of their options and to update income and other information to ensure the correct subsidy is received. Those enrolled in a plan through the exchange in 2019 who are eligible for auto-renewal and choose not to re-enroll or enroll in a different plan by Dec. 15, 2019, will be automatically re-enrolled in their current or similar plan. For the 2020 coverage year, the key dates are as follows:

- Nov. 1, 2019: Open enrollment starts—the first day a consumer can apply for 2019 coverage.
- Dec. 15, 2019: The last date to enroll for coverage that starts Jan. 1, 2020. Consumers who miss this deadline can’t sign up for a health plan inside or outside the exchange or change plans unless they qualify for a special enrollment period (SEP). (See Question 12.)
• **Dec. 31, 2019**: The date when all 2019 exchange coverage ends, no matter when the consumer enrolled.
• **Jan. 1, 2020**: The date 2020 coverage can start if consumers applied by Dec. 15, 2019, or consumers were automatically enrolled in their 2020 plan or a similar plan.

During the year, consumers with coverage through the [insert name of state exchange] must report certain life changes to the [insert name of state exchange]. Consumers should report changes as soon as possible, especially in the case of changes that qualify a consumer for an SEP. Consumers eligible for an SEP typically have 60 days to enroll in new coverage. (See Question 12.) Changes include changes in income from a new job and getting married or divorced. See www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/ for information about reporting life changes.

Consumers who have not requested financial assistance do not need to report changes related to financial assistance eligibility.

**Q 66: How will insurance agents and brokers be able to help consumers with enrollment through the [insert name of state exchange]?**

In [insert name of state], health insurance companies will appoint agents and brokers. Insurance companies will make sure the agent’s license is valid and registered with the [insert name of state exchange]. The agent can help consumers log on to the [insert name of state exchange]. Consumers should log into their own [insert name of state exchange] account. The agent or broker can help consumers as needed. The agent or broker will then work with consumers to complete the application. Consumers will be prompted to enter the insurance professional’s [insert name of state exchange] user identification number and national producer number on the application to show that the professional helped them.

**Drafting Note**: States should change this answer as appropriate to reflect the process in the state.

**Q 67: How will a navigator be able to help consumers with enrollment through the [insert name of state exchange]?**

In [insert name of state], navigators can help consumers create an account and log on to the [insert name of state exchange]. Consumers should log into their own [insert name of state exchange] account. The navigator can help consumers as needed to complete the application. Consumers may be prompted to enter the navigator’s [insert name of state exchange] user identification number on the application to show that the navigator helped them.

The navigator can help consumers to compare health plans and answer questions about health insurance policies in general. The navigator can answer questions from consumers about the differences in health plans and what they might mean for them, but the navigator CANNOT recommend or suggest which health plan would be best for consumers and their families. Navigators aren’t permitted to collect premium payments on behalf of an insurer or the [insert name of state exchange]. Consumers will be asked to enter the navigator’s [insert name of state exchange] user identification number on the enrollment page to show that the navigator helped them.

Navigators CANNOT sell, solicit or negotiate a health plan through the [insert name of state exchange]. They CANNOT suggest that one plan would be better for the individual than another.

**Drafting Note**: States should change this answer as appropriate to reflect the process in the state.

**Q 68: How will the in-person assister or the certified application counselor be able to help consumers with enrollment through the [insert name of state exchange]?**

In [insert name of state], the in-person assister or certified application counselor can help consumers create an account and log on to the [insert name of state exchange]. Consumers should log in to their own [insert name of state exchange] account. The in-person assister or certified application counselor can help consumers as needed to complete the eligibility application. Consumers may be prompted to enter the in-person assister’s or the certified application counselor’s [insert name of state exchange] user identification number on the application to show that the assister or counselor helped them.
The in-person assister or certified application counselor can help consumers compare health plans and answer questions about health insurance policies in general. The assister or counselor can answer questions from the consumer about the differences in health plans and what they might mean to them (such as explaining deductibles or out-of-pocket limits), but the assister or counselor cannot recommend or suggest which health plan would be best for consumers and their families. Consumers will be asked to enter the in-person assister’s or certified application counselor’s [insert name of state exchange] user identification number on the enrollment page to show that they helped them.

The in-person assister or certified application counselor cannot sell, solicit, or negotiate a health plan through the [insert name of state exchange]. They cannot suggest that one plan would be better for the individual than another.

**Drafting Note**: States should change this answer as appropriate to reflect the process in the state.

**Q 69: Can small employers use licensed insurance agents or brokers to buy health insurance through [insert name of state SHOP exchange]?**

Yes. Licensed insurance agents and brokers are available to help small employers compare and determine which health plan best meets their needs, like they do today. This is true whether they’re interested in buying coverage in the market outside the [insert name of state SHOP exchange] or through the [insert name of state SHOP exchange].

Licensed insurance agents and brokers will be able to compare plans in the market outside the [insert name of state SHOP exchange] against those offered through the [insert name of state SHOP exchange] to decide where they can buy the plan best for them. Employers may wish to talk with more than one agent or broker before making a decision about which plan to buy.

**Q 70: Will small employers be able to use navigators to buy health insurance?**

Navigators, by law, aren’t allowed to sell health insurance unless they have an agent/broker license. Navigators are available to help small employers view plan options displayed on the [insert name of state SHOP exchange] website and can help consumers small employers with enrolling through the SHOP. Navigators can explain the parts of the plans offered through the [insert name of state SHOP exchange] but cannot legally offer advice as to which plan is a better fit for the small employer. Only a licensed insurance agent or broker is qualified and allowed to offer this service.

**Q 71: How can an insurance agent or broker help a small employer interested in participating in the [insert name of state SHOP exchange]?**

An insurance agent or broker can help any small employer, as has been true in the past. The agent or broker can help the employer decide which health insurance policy would be best for them, enroll employees in the plan, file health insurance claims, and understand the process of enrollment.

In the [insert name of state SHOP exchange], the HHS expects that insurance agents and brokers will be in contact with employers both before and after enrollment, as they will be a primary contact for customer service issues.

**Q 72: What is the benefit of using an insurance agent to enroll in the [insert name of state exchange] or [insert name of state SHOP exchange]?**

Whether consumers are individuals or small group businesses, the insurance agent or broker can work with their needs and requirements. Agents and brokers have a working knowledge of the qualified health plans and their benefits. An agent or broker may help individual consumers or small employers to create an account with the [insert name of state exchange] if needed, but consumers, or a legally authorized representative, must create their own [insert name of state exchange] username and password. Consumers should not share this information with third parties, including insurance agents or brokers.
**Q 73: Will an insurance agent or broker show consumers all of the plan choices available through the [insert name of state exchange]?**

In [insert name of state], agents and brokers aren’t required to show consumers all available health plans. If the consumer is using the [insert name of state exchange] website with the help of an agent or broker, all QHP choices will be displayed. If the agent or broker goes through an insurance company portal, all plans available through the [insert name of state exchange] may not be shown, but other plans available in the market outside the exchange—that aren’t eligible for the advance premium tax credit—may be shown. Consumers should ask the insurance agent or broker if they’re being shown all of the plans available through the [insert name of state exchange] and whether tax credits or cost-sharing reductions apply to the plans they are looking at.

All agents and brokers must follow applicable [insert name of state] laws, regulations, and [insert name of state exchange] requirements, including standards related to relationships or appointments with insurance companies.

[Insert name of state] expects that the insurance agent or broker will tell consumers if the information given is about health plans with which the agent or broker has a business relationship and that consumers can always directly access the [insert name of state exchange] website. They’ll find information about other available qualified health plans there. The [insert name of state] expects that insurance agents and brokers will advise consumers to check with the [insert name of state exchange] about available tax credits or cost-sharing reductions.

**Drafting Note:** States should modify this answer if agents and brokers are required to show consumers all options available through the exchange.

**Q 74: Will consumers have to share their personal information, including their tax returns, with an agent or broker, navigator, in-person assistance personnel, or certified application counselor?**

No. A consumer isn’t required to share personal information, including tax returns, with an agent or broker, navigator, in-person assistance personnel, or certified application counselor. When consumers complete the application on the [insert name of state exchange] website with the help of an agent or broker, navigator, or assister, they should be able to fill out and submit their eligibility application without the agent, navigator or assister in direct view of the application. While consumers applying for financial assistance are asked to enter income amounts, income figures from the IRS won’t be shown during the application process, whether or not the consumer gets help filling out the application or does it independently. In [insert name of state], after completing the registration and training, agents or brokers, navigators, in-person assistance personnel, and certified application counselors must complete and comply with a privacy and security agreement and get a user ID to use with the [insert name of state exchange].

**Q 75: Will consumers have to share their account username and password with an insurance agent or broker, navigator, in-person assister, or certified application counselor?**

No. An agent or broker, navigator, in-person assistance personnel, or certified application counselor shouldn’t ask for a consumer’s account username and password. If a consumer is asked to share a username or password, he or she should contact the [insert name of state insurance department] at [insert phone number] and discuss this with the consumer assistance representatives.

**Q 76: What help should an insurance agent or broker, navigator, in-person assister, or certified application counselor give consumers if they or their dependents are eligible for Medicaid or CHIP?**

Agents or brokers, navigators, in-person assistants, and certified application counselors will work with all consumers who ask for help with [insert name of state exchange] enrollment, including those eligible for Medicaid or CHIP. The [insert name of state exchange] will send a notice to consumers who are eligible for Medicaid or CHIP. An agent or broker, navigator, in-person assister, or certified application counselor working with these consumers is expected to refer consumers to the [insert name of state Medicaid and CHIP agency]. Agent and broker, navigator, in-person assister, and certified application counselor training will include information about where to direct Medicaid- or CHIP-eligible consumers.
Agents and brokers should be able to give consumers a referral to a navigator, in-person assister, certified application counselor, or the [insert name of state Medicaid agency]. Navigators, in-person assisters, and certified application counselors should help all consumers seeking assistance with completing an application through the [insert name of state exchange]. If the [insert name of state exchange] assesses the consumer as Medicaid- or CHIP-eligible, the navigator, in-person assister, or certified application counselor may refer the consumer to the state Medicaid agency for more information. Navigators, in-person assisters and certified application counselors often are not required to help consumers fill out a state Medicaid application if it is different from the application used by the [insert name of state exchange], but they can refer consumers to appropriate resources in those cases.

Q 77: May an insurance agent or broker continue to work with consumers once they’re enrolled in a plan through the [insert name of state exchange]?

Insurance agents and brokers may continue to communicate with consumers after they’ve enrolled in a plan through the [insert name of state exchange], as long as the communications follow any laws and regulations that apply.

The communications also must follow the privacy and security standards the [insert name of state exchange] has adopted (pursuant to 45 C.F.R. §155.260). These standards limit how an agent or broker may use any information gained to provide help and services to qualified consumers.

COSTS AND ASSISTANCE WITH COSTS

Q 78: Is there cost-sharing for contraceptives?

With the exception of health plans sponsored by certain employers that have religious or moral objections to contraception, all plans, including those offered through the [insert state name of state exchange], must cover in-network doctor-prescribed FDA-approved methods of contraception without cost-sharing.

For specific information about a plan’s contraceptive coverage, consumers should check the plan’s SBC or ask their employer or benefits administrator. There’s more information about contraceptive coverage on the federal website at www.healthcare.gov/coverage/birth-control-benefits/ and www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf.

Q 79: How much do plans offered through the [insert name of state exchange] cost?

There are a variety of plans intended to fit different budgets, both through the [insert name of state exchange] and in the market outside the exchange. Also, many consumers purchasing coverage through [insert name of state exchange] qualify for the premium tax credits (see Questions 82-83), which pay for part of their premium and help lower the cost of coverage. To see specific costs of plans offered through the [insert name of state exchange], go to [insert state exchange webpage], call [insert state exchange telephone number], or talk to a navigator, certified application counselor, in-person assister, insurance agent or broker, or other assister. (See Question 59.)

Q 80: Do plans offered through the [insert name of state exchange] have large out-of-pocket costs?

The health insurance plans available through the [insert name of state exchange] feature a variety of out-of-pocket costs for consumers. But, the ACA requires that all non-grandfathered plans (including most plans that people get from an employer) limit consumers’ annual out-of-pocket costs for in-network EHB services to no more than $8,150 for individuals and $16,300 for families in 2020. These maximum out-of-pocket amounts will go up in future years. However, out-of-network services do not count toward these limits on annual out-of-pocket costs. (See Question 27.) There are separate out-of-pocket maximums for stand-alone dental plans.

Plans are required to cover certain preventive services without cost-sharing. (See Question 24.) Also, consumers whose incomes are below a certain amount may be eligible for a premium tax credit and a Silver plan that features lower cost-sharing and lower out-of-pocket costs (co-payments, coinsurance and deductibles) without paying a higher premium. Check with the [insert name of state exchange] at [insert link] or direct the consumer to an online calculator to estimate whether they...
may qualify for subsidies: https://www.kff.org/interactive/subsidy-calculator/. Navigators, certified application counselors, in-person assisters, agents or brokers, or other assisters should be able to help consumers learn if they qualify. Also, the exchange application tells consumers whether they might be eligible for Medicaid or CHIP programs, which have very limited out-of-pocket costs.

**Q 81: Where can consumers inquire to learn if they’re eligible for help paying premiums or for Medicaid?**

Consumers may apply with the [insert name of state exchange] or the [insert name of state Medicaid agency].

The [insert name of state exchange] determines eligibility for advance payments of premium tax credits and cost-sharing reductions. They also assess Medicaid and CHIP eligibility and make a referral, if appropriate, to the [insert name of state Medicaid agency] for a final determination.

Consumers also may apply directly with the [insert name of state Medicaid agency]. The [insert name of state Medicaid agency] will enroll eligible consumers in Medicaid or CHIP, or send their information to the [insert name of state exchange] to determine their eligibility for advance payments of the premium tax credit and cost-sharing reductions if they aren’t eligible for Medicaid or CHIP.

**Drafting Note:** States with a different process will need to modify this answer accordingly.

**Q 82: Is there help for consumers who can’t afford coverage?**

Yes, consumers with low or moderate incomes can qualify for reduced costs, either through Medicaid, CHIP, or exchange coverage, but eligibility rules apply. In [insert name of state], nonelderly adults without minor children don’t qualify for Medicaid. Beginning in 2014, some states used federal government funds to expand the program so that Medicaid also would cover adults with an income at or lower than 138% of the federal poverty level. In 2020, that is roughly $17,200 for a family of one and $35,500 for a family of four. Consumers should contact the [insert name of state exchange] or the [insert name of state Medicaid agency] directly if they think they might be eligible for Medicaid.

In [insert name of state], children may be able to get coverage through Medicaid or CHIP programs for which their parents aren’t eligible. Some families may find it more affordable to enroll their children in Medicaid or CHIP and buy coverage for the parents through the exchange.

**Drafting Note:** States may need to modify the answer to this question depending on the state’s decisions regarding Medicaid expansion.

**Q 83: Who’s eligible for premium tax credits and cost-sharing reductions?**

The ACA created premium tax credits and cost-sharing reductions to help cut costs for eligible consumers who buy a plan through the [insert name of state exchange]. (See Question 82.) The amount of the tax credit or cost-sharing reduction depends on family size and income. The amount of the tax credit and cost-sharing reductions varies on a sliding scale: Larger families and families with lower incomes get the most help. Tax credits and cost-sharing reductions aren’t available for individuals who are eligible for Medicaid, CHIP, Medicare or qualifying employer-sponsored coverage. More information about tax credits and cost-sharing reductions is available at www.healthcare.gov.

This link has general information about income levels at which financial help or coverage is available, as well as what counts as income: www.healthcare.gov/lower-costs/qualifying-for-lower-costs/.

**Q 84: How do premium tax credits to buy coverage through the [insert name of state exchange] work?**

Consumers who qualify for the premium tax credits can either receive them in advance, or they can wait until they file their taxes. The advance payment is sent to the insurance company that offers the plan the consumer has chosen and is used to reduce the monthly insurance premium. Consumers also have the choice to wait to receive their tax credits until they file their taxes. They also can use just part of their estimated tax credit in advance.
Consumers who want to use their tax credit in advance need to be as accurate as possible to estimate how much income they expect to have in the year they get coverage. If they underestimate their income and the tax credit is overestimated, they may have to repay part of their tax credits at tax time.

Consumers need to update the [insert name of state exchange] during the year about any changes in income, family size (like having a baby), employment (like getting a job where health coverage is offered) or becoming eligible for Medicare. The [insert name of state exchange] will change the tax credit amount to reflect the new information. Consumers who forget to update the [insert name of state exchange] about such changes might owe money at tax time or realize they could have been using a larger tax credit amount in advance.

Consumers who don’t use the tax credit in advance don’t have to tell the [insert name of state exchange] about any changes to their income or employment during the year. They can get the tax credit on their tax returns.

Consumers may go to the [insert name of state exchange] website at [insert link] or call the [insert name of the state exchange] at [insert telephone number] for more information about tax credits. Navigators, certified application counselors, in-person assisters, agents or brokers, or other assisters also are able to give consumers information about the tax credit. There’s more information about premium tax credits on the federal website at www.healthcare.gov.

Q 85: Is an individual who is a victim of domestic abuse and separated (but not divorced) from his or her spouse eligible for subsidies on the exchange?

Yes. In general, married couples must file a joint tax return in order to be eligible for a premium tax credit and cost-sharing reductions. For victims of domestic abuse, however, contacting their spouse to file a joint return may present a risk and may be legally prohibited if a restraining order is in place. As a result, married individuals who are victims of domestic abuse may still be eligible for subsidies if they are living separately from their spouse. Consumers in this situation should list “unmarried” on their exchange application and can do that without fear of penalty for misstating their marital status. For more information, see www.healthcare.gov/income-and-household-information/household-size or www.irs.gov.

Q 86: If a consumer is eligible for subsidy assistance, is there a grace period before a company can terminate the consumer for non-payment of premiums?

Yes. The ACA requires insurance companies to give enrollees who receive subsidies a 90-day grace period for non-payment of premiums before the policy can be terminated, provided the enrollee has paid at least one month’s premium. Claims must be paid during the first 30 days of the grace period, but the insurer may suspend payments to providers during the remainder of the grace period. In order to keep coverage at the end of the grace period, a consumer’s account must be fully paid within 90 days of missing a premium payment. For example, if a consumer misses a payment in July but makes payments in August and September, the consumer will be terminated in October if he or she has not also paid the missing payment from July. And, a company may deny coverage in the next year if the consumer is in the grace period. For example, if the consumer misses a payment in November and December, the consumer may be denied coverage in January if they haven’t paid premiums due the year before.

Drafting Note: States should review their laws for other grace periods that might otherwise apply.

Q 87: What should consumers do if they find themselves enrolled in both Medicaid/CHIP and exchange coverage with premium tax credits?

The [insert name of exchange] conducts periodic data matching to identify individuals enrolled in both Medicaid/CHIP and private insurance with premium tax credits and sends notices to those consumers. Upon receiving the notice, consumers may end their exchange coverage with premium tax credits by contacting the exchange. If a consumer wants to maintain exchange coverage while enrolled in Medicaid, he or she may apply for coverage without financial assistance, during the annual open enrollment period or a special enrollment period (SEP). Consumers whose enrollment status has changed since the data match (either in Medicaid or CHIP or exchange coverage with premium tax credits) should take no further action with the [insert name of state exchange]. Consumers might opt to contact their state Medicaid or CHIP agency to confirm that they are not enrolled. If found to be enrolled in Medicaid or CHIP coverage, they should follow the steps above to end exchange coverage with premium tax credits, if applicable, because consumers determined eligible for Medicaid or CHIP are not eligible for exchange coverage with premium tax credits or cost-sharing reductions.
If consumers are enrolled in exchange coverage with premium tax credits or cost-sharing reductions and are enrolled in Medicaid or CHIP, when the tax filer(s) file their tax return, they will likely have to pay back all or some of the tax credits received for the months following the eligibility determination for Medicaid or CHIP. Consumers who receive the notice but have more recently been denied eligibility for Medicaid or CHIP do not need to take any further action with [insert name of state exchange], but they may wish to contact their state Medicaid or CHIP agency to confirm that they’re not enrolled.

**QUESTIONS ABOUT OTHER TYPES OF COVERAGE**

**Q 88: What is available in the market outside the [insert name of state exchange]?**

In [insert state name], health insurance coverage is also available in the market outside the [insert name of state exchange]. However, if consumers want to take advantage of premium tax credits to help pay for part of their premiums or for cost sharing assistance, they must buy coverage through the [insert name of state exchange]. (See Question 83 and Question 84.) Consumers may buy plans in the market outside the exchange that aren’t required to cover the EHB, such as fixed indemnity plans, short-term policies, or insurance coverage and discount plans that include only specialty or ancillary services (for example, hearing, chiropractic, etc.) Note, though, that these policies do not have to comply with ACA reforms such as the prohibition on excluding coverage for pre-existing conditions. (See Question 4.) The NAIC has some resources discussing these types of plans:

- www.insureuonline.org/consumer_guide_cancer.pdf
- https://www.naic.org/documents/consumer_alert_health_sharing_ministries.htm

Contact [insert Department of Insurance contact] or an insurance agent or broker for help.

**Q 89: What are short-term plans?**

Under federal law, short-term plans are those with an initial term of no more than 364 days and that include a statement describing potential coverage limitations. Short-term plans may be renewed at the option of the insurer, but the same policy may only be in effect for up to three years in total. Short term plans are not required to comply with many of the consumer protections of the ACA. For instance, they may charge different premiums based on an applicant’s health conditions, exclude essential health benefits, and exclude coverage for pre-existing conditions.

**Drafting note:** States with their own regulations on short term plans should add a statement that describes allowable short-term plans, including duration restrictions, rating requirements, or benefit mandates.

**Q 90: If consumers already have coverage, may they buy separate policies for their children?**

Consumers who already have coverage for themselves are eligible to buy a policy for a child through the [insert name of state exchange]. The ACA requires that any health plan offered through the exchange also must be offered as a child-only plan at the same tier of coverage. Consumers also may be eligible for tax credits for child-only plans they buy through the [insert name of state exchange]. Visit the [insert name of state exchange] website at [insert website for the state exchange] for more information about child-only plans available through the [insert name of state exchange].

However, children who aren’t legal residents of the United States aren’t eligible for child-only plans through the [insert name of state exchange]. Consumers may be able to buy a child-only policy in the market outside the [insert name of state exchange], either directly from an insurer or through an agent or broker. For a list of licensed insurers in [insert name of state], visit the [name of state department of insurance] website at [insert website of state dept. of insurance]. A child also may be eligible for Medicaid (contact [insert name of state Medicaid agency] at [insert contact information]) or coverage through [insert state Children’s Health Insurance Program (CHIP)]. To learn more about CHIP plans, visit www.insurekidsnow.gov.
ACA MEDICARE-RELATED QUESTIONS

Q 91: Who should consumers contact with questions about Medicare, Medicare Supplement insurance, or Medicare Advantage plans?

Medicare coverage, Medicare Supplement insurance (Medigap), and Medicare Advantage plans aren’t available through the [insert name of state exchange]. Consumers who are currently enrolled in Medicare may not buy coverage through the exchange. Direct questions involving the ACA and Medicare, Medicare Supplement insurance, or Medicare Advantage Plans to [insert name of State Health Insurance Program (SHIP)] at [insert contact information]. The federal government’s Medicare website, www.medicare.gov, also has more information about health reform and Medicare changes.

Drafting Note: Some states have enrollees who are on Medicare because of end stage renal disease (ESRD) or some other high-cost medical disorder. In those states, beneficiaries with ESRD may be able to enroll through that state’s exchange. Medicare beneficiaries with other high-cost medical disorders in those states may have a limited special right to enroll in a Medicare Advantage plan.

Q 92: Are people who pay premiums for Medicare Part A able to enroll through the [insert name of exchange]?

If individuals who desire Medicare have to pay the premium for Part A because they aren’t entitled to those benefits, they can buy coverage through [insert name of exchange] instead of Medicare, and they may also be eligible for a tax credit. This includes those beneficiaries who only enrolled in Medicare Part B because they couldn’t afford the Part A premium. In both cases, these beneficiaries have to disenroll from Medicare Part A, if they have it, and from Medicare Part B, if they have it. There are consequences to substituting a QHP for Medicare. Consumers may pay higher premiums for Medicare if they decide to enroll in the future and may have a gap in benefits. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about their choices.

Q 93: Can a person with ESRD (End Stage Renal Disease) enroll in or stay in a QHP instead of enrolling in Medicare?

If a consumer with ESRD has not applied for Medicare, she or he can stay in or apply for coverage through the [insert name of exchange]. However, there are consequences to delaying Medicare benefits. Individuals with ESRD may not be eligible for certain Medicare benefits if they enroll in Medicare in the future, may pay a higher premium for late enrollment, or may have a delay in when benefits begin. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about these complex choices.

Q 94: If individuals become eligible for Medicare and are already in a QHP, can they stay in their plan?

If a person stays in a QHP* and is eligible for or enrolled in Medicare, he or she is no longer eligible to receive any tax credits. If the consumer has been receiving an advance premium tax credit, the consumer must report the change to the [insert name of state exchange] to end the tax credit. If the consumer does not do this, the consumer will be liable to repay the tax credits for which he or she was not eligible.

Although under federal laws the QHP cannot terminate coverage from the same policy to which the individual was enrolled upon becoming eligible for Medicare, a QHP is not designed to coordinate its benefits with Medicare. Both the premium and the benefits of a QHP are designed to provide primary coverage, not supplemental coverage. Depending on state law, a QHP may reduce its benefits to pay covered expenses that remain after Medicare pays, but the premium will stay the same. This may happen even if the individual does not sign up for Part B of Medicare. Consumers are encouraged to enroll in Medicare when they are eligible to do so to avoid premium penalties and delayed benefits later. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about how and when to enroll in Medicare and any penalties that can apply.

*Note that this information (except for the tax credit) applies to individual coverage inside and outside an exchange.
Q 95: Is there anything consumers and their dependents who are already on Medicare and have employer-based coverage need to do because of the ACA?

Generally, there’s nothing consumers need to do because of the ACA if they’re already on Medicare and have employer-based coverage. If consumers have coverage through an employer and that employer’s current benefits pay first and Medicare pays second, the ACA didn’t change that.

If the employer changes the benefits that cover consumers or their dependents, then they will send consumers a notice about those changes. Consumers can ask their employer’s human resources department how those changes work with Medicare.

The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about how their existing coverage works with Medicare.

Q 96: Is there anything consumers and their dependents who are already on Medicare and have retiree coverage from an employer need to do because of the ACA?

The ACA didn’t change those benefits. Consumers should contact their employer’s human resources department for help. If they need more information about how Medicare and retiree benefits work together, they can contact the SHIP at [insert contact information].

Q 97: Will consumers with Medicare Supplement insurance be affected by the ACA?

No. The ACA doesn’t change the cost sharing for Medicare supplement policies.

Q 98: How will consumers’ Medicare prescription drug “donut hole” be affected?

The ACA began closing the “donut hole” in 2011, and it was closed entirely effective for 2019. The donut hole was closed by combining a 50% discount on the cost of brand-name drugs and a gradual increase in the share of prescription drug costs for both generics and brand-name drugs that Medicare pays, until a beneficiary only owes 25% of the total cost. Medicare beneficiaries whose prescription drug costs are greater than the Part D deductible will need to pay only a 25% coinsurance rate (after meeting the plan’s deductible, if any) until their expenditures reach the catastrophic level.

For more information, contact Medicare at www.medicare.gov or 1-800-MEDICARE or by contacting [insert name of SHIP] at [insert contact information].

Q 99: What about LTC insurance policies?

The [insert name of state exchange] doesn’t include LTC insurance policies, and policies sold on the [insert name of state exchange] don’t typically cover LTC services. Insurance agents and brokers still sell LTC insurance outside the exchange. The HHS website https://longtermcare.acl.gov/ has information about LTC insurance.

ACA MEDICAID-RELATED QUESTIONS

Q 100: Where can consumers find more information about Medicaid?

Contact the [insert name of state Medicaid agency] at [insert contact information] with any questions or concerns about Medicaid and the ACA. Also, the HHS website has basic information about Medicaid posted at www.healthcare.gov.

Q 101: Did consumers’ eligibility for Medicaid changed under the ACA?

The same categories of consumers continue to be eligible for Medicaid, although the financial methodology has changed. They still need to be part of an eligible group, such as children, pregnant women, parents (or other caretaker relatives), blind, disabled, or elderly, and they still need to meet the financial eligibility test set by [insert name of state]. Contact the [insert state Medicaid agency] at [insert contact information] for more information.
Drafting Note: States that have expanded Medicaid should modify this answer as appropriate.

There is more information about who is eligible for Medicaid at this link: https://www.healthcare.gov/medicaid-chip/.

Q 102: What is the expanded Medicaid eligibility under the ACA?

Adults who weren’t eligible for Medicaid in the past may be eligible under the ACA. [Insert name of state] has decided to expand Medicaid coverage to new groups, now covering [explain new eligibility criteria]. Contact the [insert name of state Medicaid agency] at [insert contact information] for more information.

Drafting Note: States that have not expanded Medicaid will need to revise this answer accordingly.

There is more information on who is eligible for Medicaid at this link: https://www.healthcare.gov/medicaid-chip/.

Q 103: What is the federal poverty level (FPL), and why is it important in the context of health care coverage?

The FPL is how the federal government defines poverty, and it’s used to decide who’s eligible for federal subsidies and entitlement programs. In states that expanded Medicaid, people under 65 with incomes up to 138% of the FPL (or about $35,500 for a family of four) generally can get Medicaid coverage. People with incomes above this level but less than 400% FPL may be eligible for premium tax credits to help them buy a plan through the [insert name of state exchange]. Cost-sharing reductions are available until a family’s income reaches 250% of the FPL.

Drafting Note: States that didn’t expand Medicaid will need to revise the previous paragraph accordingly.

This link has general information about income levels at which financial help or coverage is available, as well as what counts as income: www.healthcare.gov/lower-costs/qualifying-for-lower-costs/.

Q 104: What benefits will be available for adults newly eligible for Medicaid?

Each state can define the benefit package for this newly eligible group. The benchmark benefit package needs to at least include the EHB available through the [insert name of state exchanges]. (See Question 17.) Contact the [insert name of state Medicaid agency] at [insert contact information] for more information.

Q 105: Are undocumented immigrants eligible for Medicaid?

Undocumented immigrants are not eligible for most categories of Medicaid coverage, but may receive services in emergency circumstances.

Q 106: How do consumers apply for Medicaid?

Consumers can apply online through the [insert name of state exchange]. They also can apply by mail, fax or in person. If a consumer applies through the [insert name of state exchange], his or her eligibility for Medicaid also will be assessed, and the consumer’s application will be transferred to the [insert name of state Medicaid agency] for final determination. Under the law, there’s “no wrong door” to apply for health coverage, whether it’s through [insert name of state Medicaid agency], CHIP, or the [insert name of state exchange]. If a consumer isn’t eligible for Medicaid, then the consumer’s eligibility for coverage through the [insert name of state exchange] and for premium tax credits or cost-sharing reductions will be evaluated.

Q 107: Will consumers still need to submit documents to prove their income?

As much as possible, the [insert name of state exchange] uses existing data sources or gets information from various federal and state agencies, such as the IRS, to verify income. The rules are designed to ensure a high degree of program integrity and reduce the amount of paperwork that consumers need to provide.
Some consumers will be asked to provide documents to prove their income. There are separate processes to verify income in order to qualify for Medicaid and CHIP and for premium tax credits and cost-sharing reductions. To verify income for Medicaid, CHIP, premium tax credits, and cost-sharing reductions, [insert name of state exchange] will use data from the IRS, the Social Security Administration (SSA) and other income data sources.

For Medicaid and CHIP, issues that come up about verifying income will be resolved through a process of explanations and documentation. For premium tax credits and cost-sharing reductions, most verification issues will be resolved through a process of explanations and documentation. But, to limit the administrative burden, the [insert name of state exchange] may use a sample-based review in some cases.

**COMMON CONCERNS ABOUT HOW THE ACA AFFECTS CONSUMERS**

**Q 108: Does the ACA eliminate private health insurance?**

No. There is still private health insurance under the ACA. The ACA created health insurance exchanges (see Questions 5-6) where consumers can compare and shop for private insurance plans. The ACA also sets many new federal rules and protections that apply to people in each state who purchase private health insurance. (See Questions 2 and 4.)

**Q 109: Does the ACA include rules about insurance premiums?**

For individual and small group health insurance market plans covered by the ACA’s rating rules, premiums may only vary based on an individual’s age, the area of the state in which the policy is sold, tobacco use, and family composition. For covered plans, these are the only factors that an insurance company can use when it sets premiums. Covered plans can’t refuse to insure or charge higher premiums to consumers with medical problems. The ACA also reduces the difference in premiums covered plans charged for younger and older people and eliminates differences between premiums charged for men and women. These rating rules cover individual and small group health plans offered through the exchanges or outside of them, but do not apply to short-term, limited duration plans.

To help make coverage affordable, many consumers who buy qualified health plans through the individual market exchanges are eligible for premium tax credits. Also, consumers under age 30 or who can’t afford coverage may be eligible to buy catastrophic plans, which cost less.

**Drafting Note:** States may want to link to rate submissions and final approvals. States that don’t allow the tobacco surcharge or use a different ratio than 1.5:1 should note that health insurance companies are prevented from charging consumers a higher premium for being a tobacco user or limited in the amount of tobacco surcharge that can be applied.

**Q 110: Does the ACA address discrimination?**

ACA explicitly prohibits insurance companies from discriminating on the basis of race, color, national origin, sex, age, or disability. The ACA regulations additionally prohibit discrimination against individuals on the basis of expected length of life, degree of medical dependency, quality of life, other health conditions, sex stereotypes, gender identity, or sexual orientation. These nondiscrimination standards apply to the exchanges and exchange activities, insurers and insurance plans, navigators, certified application counselors, insurance agents or brokers, other assisters, and the EHB, among others. As of October 2019, changes to these regulations have been proposed, but not yet finalized by the federal government.

Section 1557 of the ACA prohibits discrimination by any health program or activity receiving funds from HHS. The scope of this prohibition was first outlined via final rule in 2016; however, challenges to the scope of the rule, specifically with respect to gender identity or termination of pregnancy, resulted in a national preliminary injunction that bars HHS from enforcing the 2016 final rule as written. Health insurers, however, must follow any state laws and regulations that apply to marketing and can’t use marketing practices or benefit designs that will discourage individuals with significant health needs from enrolling. Health insurers must also provide meaningful access for individuals with limited English proficiency and post taglines in the languages spoken by persons with limited English proficiency.
Insurance companies won’t pay for services not covered by a plan, such as care that isn’t medically necessary. Consumers have the right to ask their insurance company to reconsider a decision to deny coverage and, after that, consumers have the right to an independent external review of the decision. (See Question 115.)

**Q 111: What are the income tax implications of the ACA?**

The [insert name of department of insurance] does not interpret or enforce obligations under the tax code. Consumers can contact the IRS or their tax advisor for information.

**Q 112: Where else can consumers find answers to health insurance questions?**

[Insert links to State DOI, Exchange, Medicaid, navigator organizations, etc.]

**Q 113: What does the health plan “accreditation status” information on the exchange Web page mean?**

Accreditation is a comprehensive process by private, nonprofit organizations that review how well health plans deliver care and how they work to improve the delivery of care over time. Health plans offered through the [insert name of state exchange] must be certified by a recognized accrediting body, such as URAQ and/or the National Committee for Quality Assurance (NCQA).

Part of the certification requires that the plan is accredited by a recognized accrediting entity within a time frame set by the [insert name of state exchange]. Accreditation ensures that the plans sold on the [insert name of state exchange] meet minimum quality, access, nondiscrimination, and marketing standards in the ACA.

**Q 114: What does the health plan “consumer experience” information on the [insert name of state exchange] Web page mean?**

Consumer experience ratings come from surveys that ask individuals who have coverage through a health insurance plan how they like the plan. These individuals also rate the quality of the medical care they receive and the accessibility of the medical care that they need.

**Q 115: What appeal rights do consumers have?**

Consumers have a right to appeal an unfavorable coverage decision by their health insurance company. Insurance companies must give consumers owning an individual policy a first-level internal appeal, administered by the company, and if the company upholds its initial unfavorable coverage decision, it must provide an external review administered by an independent third party. Consumers in individual policies may also be able to request a voluntary second-level internal appeal. However, those two levels of internal appeals must also be done within the time limit imposed by the law for all internal appeal process, whether one- or two-levels. Expedited review for emergency situations is available. For group policies, the insurance company may require two levels of internal appeals before the external review option. For more information about how to appeal a health insurance company’s unfavorable decision, the consumer can refer to the notice of the insurance company’s unfavorable coverage decision (often referred to an Explanation of Benefits, or EOB), plan or policy documents, or contact [insert state insurance department] at [insert telephone number].

Consumers also can file complaints with [insert name of state insurance department] when claims are denied, or when they believe that their health insurance company isn’t properly following the legal appeals process. To reach the state insurance department, consumers can contact [insert contact information].

Note that there is a separate appeals process if a consumer is dissatisfied with an eligibility decision made by [insert name of state exchange]. The consumer can contact [insert name of state exchange] for more information.
Q 116: Where do consumers file a complaint for a product sold through the [insert name of state exchange]? What about plans sold in the market outside the [insert name of state exchange]?

Consumers should first contact the insurance company with any complaint about benefits or services they're not receiving. If consumers aren’t satisfied, they should contact the [insert name of state exchange] for help with questions or complaints.

The [insert state department of insurance] investigates complaints about insurance companies and can either look up consumers’ complaints or direct consumers to the right place to file a [insert name of state exchange] related complaint. The [insert state insurance department] is ready to help consumers with any question or complaint they may have about their coverage. To find out more about filing appeals, consumers can contact the [insert state department of insurance] at [insert contact information].

Q 117: If consumers apply for coverage in the market outside the [insert name of state exchange], what are the rules regarding open and special enrollment?

In [insert name of state], insurance companies sell policies in the market outside the exchange. Enrollment periods for coverage outside the [insert name of state exchange] generally are the same as enrollment periods through the exchange. (See Question 12.) Contact the [insert name of state department of insurance] at [insert contact information], or an insurance agent or broker, for more information about enrollment.

If someone is not eligible to enroll in health coverage through the [insert name of state exchange] or does not want to enroll in coverage through the [insert name of state exchange], insurers must make policies available in the [insert name of state exchange] available outside the [insert name of state exchange], although the policies aren’t required to be marketed as available outside the [insert name of state exchange].

For more information about special enrollment periods (SEPs), see this link: www.healthreformbeyondthebasics.org/wp-content/uploads/2015/06/SEP-Reference-Chart.pdf.

QUESTIONS INVOLVING SPECIAL CIRCUMSTANCES AND POPULATIONS

Q 118: What is available for consumers with chronic conditions? Does the ACA help them get better coverage?

Yes. All plans subject to the ACA must insure consumers with a chronic or pre-existing medical condition, must cover pre-existing conditions, and can’t charge higher premiums because of a health or medical condition. They are also required to offer comprehensive coverage. Discrimination on the basis of age, disability or expected length of life is prohibited. Coverage for these benefits is available from the beginning of the policy coverage period, without a waiting period, even if there was no prior coverage. Many plans include wellness programs to help consumers manage chronic conditions.

Q 119: What options are there for consumers with children who aren’t citizens or legal residents?

Consumers won’t be able to buy a policy through the [insert name of state exchange] for those children who aren’t lawfully present, but they may be able to buy a policy directly from an insurance company or through an agent. Insurers that sell policies through the exchange, however, must make those policies available upon request to individuals, including children, who are not eligible to participate in the [insert name of state exchange]. For a list of licensed insurance companies in [insert name of state], visit [insert link]. Lawfully present children also may be eligible for the [insert name of state Medicaid and CHIP]. To learn more about these plans, go to www.insurekidsnow.gov.

Q 120: Are immigrants not legally present eligible for coverage through the [insert name of state exchange] or for premium tax credits?

No. Immigrants not legally present aren’t eligible for coverage through the [insert name of state exchange]. They also aren’t eligible for advance payment of premium tax credits. Insurers that sell policies through the exchange, however, must make those policies available upon request to individuals, including children, who are not eligible to participate in the [insert name of state exchange].

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Q 121: Are incarcerated people eligible for coverage through the [insert name of state exchange] or for premium tax credits?

No. Incarcerated people aren’t eligible for coverage through the [insert name of state exchange]. They also aren’t eligible for advance payments of the premium tax credits. Consumers who are incarcerated pending the disposition of charges still are eligible. Insurers that sell policies through the exchange, however, must make those policies available upon request to individuals, including children, who are not eligible to participate in the [insert name of state exchange].

Q 122: Are tribal members eligible for coverage through the [insert name of state exchange] or for premium tax credits?

Yes. Tribal members may buy coverage through the [insert name of state exchange]. Tribal members have access to enrollment continuously. They’re also eligible for premium tax credits. And, because of the federal government’s special trust responsibility, members of federally recognized Indian tribes are eligible to receive benefits not available to others, such as plans with no cost-sharing, under certain circumstances. For more information, go to www.healthcare.gov or the website for the Indian Health Service (IHS) agency within the HHS at www.ihs.gov/.

QUESTIONS ABOUT MLR

Q 123: What is the Medical Loss Ratio (MLR) requirement?

The ACA’s MLR requirement is that health insurers must spend at least a certain percentage of consumers’ premium dollars on direct medical care and health care quality improvement. That limits the amount of premium dollars spent on administrative expenses, such as overhead, marketing, salaries, and profit.

The ACA requires that health insurance companies providing coverage in the large employer market (usually 50 or more employees) must spend at least 85% of premiums on direct medical care and quality improvement activities. Health insurers who provide coverage in the small employer market (usually fewer than 50 employees) and individual market must spend at least 80% of premiums on direct medical care and quality improvement activities, or they have to rebate (refund) the extra premium.

Q 124: What is an MLR Rebate?

Under federal law, if a health insurer doesn’t meet the MLR target (described in Question 123), that health insurer must give consumers or employers a rebate for the amount of premiums it collected that was greater than the target.

Q 125: How can consumers learn if their insurer paid rebates?

Companies that pay rebates send notices to enrollees. The list of the rebates paid can be found at www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.

QUESTIONS ABOUT WHETHER A PLAN IS LEGITIMATE

Q 126: Why is this a time to be especially on guard against health insurance fraud?

Health insurance rules and regulations are constantly changing. Con artists posing as representatives of the federal government or posing as legitimate insurance agents, brokers, or navigators might try to steal consumers’ money or identity through various health insurance schemes. For instance, criminals might try to steal consumers’ personal information to receive a “national health insurance card” or a new Medicare card under the ACA. Or they might try to sell consumers health insurance policies that are fake, worthless, or not what they claim to be. These scams are often attempted through automated telephone calls or websites that mimic legitimate sites.
Q 127: Can consumers get help from their current insurance agent or insurance company to buy health insurance coverage through the [insert name of state exchange]?

Yes. Working with individuals known personally or known to be working for legitimate organizations is a dependable way to avoid fraud.

Q 128: If consumers don’t have a relationship with an insurance agent or company, where should they go for help?

When consumers contact the [insert name of state exchange], they’ll have the option to contact a navigator specifically trained to help them choose the best health insurance product for their needs.

Drafting Note: States without navigators should update this response to provide alternate sources for consumer assistance.

Q 129: If someone comes to consumers’ homes, calls consumers out of the blue, or sends emails to offer consumers health insurance coverage for a terrific premium, how will consumers know whether the person and the health insurance coverage are legitimate?

Remember this simple formula: STOP – CALL – CONFIRM.

STOP – Consumers should ask the person for identification and a phone number where they may be reached later. If the person refuses to give this information for any reason, or tries to pressure them into signing any document, consumers should immediately hang up, close their door, or walk away.

Consumers should NOT volunteer their Social Security number (SSN) or a credit/debit card number to anyone unless they personally know the individual. Likewise, they should NOT sign any paperwork or write a check.

CALL – Consumers then should contact the [insert name of state department of insurance] or the [insert name of state exchange]. The insurance company or agent or broker, as well as the navigator, must be registered or licensed with the [insert state department of insurance] before they can sell coverage or counsel consumers through the [insert name of state exchange].

Drafting Note: States should modify the previous paragraph as necessary to reference the entity charged with registering or licensing navigators.

CONFIRM – Consumers should always confirm that the company, agent, or broker offering insurance coverage, or the navigator trying to provide assistance, is authorized to provide information or coverage before they sign any documents or give any personal information.

Remember that if something seems too good to be true, it usually is.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Oct. 7, 2019. The following Subgroup members participated: Angela Nelson, Chair, Amy Hoyt, Jessica Schrmpf and Mary Mealer (MO); Michelle Baldock and Mike Chrysler (IL); LeAnn Crow (KS); Mary Kwei (MD); Melinda Domzalski-Hansen (MN); Cuc Nguyen and Rebecca Ross (OK); David Buono and Katie Dzurec (PA); Candy Holbrook and Gretchen Brodkorb (SD); Heidi Clausen and Jaakob Sundberg (UT); and Jennifer Stegall and Sue Ezalarab (WI). Also participating were: Chelsey Maller and Jacob Lauten (AK); Erin Klug (AZ); Julia Yee (CA); Dayle Axman (CO); Howard Liebers (DC); John Reilly (FL); Teresa Winer (GA); Cynthia Banks Radke (IA); Emily DeLaGarza (MI); Jeannie Keller and Pam Koenig (MT); Chanell McDevitt (NJ); Mark Jordan (NM); Jana Jarrett (OH); Jennifer Ramcharan and Vickie Trice (TN); Marcus Wilhouse and Rachel Bowden (TX); Jackie Myers and Yolanda Tennyson (VA); Dena Wildman and Joylynn Fix (WV); and Denise Burke and Tana Howard (WY).

1. Discussed a Consumer Guide on Using Health Insurance

Ms. Nelson reminded the Subgroup that the intended audience for the consumer guide, *Using Your Health Coverage*, is individuals who are already enrolled in health plans and would like help understanding their plans. She said her goal is to have a document ready for distribution by Jan. 1, 2020.

Ms. Nelson asked for comments on proposed changes to the listing of the document’s contents. Brenda J. Cude (University of Georgia) asked how readers with a hard copy could use internal links, and the Subgroup agreed to add page numbers to the table of contents.

Ms. Nelson asked the Subgroup for suggestions on how to provide direction to readers seeking information in languages other than English. Ms. Ramcharan said any information should be earlier in the document, since those with limited English proficiency will not make it far into the document. Ms. Baldock suggested that the states could translate the document or provide other assistance. Ms. Nelson said it was worth inquiring with the NAIC Communications Department about whether it could translate the document, at least into Spanish.

The Subgroup discussed the section on life changes. Ms. Cude said it need not mention every possible life change. Ms. Domzalski-Hansen said it should mention developing a disability. Mr. Buono urged the inclusion of information on the time limits associated with Special Enrollment Periods. Ms. Ezalarab suggested adding information on becoming eligible for Medicare. Candy Gallaher (America’s Health Insurance Plans—AHIP) said there should be some direction to readers as to what steps to take after a life change. Ms. Baldock suggested separate headings for each life event that show who to contact about a life change. Ms. Gallaher suggested starting with categories for each type of health coverage, employer, individual, etc. Ms. Baldock volunteered to start a draft of a table with this information.

Ms. Nelson reviewed the different sections in the document and explained that the next consumer guide would be focused on claims and denials.

Ms. Nelson discussed next steps for *Using Your Health Coverage* and encouraged members of the Subgroup and interested parties to focus on the content and the look of the document. She asked for ideas for info graphics and text boxes to highlight important points. She said after these ideas are incorporated, Ms. Cude can review the document for readability.

2. Discussed FAQ about Health Care Reform

Ms. Nelson brought up the need to update Frequently Asked Questions (FAQ) about Health Care Reform for the 2020 plan year. She explained that the document is intended for insurance department staff, not for consumers directly; though staff can use it in answering consumer questions. She reviewed edits to the document made by Joe Touschner (NAIC), highlighting one removed question on multi-state plans and one added question on health reimbursement arrangements.
Ms. Nelson asked about the existing question on protections against discrimination. She asked whether the existing answer should be changed in light of court decisions limiting enforcement of the protections and a proposed rule to change their application. Ms. Dzurec said the answer should point out the proposals to change the protections and encourage insurance department staff to check state laws that may offer similar protections. She said she would work on suggested edits to the answer.

Ms. Dzurec suggested that, rather than removing the question on multi-state plans, it be replaced with an explanation of the change in policy. She said it would be useful to clarify what happened to not just this policy, but others like co-ops. Ms. Nelson responded that staff can research elsewhere regarding policy changes and the document should not be unwieldy with these types of explanations. Ms. Gallaher suggested that the document could have an archive at the end with information about superseded policies.

Ms. Nelson asked when the document should be modified, as discussed, and posted or reviewed during the next conference call. The Subgroup decided to review it during the next call.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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Health Innovations (B) Working Group  
Austin, Texas  
December 7, 2019

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Austin, TX, Dec. 7, 2019. The following Working Group members participated: Marie Ganim, Chair (RI); Martin Swanson, Vice Chair, and Laura Arp (NE); Andrew Stolfi, Vice Chair, and TK Keen (OR); Jacob Lauten (AK); Howard Liebers (DC); Andria Seip (IA); Alex Peck (IN); Craig Van Aaslt (KS); Marti Hooper (ME); Chrystal Bartuska (ND); Maureen Belanger (NH); Marlene Caride (NJ); Paige Duhamel (NM); David Cassetty (NV); Katie Dzurec (PA); Kent Sullivan and Doug Danzeiser (TX); Tanji Northrup (UT); Molly Nollette (WA); Nathan Houdek and Jennifer Stegall (WI); and Ellen Potter (WV). Also participating were: Kate Morthland (IL); and Nancy G. Atkins (KY).

1. **Adopted its Oct. 28 and Summer National Meeting Minutes**

The Working Group met Oct. 28 and Aug. 3. During its Oct. 28 meeting, the Working Group took the following action:

1) discussed state efforts to address prescription drug costs; and
2) discussed state laws and regulations that pertain to telehealth.

Commissioner Caride made a motion, seconded by Commissioner Stolfi, to adopt the Working Group’s Oct. 28 (Attachment Five-A) and Aug. 3 (see NAIC Proceedings – Summer 2019, Health Insurance and Managed Care (B) Committee, Attachment Eight) minutes. The motion passed unanimously.

2. **Heard Two Presentations on Innovative Insurer Practices to Contain Health Care Costs from UHG and Medica**

Dr. Richard Migliori (UnitedHealth Group—UHG) said that innovation has to be practical and focused on an identified problem. He said that 30% of health care spending is wasteful, which he defined as doing the wrong thing or doing the right thing, but executing it poorly. He noted wide variation in prices for the same services, giving the example of MRI services. He said that transparency that allows comparisons across health systems is vital. He said that consumer-directed health plans can accomplish a one-time reduction in spending but that existing trends of cost increases continue afterwards.

Dr. Migliori emphasized the importance of looking at the total cost of care. He said pushing on the balloon in one place can lead costs to increase in others, but also increased spending in one place can bring savings in another. He said expensive medications can bring down the total cost of care for patients living with a condition.

Dr. Migliori said changing behaviors and lifestyle are important to reducing costs. He highlighted UHG’s Motion program, which provides incentives for healthy behaviors. He shared that claims data allows his company to see many behavior choices and target innovations. He said that examining data from Delta Airlines showed the airports with the highest health activation also had lower injuries, fewer delayed flights and higher customer satisfaction, so the returns to better health choices can go beyond health spending.

Dr. John Piatkowski (Medica) described his company’s work with accountable care organizations (ACOs). He defined ACOs as health system partners that want to reduce costs. He said Medica has gotten away from the sticky attribution question. He said enrollees with ACOs are happier, in part because they have less duplication of services. He said the process has to start with an analysis of where a health system is; some have accepted upside and downside risk for years, while others are just starting. He said that it is always an iterative process with incremental gains.

Dr. Piatkowski said ACOs working with Medica have shown risk-adjusted cost improvement in five of six cases. He said individuals ACOs are getting big enough to be sustainable, which generally requires more than 5,000 members. He said state insurance regulators can encourage effective ACOs is different ways. A first step is getting adequate coverage for members and developing ways to communicate claims data. He observed that different health information rules in different states are a problem. Also, any willing provider laws are a barrier. He said that having tight networks is a benefit, so surprise billing laws should protect insurers’ ability to manage networks.
Ms. Dzurec asked how behavioral health fits into these practices. Dr. Migliori replied that it has to be treated because it can really increase costs. He gave an example of an intervention to allow treatment facilities to distribute medications because getting patients to take the first dose of a drug increases later adherence. Dr. Piatkowski said there is a need for greater parity in behavioral health treatment and that frequent users of emergency departments often have a mental health diagnosis.

Ms. Seip asked why only 30% of contracts have payment based on quality and how state insurance regulators can encourage more. Dr. Migliori said some practices are not ready and must change and get bigger so they can invest in the infrastructure needed to take on the responsibility of managing care.

Dr. Danzeiser ask whether ACOs must take on downside risk. Dr. Piatkowski said Medica requires them to take it but caps the amount for smaller organizations. Dr. Migliori said that when ACOs take downside risk, the insurer can share more of the upside with them.

Health Commissioner Ganim said the Working Group may need to look more into alternative payment models. Ms. Dzurec said it should look at transparency but acknowledged that it is not natural for consumers to shop for health services.

3. Heard a Presentation on Health Care Cost Data from the HCCI

Niall Brennan (Health Care Cost Institute—HCCI) described his organization’s dataset as one of the largest concentrations of employer data, covering roughly one-third of the employer market. He said policymakers struggle to get a handle on health care spending because it is a big part of national and local economies. It drives jobs, which makes people nervous about changes, even though consumers are caught in the middle.

Mr. Brennan said value-based care may be working at the margins but has only been rigorously evaluated in Medicare. He said the data shows Americans have been using less care but paying more for it. He said there is a need for system transparency, not consumer transparency. He said three-fourths of hospitals markets are concentrated and that concentration is increasing in most areas. He said value-based care will not save us if price increases continue as they have, using the example of emergency department prices.

Health Insurance Commissioner Ganim asked what state insurance regulators can do about the prices of health care providers. Commissioner Stolfi said one thing Oregon has done is establish a cost growth benchmark. He said Oregon will spend the next year figuring out the data it needs, how best to measure costs and what limits to place on them. He said the state will consider whether it can enforce the cost growth benchmark against all payers and providers. He said it has already been in place for Medicaid, saving $2 billion over a couple of years.

4. Heard a Provider Perspective on Cost Containment Practices from the TMA

Dr. Debra Patt (Texas Medical Association—TMA) said physicians want to assure value as well as appropriate care, and they want to reduce administrative waste.

Dr. Patt said doctors know utilization management is not going away, but it should not diminish care. She said the burden of prior authorization (PA) and step therapy has increased in recent years. She said doctors need more staff because of PA, saying doctors and their staff spend two days per week on PA.

She said PA should not be a blunt instrument. It should be regulated so that it does not delay care. She advocated for greater transparency and said that issuers should be limited in their ability to ask for additional data after the initial PA request. She said standards should apply to the time issuers can take to process PA requests and that physicians, preferably in the state, should be the ones making PA decisions because of their training. Further, she said regulations should disallow retroactive denials and make PA valid for one year.

She also discussed price increases for prescription drugs and ways to stabilize health insurance markets. She said that short-term, limited duration (STLD) plans can be shoddy products. She urged states to expand Medicaid and increase competition in their markets.
Dr. Patt said real innovation is in alternative payment models because they help practices invest in solutions. And she said physician practices need better data from insurance companies.

Ms. Duhamel said that medical societies should recognize that many states already have PA standards in place. Dr. Patt agreed and said physicians should not just complain to insurers, but engage state regulators when PA practices violate standards.

5. **Heard a Consumer Perspective on Cost Containment Practices from Families USA**

Claire McAndrew (Families USA) shared data on consumer views and experiences with health care costs. She said even among those with comprehensive insurance, 25% limited the care they received because of cost. She said that from 2013–2017, overall health care utilization went down while prices went up, so overall cost of health care went up. She said this shows policymakers have to target prices.

Ms. McAndrew discussed some state efforts to address costs. She said Washington passed a public option plan that ties payment to Medicare rates. She noted state efforts on prescription drug costs: Maryland created a board to review drug affordability, and legislators in Illinois introduced a bill to prevent price gouging, which would offer rebates in the private market similar to how they are used in Medicaid.

She said states do not need to reinvent the wheel on transparency. She urged that any NAIC model law related to pharmacy benefit managers (PBMs) should have teeth. She said that legislation to address surprise bills should not raise premiums. Therefore, federal or state laws should not include an inflationary payment standard. She said that costs should not be shifted onto the backs of consumers and that wellness programs should be participatory and not based on health outcomes.

6. **Discussed Innovative Initiatives from Working Group Member States**

Ms. Bartuska described North Dakota’s health care costs study. She said it requires urban hospitals to report data, which will then be analyzed by actuaries. The analysis will be used to develop policy recommendations, but it will not disclose specific hospital data.

Having no further business, the Health Innovations (B) Working Group adjourned.
The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met via conference call Oct. 28, 2019. The following Working Group members participated: Marie Ganim, Chair (RI); Martin Swanson, Vice Chair, and Michael Muldoon (NE); Andrew Stolfi, Vice Chair, Cassie Soucy, Jesse O’Brien, Tashia Sizemore and Rick Barry (OR); Jacob Lauten (AK); Steve Ostlund and William Rodgers (AL); Andria Seip and Cynthia Banks-Radke (IA); Claire Szpara and Karl Knable (IN); Julie Holmes (KS); Amy Hoyt (MO); John Arnold (ND); Maureen Belanger (NH); Chaneil McDevitt and Diana Sherman (NJ); Paige Duhamel and Renee Blechner (NM); Katie Dzurec (PA); Douglas Danzeiser (TX); Heidi Clausen (UT); Molly Nollette, Jane Beyer and Jennifer Kreitler (WA); Nathan Houdek, Jennifer Stegall, Barbara Belling, Sue Ezalarab, Diane Dambach, Mary Kay Rodriguez and Julie Walsh (WI); and Joylynn Fix (WV). Also participating were: Mary Boatright (AZ); Christopher Citko (CA); Adam Boggess (CO); Fleur Mc Kendell and Leslie Ledogar (DE); Chris Struk (FL); Kathy McGill (ID); Ryan Gillespie and Sara Stanberry (IL); Melinda Domzalski-Hansen (MN); Bob Williams (MS); Ashley Perez, Michelle Scaccia, and Pam Koenig (MT); Robert Croom, Ted Hamby and Mike Wells (NC); Laura Miller (OH); Kendall Buchanan (SC); Jill Kruger (SD); and Bob Grissom and Yolanda Tennyson (VA).

1. Discussed State Efforts to Address Prescription Drug Costs

Commissioner Stolfi and Ms. Soucy shared an overview of Oregon’s Prescription Drug Price Transparency program. Commissioner Stolfi described the requirements the program imposes on both prescription drug manufacturers and health insurers. He said health insurers must provide information on the top 25 highest cost drugs and the contributions of drug prices to premium increases. He reported that as of September, 300 manufacturers had filed 700 reports, which are available on a state website. The reports include price increases over the past five years and the prices the manufacturers charge in other countries. He said that Oregon plans to do more analysis of the reported data next year. He noted that fulfilling the consumer notice provisions of the law has been challenging, but his department has sent flyers to pharmacies. Ms. Soucy said that Oregon needed to identify the manufacturers that were required to report and that the Board of Pharmacy helped with a list. She said that education is needed to get the manufacturers to report correctly as many of them lack the specifics required to support their claims of trade secrets.

Joel Ario (Manatt Health) described activity in other states around drug pricing. He said 33 states have passed 59 laws on prescription drugs, many of them related to transparency and volume-based pricing. He explained California’s test of bulk pricing. He said California’s pool has 13 million people and includes Medicaid enrollees in the state. He noted that California’s experience will show how effective this strategy can be. He also mentioned California’s law on pay for delay. Mr. Ario also described Maryland’s drug price reforms. He said the first effort was stopped in the courts and warned that drug companies will look to litigation on all of these types of laws. He said that Maryland’s drug cost board will review the entire pharmaceutical supply chain and issue a report by December 2020. The report will consider direct price controls, a reverse auction and bulk purchasing as in California. He said that Maine has also enacted a drug affordability board with a 2021 start date, and it will consider spending targets and moving to more direct price controls over time.

2. Discussed State Laws and Regulations That Pertain to Telehealth

Health Insurance Commissioner Ganim said that telehealth is an innovative practice with the potential to reduce costs. She said that in Rhode Island, insurers are contracting with providers to provide telehealth services, but the providers may be from a national network and are not part of the patient’s medical home. She said that pediatricians in the state want to be the contracted entity to provide telehealth services to their patients to improve continuity of care. She said that in her state, state law is very general and only says that insurers must pay for telehealth.

Ms. Bartuska spoke about North Dakota’s laws. She said that the law defines facility and provider, and providers must meet the standards for medical professionals. Health insurance policies must cover telehealth and provide the same coverage for services delivered in person. However, she said that not all services are allowed via telehealth, and a carrier may define medical necessity. Ms. Sizemore said that Oregon grappled with the same questions about payment parity but that many of the questions have sorted themselves out without new laws or regulations. Ms. Bartuska added that North Dakota protects consumers from disparate co-pays for telehealth but does not get involved in payment amounts between carriers and providers. Commissioner Ganim asked whether North Dakota requires any invested in infrastructure, and Ms. Bartuska responded that...
that was not necessarily something the department of insurance (DOI) would be aware of. Ms. Hoyt and Ms. Duhamel said Missouri and New Mexico have parity laws, as well. Ms. Duhamel said that New Mexico has Project ECHO, which allows providers to consult with other providers via telehealth.

Erika Melman (federal Centers for Medicare & Medicaid Services—CMS and Center for Consumer Information and Insurance Oversight—CCIIO) asked how states define telehealth and whether it can include communications like phone or email. Ms. Sizemore said Oregon law requires two-way synchronous communication; other states said they have similar requirements. Ms. Melman asked whether providers provide the site with the remote connection. Ms. Sizemore responded that providers might, but not issuers, and that senior centers or libraries can also provide sites. Runi Shukla (CMS–CCIIO) asked how telehealth affects network adequacy measures such as time and distance. Ms. Duhamel said it is hard to count telehealth providers as an addition to a plan’s network because providers already have full panels and cannot add more patients through telehealth. She said there is some advantage in provider-to-provider consultations, though. Ms. Sizemore said that in Oregon, insurers use telehealth to allow patients in areas with booked clinics to see providers in areas where clinics are not as busy. Ms. Melman asked where issuers provide access through telehealth to providers licensed in another state. Ms. Bartuska said some carriers allow for consultations with out-of-state providers, but only when the provider has a contract with an in-state hospital. Other states said they have similar arrangements.

Having no further business, the Health Innovations (B) Working Group adjourned.
HEALTH ACTUARIAL (B) TASK FORCE

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The Health Actuarial (B) Task Force met in Austin, TX, Dec. 6, 2019. The following Task Force members participated: Anita G. Fox, Chair, represented by Kevin Dyke (MI); Jim L. Ridling, Vice Chair, represented by Steve Ostlund (AL); Lori K. Wing-Heier represented by Jacob Lauten (AK); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Paul Lombardo (CT); Dean L. Cameron represented by Weston Trexler (ID); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Marti Hooper (ME); Steve Kelley represented by Grace Arnold (MN); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); John G. Franchini represented by Anna Krylova (NM); Jillian Froment represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica Altman represented by Tracie Gray (PA); Kent Sullivan represented by Mike Boerner and Raja Malkani (TX); Todd E. Kiser represented by Jaakob Sundberg (UT); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Adopted its Sept. 17, Aug. 27 and Summer National Meeting Minutes**

The Task Force met Sept. 17, Aug. 27 and Aug. 2. During its Sept. 17 meeting, the Task Force adopted its 2020 proposed charges. During its Aug. 27 meeting, the Task Force heard a presentation on a replacement for the 2005 Group Term Life Waiver Mortality and Recovery Tables from Willis Towers Watson.

Mr. Lombardo made a motion, seconded by Ms. Miller, to adopt the Task Force’s Sept. 17 (Attachment One), Aug. 27 (Attachment Two), and Aug. 2 (see NAIC Proceedings – Summer 2019, Health Actuarial (B) Task Force) minutes. The motion passed unanimously.

2. **Heard an Update from the SOA on Health Insurance Research**

Dale Hall (Society of Actuaries—SOA) gave an update (Attachment Three) on recent SOA health insurance research.

3. **Adopted the Report of the Long-Term Care Actuarial (B) Working Group**

Mr. Ostlund said the Long-Term Care Actuarial (B) Working Group met Dec. 6 and took the following action: 1) adopted the reports of the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup; 2) heard an update from the American Academy of Actuaries (Academy) regarding its Long-Term Care Valuation Work Group’s development of mortality and lapse valuation tables for long-term care insurance (LTCI); and 3) heard an update from the SOA on recent work on the SOA’s Long-Term Care Experience Study.

Mr. Ostlund made a motion, seconded by Mr. Shea, to adopt the report of the Long-Term Care Actuarial (B) Working Group (Attachment Four). The motion passed unanimously.

4. **Adopted the Report of the Health Care Reform Actuarial (B) Working Group**

Mr. Shea said the Health Care Reform Actuarial (B) Working Group has not met since the Summer National Meeting.

Beth Parish (federal Center for Consumer Information and Insurance Oversight—CCIIO) and Allison Yadsko (CCIIO) gave an update (Attachment Five) on the federal Affordable Care Act (ACA) risk adjustment data validation (RADV) white paper published Dec. 6. Ms. Parish asked the Task Force to provide comments on the white paper by Jan. 6, 2020.

Mr. Shea made a motion, seconded by Ms. Eom, to adopt the report of the Health Care Reform Actuarial (B) Working Group. The motion passed unanimously.

5. **Heard an Update from the Academy Council on Professionalism**

Shawna Ackerman (California Earthquake Authority—CEA) said the Academy will publish the Actuaries Climate Risk Index soon, which correlates climate index data with economic losses, deaths and injuries.
Kathleen Riley (Actuarial Standards Board—ASB) said the ASB continues work on Actuarial Standard of Practice (ASOP) No. 28, *Statements of Actuarial Opinion Regarding Health Insurance Liabilities and Assets*. She said ASOP No. 28 was last updated in 2011. She said guidance in the ASOP has been expanded to include actuaries making and reviewing statements of actuarial opinion. She said reviews of ASOP No. 3, *Continuing Care Retirement Communities*, and ASOP No. 18, *Long-Term Care Insurance*, are continuing. She said ASOP No. 56, *Modeling*, will be released soon.

David Ogden (Actuarial Board for Counseling and Discipline—ABCD) said the ABCD has received requests for guidance concerning a client that wanted to censor information in a report provided by an actuary, federal Affordable Care Act (ACA) risk adjustment issues, client modification of a report issued by an actuary, qualifications necessary for pricing a family leave benefit, qualifications necessary for pricing stop-loss insurance, mental health parity issues and the effects of incomplete data used in a rate filing.

6. **Heard an Update from the Academy Health Practice Council**

Barb Klever (Blue Cross and Blue Shield Association—BCBSA) gave an update (Attachment Six) on recent Academy Health Practice Council activities and publications.

Having no further business, the Health Actuarial (B) Task Force adjourned.

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The Health Actuarial (B) Task Force met via conference call Sept. 17, 2019. The following Task Force members participated: Anita G. Fox, Chair, represented by Kevin Dyke (MI); Jim L. Ridling, Vice Chair, represented by Steve Ostlund (AL); Lori K. Wing-Heier represented by Jacob Lauten (AK); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais represented by Paul Lombardo (CT); Dean L. Cameron represented by Weston Trexler (ID); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Marti Hooper (ME); Mike Causey represented by David Yetter (NC); John G. Franchini represented by Anna Krylova (NM); Barbara D. Richardson represented by Jack Childress (NV); Jillian Froment represented by Laura Miller (OH); Jessica Altman represented by Tracie Gray (PA); Kent Sullivan represented by Mike Boerner (TX); Todd E. Kiser represented by Jaakob Sundberg (UT); Scott A. White represented by David Shea (VA); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Adopted its 2020 Proposed Charges**

Mr. Ostlund made a motion, seconded by Mr. Boerner, to adopt the Task Force’s 2020 proposed charges (Attachment One-A). The motion passed unanimously.

Having no further business, the Health Actuarial (B) Task Force adjourned.
2020 PROPOSED CHARGES

HEALTH ACTUARIAL (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

2. The Health Care Reform Actuarial (B) Working Group will:
   A. Assist the Health Actuarial (B) Task Force in completing its charge to provide support for issues related to implementation of, and/or changes to, the federal Affordable Care Act (ACA).

3. The Long-Term Care Actuarial (B) Working Group will:
   A. Assist the Health Actuarial (B) Task Force in completing the following charges:
      1. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices and rate changes.
      2. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.

4. The Health Reserves (B) Subgroup will:
   A. Assist the Health Actuarial (B) Task Force in completing its charge to continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.

NAIC Support Staff: Eric King
The Health Actuarial (B) Task Force met via conference call Aug. 27, 2019. The following Task Force members participated: Jim L. Ridling, Vice Chair, represented by Steve Ostlund (AL); Lori K. Wing-Heier represented by Jacob Lauten (AK); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais represented by Paul Lombardo and Wanchin Chou (CT); Eric A. Cioppa represented by Marti Hooper (ME); Marlene Caride represented by Seong-min Eom (NJ); John G. Franchini represented by Anna Krylova (NM); Barbara D. Richardson represented by Annette James (NV); Kent Sullivan represented by Raja Malkani (TX); Todd E. Kiser represented by Jaakob Sundberg (UT); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Heard a Presentation on a Replacement for the 2005 Tables from Willis Towers Watson**

Sue Sames (Willis Towers Watson) gave an update (Attachment Two-A) on work by the joint American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Group Life Waiver Valuation Table Work Group on a replacement for the 2005 Group Term Life Waiver Mortality and Recovery Tables (2005 Tables).

Mr. Chou asked what credibility standard will be used for blending company experience with the proposed replacement tables.

Ms. Sames said the Work Group will review the credibility standards used for the 2012 Group Long-Term Disability Valuation Table in *Actuarial Guideline XLVII—The Application of Company Experience in the Calculation of Claim Reserves Under the 2012 Group Long-Term Disability Valuation Table* (AG 47) and for the 2013 Individual Disability Income Valuation Table in *Actuarial Guideline L—2013 Individual Disability Income Valuation Table Actuarial Guideline* (AG 50) to inform its decision. She said the work group will also consider other credibility standards for use with the replacement tables.

Having no further business, the Health Actuarial (B) Task Force adjourned.
Update

- We are an Academy work group and SOA group collaborating on this project
- Volunteer recruiting is complete
- Work group structures and planning is set
- Work is off to a good start
- We are on target for timing

Plans for 2019–2020

- Data analysis
  - This is a double decrement table (mortality/recovery)
  - Using new techniques to determine appropriate additional dimensions
- Company experience
  - Enhancing approach to Credibility and use of company experience

Plans for 2021

- Address margins and financial impact
- Develop documentation
- Develop proposed update to AG XLIV
### Presentation Disclaimer

The material and information contained in this presentation is for general information only. It does not replace independent professional judgment and should not be used as the basis for making any business, legal or other decisions. The Society of Actuaries assumes no responsibility for the content, accuracy or completeness of the information presented.

### Society of Actuaries Research Update

**DALE HALL, FSA, MAAA**  
Managing Director of Research  
December 2019

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**SOA HEALTH EXPERIENCE STUDIES RESEARCH IN PROGRESS - December 2019**

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Economic Impact of Non-Medical Opioid Use

Economic Cost of the Opioid Crisis

Economic Cost Estimates By Year

Economic Costs by Component

## Economic Costs by Component

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### Child and Family Assistance Costs

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### Unrelated Assistance Costs - Subtotal

| Subtotal                                        | $21,000 | $24,000 | $27,000 | $30,000 | $33,000 | $36,000 | $39,000 |

### Education Costs

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<tr>
<th>Education costs</th>
<th>2018</th>
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<th>2020</th>
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### Cost Proprietorship Costs - Subtotal

| Subtotal                                        | $22,000 | $25,000 | $28,000 | $31,000 | $34,000 | $37,000 | $40,000 |

W:\National Meetings\2019\Fall\TF\HA\HATF Materials\Society of Actuaries Research Update-HATF (reduced)
The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met in Austin, TX, Dec. 6, 2019. The following Working Group members participated: Steve Ostlund (AL); Paul Lombardo (CT); John Reilly (FL); Weston Trexler (ID); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); Rhonda Ahrens (NE); Anna Krylova (NM); Laura Miller (OH); Tracie Gray (PA); Andrew Dvorine (SC); Mike Boerner and Raja Malkani (TX); and Tomasz Serbinowski (UT).

Mr. Ostlund chaired the meeting on behalf of Perry Kupferman (CA).


Ms. Ahrens made a motion, seconded by Mr. Lombardo, to adopt the Working Group’s Oct. 24 (Attachment Four-A), Sept. 24 (Attachment Four-B), Aug. 28 (Attachment Four-C), Aug. 20 (Attachment Four-D) and Aug. 2 (see NAIC Proceedings – Summer 2019, Health Actuarial (B) Task Force, Attachment One) minutes. The motion passed unanimously.

2. Heard an Update from the Academy on LTC Work Group Activities

Warren Jones (PricewaterhouseCoopers LLP) gave an update (Attachment Four-E) on the American Academy of Actuaries (Academy) Long-Term Care Valuation Work Group’s development of mortality and lapse valuation tables. He said the Academy has published the “Long-Term Care (LTC) Combination Product Valuation Practice Note,” as requested by the Working Group in July 2015.

3. Heard an Update on SOA LTCI Research

Dale Hall (Society of Actuaries—SOA) gave an update (Attachment Four-F) on recent work on the SOA’s Long-Term Care Experience Study.

4. Adopted the Report of the Long-Term Care Pricing (B) Subgroup

Mr. Lombardo said the Long-Term Care Pricing (B) Subgroup met Sept. 12 and discussed group long-term care insurance (LTCI) pricing.

Mr. Lombardo made a motion, seconded by Ms. Ahrens, to adopt the report of the Long-Term Care Pricing (B) Subgroup, including its Sept. 12 minutes (Attachment Four-G). The motion passed unanimously.

5. Adopted the Report of the Long-Term Care Valuation (B) Subgroup

Mr. Andersen said an Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) guidance document (Guidance Document) was developed to be used for year-end 2019 AG 51 filings, and it is available on the Subgroup’s web page. He said a review group composed of Subgroup members has reviewed AG 51 year-end 2018 filings for the 50 largest LTCI companies, based on policyholder exposure. He said the review group has conducted in-person meetings with 11 insurers to further discuss their AG 51 filings.

Mr. Andersen made a motion, seconded by Mr. Boerner, to adopt the report of the Long-Term Care Valuation (B) Subgroup, and the Guidance Document (Attachment Four-H). The motion passed unanimously.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Oct. 24, 2019. The following Working Group members participated: Perry Kupferman, Chair (CA); Steve Ostlund (AL); Paul Lombardo (CT); Benjamin Ben (FL); Marti Hooper (ME); Fred Andersen (MN); Rhonda Ahrens (NE); Anna Krylova (NM); Bill Carmello (NY); Chuck Sha (TX); and Jaakob Sundberg (UT).

1. **Discussed a Draft of Revisions to the Forms**

   Mr. Kupferman presented draft of revisions (Attachment Four-A1) to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement and instructions (Attachment Four-A2) for the revised forms. He said the draft was produced as a response to a referral from the Financial Analysis (E) Working Group that requests assistance from the Long-Term Care Actuarial (B) Working Group with long-term care insurance (LTCI) total reserve reporting in the Forms and the annual financial statement.

   Mr. Kupferman said Form 1 has been modified to make a distinction between direct, assumed and ceded amounts. He said the column to report net reserve has been removed. He said reporting in Form 1 is no longer at the policy form level.

   Paul Graham (American Council of Life Insurers—ACLI) said column 9, column 10 and column 11 of Form 1 are duplicates of information that is reported in the recently revised Exhibit 6 of the annual financial statement, and he suggested these three columns be eliminated from Form 1.

   Mr. Kupferman said he will compare Exhibit 6 and the draft Form 1 for duplicate information. He said Form 1 is structured in a way that will show that insurers are responsible for the reserves associated with ceded business.

   Mr. Graham said he thinks for total inception to date rows, column 1 and column 2 the only columns where this category is applicable.

   Mr. Kupferman said he will review Form 1 given this suggestion.

   Mr. Kupferman asked if Form 1 should, as proposed, be split between individual and group business.

   Mr. Andersen said this distinction is helpful due to the differences between individual and group business.

   Mr. Graham said Exhibit 6 of the annual financial does not separate individual and group business.

   Mr. Andersen asked why Form 2 reports incurred claims but not earned premium. He said he thinks reporting percent of male lives insured is not necessary, as this number is fairly consistent among insurers.

   Ms. Ahrens said many insurers offered unisex rates, and reporting percent of male lives insured could help identify companies whose block is disproportionately weighted in subsidized cells.

   Mr. Ben said that the percent of male lives insured is useful for rate review and that he supports reporting earned premium in Form 2.

   Ray Nelson (America’s Health Insurance Plans—AHIP) said it will not be burdensome for companies to provide percent of male lives insured for current in-force policies, but this may not be true for total inception-to-date.

   Mr. Kupferman said the draft of revisions to the Forms does not propose any changes to the current Form 3.

   Mr. Andersen and Mr. Lombardo suggested the addition of earned premium to the draft revisions to Form 4.
Mr. Graham said that he does not understand how reporting third-party funding percentages in Form 4 is useful and that reporting an accurate figure for this category will be difficult.

Mr. Kupferman said the draft of revisions to the Forms removes reserve reporting from Form 5.

Mr. Graham said the rate increase pending column may be misleading to users of Form 5 and may not be easy for companies to accurately report. He said state insurance regulators can obtain this information directly from rate increase requests received by states.

Ms. Ahrens said she does not find it useful to include this in Form 5, as the information can be obtained elsewhere.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
<table>
<thead>
<tr>
<th>Line</th>
<th>$ Earned Premiums</th>
<th>$ Incurred Claims</th>
<th># New Claims During Year</th>
<th># Claims Closed During Year</th>
<th># Open Claims</th>
<th># Terminations</th>
<th># Policies In-force Year End</th>
<th># Lives In-force Year End</th>
<th>$ Active Life Reserves</th>
<th>$ Claim Reserves</th>
<th>$ Other Reserves</th>
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### LTC Experience Reporting Form 2 ($000’s)

#### Direct Individual Experience

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<tr>
<th>Calendar Year of Peak Issues</th>
<th>Line</th>
<th>% Male Lives Insured</th>
<th>Lives In-force End of Year</th>
<th># New Lives Insured</th>
<th># Terminations</th>
<th>$ Incurred Claims</th>
<th>Average Attained Age</th>
<th># Claims</th>
</tr>
</thead>
</table>

**Primarily 2002 and Prior Issue Years**

- **Current (Comprehensive)**
- **Total Inception-to-date (Comprehensive)**
- **Current (Institutional only)**
- **Total Inception-to-date (Institutional only)**
- **Current (Non-Institutional only)**
- **Total Inception-to-date (Non-Institutional only)**
- **Current (Grand Total)**
- **Total Inception-to-date (Grand Total)**

**Primarily 2003 to 2009 Issue Years**

- **Current (Comprehensive)**
- **Total Inception-to-date (Comprehensive)**
- **Current (Institutional only)**
- **Total Inception-to-date (Institutional only)**
- **Current (Non-Institutional only)**
- **Total Inception-to-date (Non-Institutional only)**
- **Current (Grand Total)**
- **Total Inception-to-date (Grand Total)**

**Primarily 2010 and Later Issue Years**

- **Current (Comprehensive)**
- **Total Inception-to-date (Comprehensive)**
- **Current (Institutional only)**
- **Total Inception-to-date (Institutional only)**
- **Current (Non-Institutional only)**
- **Total Inception-to-date (Non-Institutional only)**
- **Current (Grand Total)**
- **Total Inception-to-date (Grand Total)**
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<th>Total Inception-to-date (Institutional only)</th>
<th>Current (Non-Institutional only)</th>
<th>Total Inception-to-date (Non-Institutional only)</th>
<th>Current (Grand Total)</th>
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<tr>
<td>Line</td>
<td>State Code</td>
<td>Earned Premiums</td>
<td># New Lives</td>
<td># Lives In-force End of Year</td>
<td>Average Attained Age</td>
<td>Incurred Extended Benefits Claims</td>
<td>New Open Claims</td>
<td>Rate Increase(s) Pending (Y/N)?</td>
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Form 1

Definitions and Formulas

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of policies.

**Assumed /Ceded Rows**
Does not include YRT reinsurance transactions. For columns that are designated with a # rather than a $, assumed/ceded business is only recorded here if the business is 100% coinsured.

<table>
<thead>
<tr>
<th>Column 1 – Earned Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.</td>
</tr>
</tbody>
</table>

**Life, Accident & Health, Fraternal and Property/Casualty Only**
Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

<table>
<thead>
<tr>
<th>Column 2 - Incurred Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.</td>
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</tbody>
</table>

Paid claims in the year of incurral are discounted one-quarter year.
Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
Outstanding claim reserves for a given incurred year plus transferred reserves from Form 3, Part 3 are discounted from the valuation date to the midpoint of the incurred year.
Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

<table>
<thead>
<tr>
<th>Column 3 – New Claims During the Year</th>
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<tbody>
<tr>
<td>The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.</td>
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<thead>
<tr>
<th>Column 4 - Claims Closed During Year</th>
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<tbody>
<tr>
<td>Number of claims that were closed during the year due to recovery, exhaustion of benefits, or death.</td>
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<tr>
<th>Column 5 – Open Claims</th>
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<tbody>
<tr>
<td>Open claims are all claims that have not been closed. Include IBNR as well as claims in course of settlement.</td>
</tr>
</tbody>
</table>
Column 6 – Terminations

Total number of policyholders whose coverage ended during the year for any reason, including death, lapse, or benefit exhaustion.

Column 7 – Policies In-force at Year End

Total number of policies or certificates in force at the end of the year.

Column 8 – Lives In-force at Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Active Life Reserves

Total amount of reserves held for policyholders who are not currently on claim.

Column 10 – Claim Reserves

Total amount of reserves held for payment of claims that have been incurred but not yet paid.

Column 11 – Other Reserves

Total amount of other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves. For the additional actuarial reserve, use the lesser of the aggregate additional reserve and a reserve calculated specifically for LTC business.

The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health, and fraternal only.

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.
Form 2

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Comprehensive
Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only
Policy forms that provide institutional coverage only.

Non-Institutional Only
Policy forms that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues
Calendar Year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain in force as of 12/31.

Column 2 – Male/Female Mix% Male Lives Insured
Percentage of males/women within the block of policyholders. For example, a block consisting of 60% males would be reported as 60, and 40% females would be reported as 60/40.

Column 3 – Average Attained Age
Unweighted average of the attained ages of all in force policyholders in the block.

Column 4 – Annual Net Premium
\[
\text{Annual Net Premium} = \sum (\text{annual valuation net premiums for policies issued in calendar year } n \text{ at the start of calendar duration } t). \text{ Companies may report zero (0) for the net premiums during the Preliminary Term period. For calendar duration 0, the annual net premiums at issue should be reported.}
\]

Column 5 – Annual Gross Premium
\[
\text{Annual Gross Premium} = \sum (\text{Annualized Premium In Force, including mode loadings for policies issued in calendar year } n \text{ at the start of calendar duration } t). \text{ For calendar duration 0, the annual gross premiums collected at issue should be reported.}
\]
**Column 6 – Net/Gross Premium Ratio**

\[
\text{Net/Gross Premium Ratio} = \frac{\text{[Column 4]}}{\text{[Column 5]}}
\]

**Column 47 – Incurred Claims**

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

- Paid claims in the year of incurrence are discounted one-quarter year.
- Paid claims subsequent to the year of incurrence are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year are discounted from the valuation date to the midpoint of the incurred year.
- Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

**Column 58 – Lives In-force at End of Year**

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

**Column 69 – Terminations**

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

**Column 710 – New Lives Insured**

Total number of new LTC policies issued during the year.
Form 4

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Comprehensive
Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only
Policy forms that provide institutional coverage only.

Non-Institutional Only
Policy forms that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues
Calendar Year in which the largest number of policies in the block were sold.

Column 2 – Third Party Funding
Indicate whether premiums are paid in whole or in part by a third party such as an employer. Example: If the level of third party funding is 25%, enter “25” in this column.

Column 3 – Average Attained Age
Unweighted average of the attained ages of all inforce policyholders in the block.

Column 4 – Annual Net Premium

Annual Net Premium = Σ (annual valuation net premiums for policies issued in calendar year n at the start of calendar duration t). Companies may report zero (0) for the net premiums during the Preliminary Term period. For calendar duration 0, the annual net premiums at issue should be reported.

Column 5 – Annual Gross Premium

Annual Gross Premium = Σ (Annualized Premium In Force, including mode loadings for policies issued in calendar year n at the start of calendar duration t). For calendar duration 0, the annual gross premiums collected at issue should be reported.

Column 6 – Net/Gross Premium Ratio

Net/Gross Premium Ratio = Column 4 / Column 5
Column 47 – Incurred Claims

Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any outstanding claim reserve. The discount rate is the statutory valuation interest rate for case reserve.

Paid claims in the year of incurral are discounted one-quarter year.
Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
Outstanding claim reserves for a given incurred year are discounted from the valuation date to the midpoint of the incurred year.
Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 58 – Lives In-force at End of Year

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 69 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 710 – New Lives Insured Issues

Total number of new LTC certificates issued during the year.
Form 5

Definitions and Formulas

Current

Current calendar year of reporting.

Total Inception-to-Date

Aggregate experience data since issuance of policies.

Stand-alone LTC

An LTC product that is sold by itself, not as a rider on another type of insurance.

Life/LTC Accelerated Benefits Riders

Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

LTC Extension of Benefit Riders

Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

Column 1 – State Code

The state for which data is being reported. Example: CA for California

Column 2 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Column 3 – New Lives During Year

Total number of new lives that entered the block during the year. Joint policies are to be counted as multiple lives.

Column 4 – Lives In-force at End of Year

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.
Column 5 – Average Attained Age

Unweighted average of the attained ages of all inforce policyholders associated with the in the block.

Column 6 – Incurred LTC Claims

Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Paid claims in the year of incurral are discounted one-quarter year. Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year. Outstanding claim reserves for a given incurred year are discounted from the valuation date to the midpoint of the incurred year. Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 7 – Incurred Extended Benefits Claims

Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Paid claims in the year of incurral are discounted one-quarter year. Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year. Outstanding claim reserves for a given incurred year are discounted from the valuation date to the midpoint of the incurred year. Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 8 – Open Claims End of Year

Open claims are all claims that have not been closed. Include IBNR as well as claims in course of settlement.

Column 9 – New Claims During the Year

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.
Column 10 - New Extended Benefits Claims

The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 11 – Accelerated Benefits Available

Maximum amount of remaining death benefit available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.

Column 12 – Extended Benefits Available

Maximum amount of remaining extended benefits available to policyholders with extension of benefit riders.

Column 13 – Rate Increases

Indicate whether the company has any rate increase requests pending in that state.
1. Discussed a Draft of Revisions to the Forms

Mr. Kupferman presented draft of revisions (Attachment Four-B1) to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement, and instructions (Attachment Four-B2) for the revised forms. He said the draft was produced as a response to a referral from the Financial Analysis (E) Working Group that requests assistance from the Long-Term Care Actuarial (B) Working Group with long-term care insurance (LTCI) total reserve reporting in the Forms and the annual financial statement. He presented comments (Attachment Four-B3) from the American Council of Life Insurers (ACLI) on the proposed revisions to the Forms.

Mr. Lombardo suggested that the instructions for completing Form 1 or the exhibit should make a distinction between direct, assumed, and ceded amounts. Mr. Leung suggested that yearly renewable term (YRT) reinsurance amounts be excluded from reporting. Bob Yee (PricewaterhouseCoopers LLP) said YRT amounts should not be excluded. Ms. Ahrens said the definition of the amount to be reported in the Other Reserve column of Form 1 needs to be very clear.

Jan Graeber (American Council of Life Insurers—ACLI) asked to what extent the proposed forms report information that is also reported in revised Form 6 of the annual financial statement. She asked if it is necessary to request duplicate information. Mr. Kupferman said he will compare the revised Form 6 to the proposed forms to identify any duplicate requests.

Mr. Serbinowski suggested changing the Male/Female Mix (%) column in Form 2 to be reported as percentage male or female.

Ray Nelson (America’s Health Insurance Plans—AHIP) suggested the Annual Net Premium and Net/Gross Premium Ratio columns be removed from Form 2, as this information is reported in Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) filings. Mr. Serbinowski agreed.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
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**Form 1**

Definitions and Formulas

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of policies.

**Column 1 – Earned Premiums**
- Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

**Life, Accident & Health, Fraternal and Property/Casualty Only**
- Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

**Column 2 - Incurred Claims**
- Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

- Paid claims in the year of incurral are discounted one-quarter year.

- Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.

- Outstanding claim reserves for a given incurred year plus transferred reserves from Form 3, Part 3 are discounted from the valuation date to the midpoint of the incurred year.

- Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

**Column 3 – New Claims During the Year**
- The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

**Column 4 - Claims Closed During Year**
- Number of claims that were closed during the year due to recovery, exhaustion of benefits, or death.

**Column 5 – Open Claims**
- Open claims are all claims that have not been closed. Include IBNR as well as claims in course of settlement.

**Column 6 – Terminations**
- Total number of policyholders whose coverage ended during the year for any reason, including death, lapse, or benefit exhaustion.

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1
Column 7 – Policies In-force at Year End

Total number of policies or certificates in force at the end of the year.

Column 8 – Lives In-force at Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Active Life Reserves

Total amount of reserves held for policyholders who are not currently on claim.

Column 10 – Claim Reserves

Total amount of reserves held for payment of claims that have been incurred but not yet paid.

Column 11 – Other Reserves

Total amount of other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves.

The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health, and fraternal only.

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.
Form 2

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Comprehensive
Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only
Policy forms that provide institutional coverage only.

Non-Institutional Only
Policy forms that provide only non-institutional coverage.

Column 1 – Year of Peak Issues
Year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain in force as of 12/31.

Column 2 – Male/Female Mix
Percentage of males/females within the block of policyholders. For example, a block consisting of 60% males and 40% females would be reported as 60/40.

Column 3 – Average Attained Age
Unweighted average of the attained ages of all in force policyholders in the block.

Column 4 – Annual Net Premium

\[ \text{Annual Net Premium} = \sum (\text{annual valuation net premiums for policies issued in calendar year } n \text{ at the start of calendar duration } t) \]
Companies may report zero (0) for the net premiums during the Preliminary Term period. For calendar duration 0, the annual net premiums at issue should be reported.

Column 5 – Annual Gross Premium

\[ \text{Annual Gross Premium} = \sum (\text{Annualized Premium In Force, including mode loadings for policies issued in calendar year } n \text{ at the start of calendar duration } t) \]
For calendar duration 0, the annual gross premiums collected at issue should be reported.
Column 6 – Net/Gross Premium Ratio

= [Column 4] / [Column 5]

Column 7 – Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Paid claims in the year of incurrence are discounted one-quarter year.
Paid claims subsequent to the year of incurrence are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
Outstanding claim reserves for a given incurred year are discounted from the valuation date to the midpoint of the incurred year.
Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 8 – Lives In-force at End of Year

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 10 – New Issues

Total number of new LTC policies issued during the year.
Form 4

Definitions and Formulas

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of policies.

**Comprehensive**
Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

**Institutional Only**
Policy forms that provide institutional coverage only.

**Non-Institutional Only**
Policy forms that provide only non-institutional coverage.

Column 1 – Year of Peak Issues
Year in which the largest number of policies in the block were sold.

Column 2 – Third Party Funding
Indicate whether premiums are paid in whole or in part by a third party such as an employer. Example: If the level of third party funding is 25%, enter “25” in this column.

Column 3 – Average Attained Age
Unweighted average of the attained ages of all inforce policyholders in the block.

Column 4 – Annual Net Premium

\[
\text{Annual Net Premium} = \Sigma (\text{annual valuation net premiums for policies issued in calendar year } n \text{ at the start of calendar duration } t). \text{ Companies may report zero (0) for the net premiums during the Preliminary Term period. For calendar duration 0, the annual net premiums at issue should be reported.}
\]

Column 5 – Annual Gross Premium

\[
\text{Annual Gross Premium} = \Sigma (\text{Annualized Premium In Force, including mode loadings for policies issued in calendar year } n \text{ at the start of calendar duration } t). \text{ For calendar duration 0, the annual gross premiums collected at issue should be reported.}
\]

Column 6 – Net/Gross Premium Ratio

\[
= \frac{[\text{Column 4}]}{[\text{Column 5}]}
\]
Column 7 – Incurred Claims

Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any outstanding claim reserve. The discount rate is the statutory valuation interest rate for case reserve.

Paid claims in the year of incurral are discounted one-quarter year.
Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
Outstanding claim reserves for a given incurred year are discounted from the valuation date to the midpoint of the incurred year.
Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 8 – Lives In-force at End of Year

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 10 – New Issues

Total number of new LTC policies issued during the year.
Form 5

Definitions and Formulas

Current

Current calendar year of reporting.

Total Inception-to-Date

Aggregate experience data since issuance of policies.

Stand-alone LTC

An LTC product that is sold by itself, not as a rider on another type of insurance.

Life/LTC Accelerated Benefits Riders

Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

LTC Extension of Benefit Riders

Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

Column 1 – State Code

The state for which data is being reported. Example: CA for California

Column 2 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Column 3 – New Lives During Year

Total number of new lives that entered the block during the year. Joint policies are to be counted as multiple lives.

Column 4 – Lives In-force at End of Year

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 5 – Average Attained Age

Unweighted average of the attained ages of all inforce policyholders associated with the in the block.
Column 6 – Incurred LTC Claims

Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Paid claims in the year of incurral are discounted one-quarter year. Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year. Outstanding claim reserves for a given incurred year are discounted from the valuation date to the midpoint of the incurred year. Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 7 – Incurred Extended Benefits Claims

Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Paid claims in the year of incurral are discounted one-quarter year. Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year. Outstanding claim reserves for a given incurred year are discounted from the valuation date to the midpoint of the incurred year. Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 8 – Open Claims End of Year

Open claims are all claims that have not been closed. Include IBNR as well as claims in course of settlement.

Column 9 – New Claims During the Year

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 10 – New Extended Benefits Claims

The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 11 – Accelerated Benefits Available

Maximum amount of remaining death benefit available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.
Column 12 – Extended Benefits Available

Maximum amount of remaining extended benefits available to policyholders with extension of benefit riders.

Column 13 – Rate Increases

Indicate whether the company has any rate increase requests pending in that state.
September 20, 2019

Perry Kupferman  
Chair, NAIC Long-Term Care Actuarial Working Group (LTCAWG) 

Re: LTC Experience Reporting Forms 

Dear Mr. Kupferman, 

Thank you for the time you and other regulators have spent on the proposed revisions to the NAIC Long-Term Care Experience Exhibits. AHIP and ACLI appreciate the opportunity to provide suggestions/comments regarding potential changes to the current LTC Experience Exhibits in the NAIC Annual Statements. 

First and foremost, we want to ensure that regulators have the information they need to do their job. We also want to ensure that regulators have the information they need to assess the entire market, including data on hybrid products. 

We agree with your statements on the recent Long-Term Care Actuarial Working Group call that the intent of the revisions to the experience exhibits should not be to: 

- disclose confidential information,  
- disclose information that is better suited for submission through an alternative channel such as an AG51 report or a rate filing, or  
- create meaningless work for companies. 

While we can provide general comments on the current draft of proposed revision, we ask that you consider approaching this project as outlined below. You mentioned that you receive regular requests from both your commissioner and outside parties, such as the media, for information that you are unable to adequately answer in a timely way because the data is not readily available or currently reported. It would be very helpful to know the specific nature and focus of those questions. With that information, we could then work together to compile a list of common questions that are routinely asked, or could be asked, to better understand the LTC market. Some initial questions that come to mind are:

**Individual Stand-Alone Long-Term Care Market** 

How many carriers are actively marketing (nationwide and in each state)?  
What products are carriers marketing?  
How many policyholders are covered?  
What percentage of policies are marketed through an employer or association relationship?  
What’s the distribution of business by:  
- Inflation vs non-inflation  
- Issue age  
- Attained age  
- Benefit period
**Long-Term Care Hybrid Market**
Identify the various types of hybrid/combo products currently marketed.
Which companies sell each type?
How many policyholders are covered?
What’s the average face amount?
How many claims were death claims?
How many claims were LTC claims?

**Group Long-Term Care Market**
How many carriers currently market group business?
What’s the average issue age?
What’s the average attained age?
What’s the average daily benefit?
What’s the average benefit period?

If the working group prefers to continue moving forward with the current draft, below are some initial comments.

- Due to the low volume of business in many states, a state by state view of (1) Average Age, (2) Claim Counts, and (3) Reserve Balances will not generate meaningful insights or credible conclusions. In fact, it could be counter-productive, potentially provoking cross-state subsidization concerns as have already arisen, and possibly triggering misplaced objections or analysis from individuals who may tie rate increase need (and state rate increase approvals) to state by state claims experience.

- Encouraging focus on single state experience is inconsistent with the fact that LTC products were generally marketed on a nationwide basis and were priced, designed and sold consistent with NAIC models, so coverage features and initial pricing were consistent across states. State by state focus also seems inconsistent with one of the primary charges of the recently formed NAIC LTC EX Task Force, which is to “[develop] a consistent national approach for reviewing long-term care insurance rates that result in actuarially appropriate increases being granted by the states in a timely manner, and eliminates cross-state rate subsidization.”

**Form Specific Comments:**

**Form 1.**
- Is Form 1 necessary? The Form appears to be designed to address the FAWG request to measure total liabilities. Is this information now adequately captured in the recently changed Exhibit 6 (Aggregate Reserves for Accident and Health Contracts) in the Annual Statement that will take effect in 2019?

- We support the change made in the latest draft to combine the counts for Deaths and Lapses into one data point called Terminations on Forms 1, 2 and 4. The split data would have been problematic to collect and was generally unreliable.
Form 2.
- Question: What is the expected value or intended use of collecting the "Year of Peak Issues"?
- Are the Net Premium and Net/Gross Ratios needed/useful? What is the thinking behind these? Will these continue to be calculated as proxy's based on current Valuation data?

Form 4.
- Same comments/questions as for Form 2 apply to Form 4.
- Group cases may have different levels of 3rd party funding. It is not clear how this entry should be calculated when this is the case.

Form 5.
- Due to the low volume of business in many states, a state by state view of (1) Average Age, (2) Claim Counts, and (3) Reserve Balances will not generate meaningful insights or credible conclusions. As noted above, it could needlessly provoke cross-state subsidization concerns, and could trigger misplaced objections or analysis from individuals who may tie rate increase need (and state rate increase approvals) to state by state claims experience.
- As also noted above, encouraging focus on single state experience is inconsistent with the fact that LTC products were generally marketed on a nationwide basis and were priced, designed and sold consistent with NAIC models, with coverage features and initial pricing typically consistent across states. State by state focus is also inconsistent with the charge of the recently formed NAIC LTC EX Task Force to "develop a consistent national approach for reviewing long-term care insurance rates that result in actuarially appropriate increases being granted by the states in a timely manner, and eliminates cross-state rate subsidization."
- Similarly, "Average Attained Age," "# Open Claims End of Year," and "# New Claims" can be significantly misleading. We believe those items should be removed from Form 5. Company experience can vary, for example across ages and in group versus individual business. Recent examples where commentators have misinterpreted narrow data points (e.g., morbidity improvement) or published flawed conclusions reached by applying their own home grown modeling techniques to select data points, have caused distractions to regulators and companies alike. If regulators consider those data points to be essential, we request that those data points be included in AG 51 filings and that reserves, if required on a state by state basis, be aggregated as "Total Reserves<" not divided between "ALR," "Claim" and "Other" reserves.

Thank you for the opportunity to comment. Please note that we have not had an opportunity to fully discuss changes made to the forms that were released on September 17, 2019, with our respective
member companies. As a result, the above comments should be considered as preliminary. We would be happy to answer any questions your working group has with these recommendations.

Sincerely,

Raymond Nelson
Consultant to AHIP

Jan Graeber
ACLI
The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Aug. 28, 2019. The following Working Group members participated: Perry Kupferman, Chair (CA); Steve Ostlund (AL); Paul Lombardo (CT); Benjamin Ben (FL); Marti Hooper (ME); Fred Andersen (MN); Rhonda Ahrens (NE); Anna Krylova (NM); Laura Miller (OH); Andrew Schallhorn (OK); Jim Laverty (PA); Andrew Dvorine (SC); Chuck Sha (TX); and Tomasz Serbinowski (UT).

1. Heard an Academy Long-Term Care Valuation Work Group Update

Bob Yee (PricewaterhouseCoopers) gave an update on the American Academy of Actuaries (Academy) Long-Term Care Valuation Work Group’s development of long-term care insurance (LTCI) mortality and lapse valuation tables (Attachment Four-C1).

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
**Agenda**

1. Summary
2. Mortality
3. Lapse

**Charges to the LTC Valuation Work Group**

- Develop a replacement mortality table for LTC active life reserves
  - Based on the 2012 Annuitant Mortality Table
  - Recommend a margin for conservatism
- Develop a replacement lapse table
  - Recommend a margin for conservatism
- Consider developing tables for valuation on total lives basis as well as active lives basis
Progress to Date

- Reviewed and selected data from SOA 2000–2011 Intercompany Study
- Develop raw rates
- Smooth rates
- Determined proposed adjustment factors for tables
- Develop adjustment factors
- Compare actual lapses to expected determined from preliminary proposed rates

Proposed Adjustment Factors for Tables

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<td>Risk Class</td>
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</table>

Factors are applied to the base mortality and lapse rates to reflect the profile of the policyholder.

Base Mortality Rates

- Developed from 48,000 deaths among companies with reasonable data ("DEFN 2" companies*) during policy years 15 and beyond for experience period 2008–2011.

* 10 companies' data were deemed to be reasonably reliable:
  - Identified deaths from lapses, and
  - Less than 25% unknown terminations.

Agenda

1. Summary
2. Mortality
3. Lapse
Base Mortality Rates

- Use 2012 IAM as a guide when data is sparse.
- Generally higher than corresponding 2012 IAM rates.

Data for ages 95 & over is fairly credible with 2,878 and 1,278 deaths for female and male respectively.

LTC mortality rates are generally higher than corresponding 2012 IAM Basic and 2015 VBT Unismoker except for female ages past 100.

Durational Factors—Younger Issue Ages

- Durational selection effects extend beyond 20 years.
- Greater selection than aggregate for all issue ages.

Durational Factors—Older Issue Ages

- Durational selection effects shorter than 20 years at issue ages 75 and over.
Risk Class Factors—Preferred

- Permanent selection for issue ages under 60.

Risk Class Factors—Standard (including Substandard)

- Permanent selection for issue ages under 60.

Married Factors

- Permanent selection for issue ages under 70.
- Less selection than corresponding preferred class factors.

Not Married Factors
Background on Data

- Source of data is the 2000-2011 LTC Intercompany Study.
- Select data for DEFN 2 companies and experience years 2008–2011 only.

Select Factors for Lapse

- Key lapse factors were identified using a logistic regression method.

<table>
<thead>
<tr>
<th>Factors for Lapse in Order of Significance</th>
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<tbody>
<tr>
<td>Policy Duration</td>
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<td>Premium Paying Status</td>
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<tr>
<td>Underwriting Class</td>
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<td>Marital Status</td>
</tr>
<tr>
<td>Premium Mode</td>
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<tr>
<td>Rate Increase Indicator</td>
</tr>
</tbody>
</table>

Select Data

- Minimum 240 lapses in any rate-cell (minimum 50% partial credibility).
Select Factors for Lapse

- To be consistent with the factors selected for Mortality Table, Work Group selected the following factors for lapse:
  - Factors for Lapse in Order of Significance:
    - Policy Duration
    - Premium Paying Status
    - Issue Age
    - Underwriting Class
    - Periodic Premium Level
    - Marital Status
    - Premium Mode
    - Rate Increase Indicator

Raw Lapse Rates—Individual

- Raw rates were capped by prior year’s rates to remove increasing patterns.

Smoothed Lapse Rates—Individual

- Capped raw rates for each issue age group were fitted by either an exponential (Expon.) or a power trend line.

Preliminary Proposed Risk Class Factors—Individual

- Unsmoothed adjustment factors were used due to unevenness at the tails.
Preliminary Proposed Marital Factors—Individual

- Raw adjustment factors converted to smoothed factors using 2nd polynomial (Poly.) trend lines.

Actual Lapse to Expected—Individual

- As A/E varies by within 20% by policy duration, a decision has not yet been made to make further adjustments.

Rate Increase Status Ignored

- 48% of total exposures have unknown rate increase status.

Raw Lapse Rates—Group

- Raw rates were not capped since there are only a few instances where the rates are higher than the prior year's rates.
Smoothed Lapse Rates—Group

- Raw rates for each issue age group were fitted by either an exponential (Expon.) or a 2nd degree polynomial (Poly.) trend line.
- A/E adjustments by policy year needed for proposed rates.

Smoothing Lapse Rates by Issue Age Group and Policy Duration

- Poly. (Under 35)
- Expon. (35-39)
- Expon. (40-44)

No Other Factors for Preliminary Proposed Group Lapse Table

- Marital status data for Group was minimal.
- Underwriting risk class was deemed to be unreliable (under further review).
- Covered person (employee, spouse, family members, etc.) is not a significant lapse factor.
- Occupational class data is not available.

Actual Lapse to Expected—Group

- The high A/E at policy durations 11–15 was the result of keeping the proposed rates non-increasing.

Actual Lapses to Expected Lapses Based on Preliminary Proposed Lapse Table

Next Steps

- Develop proposed active lives tables
- Review reasonableness of total terminations
- Recommend margins
- Update NAIC LTC Actuarial Working Group on any new issues
- Produce report
### Preliminary Proposed Lapse Table—Individual

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### Preliminary Proposed Lapse Table—Group

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</tr>
</tbody>
</table>

### Questions?

**David Linn**  
Senior Health Policy Analyst  
American Academy of Actuaries  
[Link](mailto:Linn@actuary.org)  
202-785-6931
The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Aug. 20, 2019. The following Working Group members participated: Perry Kupferman, Chair (CA); Benjamin Ben (FL); Nicole Boyd (KS); Marti Hooper (ME); Rhonda Ahrens and Michael Muldoon (NE); Anna Krylova (NM); Bill Carmello (NY); Laura Miller (OH); Andrew Schallhorn (OK); Jim Laverty (PA); Andrew Dvorine (SC); Chuck Sha (TX); and Tomasz Serbinowski (UT).

1. Discuss a Draft of Revisions to the Forms

Mr. Kupferman presented a draft (Attachment Four-D1) of revisions to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement. He said the draft was produced as a response to a referral from the Financial Analysis (E) Working Group that requests assistance from the Long-Term Care Actuarial (B) Working Group with long-term care insurance (LTCI) total reserve reporting in the Forms and the annual financial statement.

Mr. Andersen asked if the draft contains completely new versions of forms 2 and 4, or if the draft represents suggested edits to the current forms 2 and 4. Mr. Kupferman said forms 1, 2, 4 and 5 in the draft are unrelated to the current respective form numbers, and are all new proposed forms.

Mr. Schallhorn asked if the information requested on draft form 1 is only for stand-alone LTCI policies, or if it also includes LTCI riders on life insurance or annuity policies. Mr. Kupferman said the intention is to collect information only on stand-alone policies. Mr. Schallhorn suggested adding a category for similar information on LTCI riders. Mr. Andersen said a clear definition of “stand-alone policy” and “rider” should be added to the instructions for completing the forms. He said “rider” should be defined as having a specific premium associated with the coverage, as the LTCI component of combination or hybrid life or annuity products with LTCI benefits comingle do not have a specific portion of their total premium clearly allocated to providing LTCI coverage. Mr. Serbinowski said combination or hybrid policies should not be excluded from information gathered in the forms.

Mr. Sha said actual-to-expected calculations should not be deleted from any future versions of the forms.

Jan Graeber (American Council of Life Insurers—ACLI) said a clear understanding of what information state insurance regulators need from the forms will help the ACLI to comment on the development of revisions to the forms. She suggested caveats may need to be included with the forms to prevent information contained in them from being used or applied incorrectly. She said conclusions drawn from state-level information from the forms could be incorrectly extrapolated to a nationwide basis. She said the instructions for completing the forms and what they represent need to be very clear to avoid misuse of the information or invalid conclusions being reached. Mr. Kupferman asked if the forms should be separated into individual and group business. Ms. Graeber said this would be helpful. She said distinctions among types of group business, such as employer-paid versus employee-paid, should be made for reporting group information.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
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<th># Open Claims</th>
<th># New Claims</th>
<th># In Force Year End</th>
<th># Deaths</th>
<th># Lapses</th>
<th>$ Active Life Reserves</th>
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LTC Experience Reporting Form 2 ($000's)

### Direct Individual Experience

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<th>$ Net Earned Premium</th>
<th>Net/Gross Premium Ratio</th>
<th>$ Incurred Claims</th>
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## LTC Experience Reporting Form 5 ($000's)

State Reporting (Net of Reinsurance)

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**Progress Since Summer Meeting**

- Graduated lapse rates on total lives basis
- Started review of actual-to-expected lapse on total lives basis
- Started review of reasonableness of total terminations on total lives basis
- Developed exposures for active life mortality

**Remaining Tasks**

- Complete review of actual-to-expected lapse on total lives basis
- Complete review of reasonableness of total terminations on total lives basis
- Develop mortality improvement from mid-point of exposure period, 2008 – 2011, to 2020
- Recommend margins for lapse and mortality
- Develop lapse and mortality on an active lives basis
- Complete Report

**Charges to the LTC Valuation Work Group**

- Develop a replacement mortality table for LTC active life reserves
  - Based on the 2012 Annuitant Mortality Table
  - Recommend a margin for conservatism
- Develop a replacement lapse table
  - Recommend a margin for conservatism
- Consider developing tables for valuation on total lives basis as well as active lives basis
### Expected Timeline

- Complete development of lapse and mortality on total and active lives bases including margins by Spring 2020 meeting
- Publish Report by Summer 2020 meeting

### Additional Information

David Linn  
Senior Health Policy Analyst  
American Academy of Actuaries  
[Linn@actuary.org](mailto:Linn@actuary.org)  
202-785-6931

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W:\National Meetings\2019\Fall\TF\HA\LTCAWG Materials\Att E_LTC Valu Work Group Dec 2019 Update
Presentation Disclaimer

The material and information contained in this presentation is for general information only. It does not replace independent professional judgment and should not be used as the basis for making any business, legal or other decisions. The Society of Actuaries assumes no responsibility for the content, accuracy or completeness of the information presented.

Data

- Data collected on policies exposed between 1/1/2000 and 12/31/2016
- 19 companies submitted data >>> 80% of all 2016 LTC Earned Premium
- Data requested was expanded from the previous study. New data collected:
  - Additional underwriting information
  - Expanded benefit information
  - ICD-9-CM/ICD-10-CM claim information

Status Update

- Completed steps
  - Validation and logic checks defined and programmed
  - Exposure calculations defined and implemented
  - Initial validation reports sent out to contributing companies
- To be completed
  - Contributing companies review data validation reports and resubmit data, if necessary
  - SOA staff and LTC experience committee review of aggregated results
Deliverables

• A database of termination and incidence data including:
  • Data dictionary
  • Summary of data collected
  • High level results
• Data will be HIPAA compliant and follow safe harbor reporting rules
  • Results for ages 90+ grouped
  • Similar level of detail as the prior study
• Expected completion date: May 31, 2020
  • Four year lag between latest data collected and publication
  • Comparable to past LTC studies

Challenges of the current study

• Heightened awareness of HIPAA compliance by participating companies resulted in:
  • Additional contracting between data compiler and contributors
  • Additional research into HIPAA compliance options

>>>> Resulted in delays in data collection phase
The Long-Term Care Pricing (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Sept. 12, 2019. The following Subgroup members participated: Paul Lombardo, Chair (CT); Jacob Lauten (AK); Steve Ostlund (AL); Benjamin Ben (FL); Marti Hooper (ME); Fred Andersen (MN); Anna Krylova (NM); Bill Carmello (NY); David Yetter (NC): Andrew Dvorine (SC); Raja Malkani (TX); and Jaakob Sundberg (UT).

1. Discussed Group LTCI Pricing

Mr. Lombardo said the Subgroup will continue its discussion of group long-term care insurance (LTCI) pricing considerations from its July 11 conference call.

Jan Graeber (American Council of Life Insurers—ACLI) said group LTCI can be classified as either true group or multi-life. She said true group LTCI uses a master policy that is issued to the group sponsor or employer, and certificates of coverage are issued to the employees or members of the group. She said true group premiums can be funded entirely by the employer, partially by the employer, or entirely by the employee, but, typically, there is at least partial funding by the employer. She said there is no master policy issued for multi-life LTCI, and individual policies are issued to each member of the multi-life group. She said true group plans that are at least partially employer-funded typically are lower risk than ones with no employer funding. She said the lower risk associated with employer-funded plans is primarily due to the risk being spread over a broader base of insured members. She said lapse rates for employees that leave the employer are higher for employer-funded plans, as the terminating employee will have to pay the portion of premium previously paid by the employer to continue coverage. She said lapse rates for terminating employees associated with plans entirely funded by the employee are similar to those seen for individual LTCI.

Ms. Graeber said employer-funded true group plans typically offer a base plan of benefits and give employees the option of purchasing increased coverage, such as a greater daily benefit. She said the average base plan daily benefit is typically lower than that for individual LTCI policies. She said most group base plans do not include inflation protection, and only a very small percentage have lifetime benefits. She said there are generally not gender-distinct rates or underwriting classes, and the base coverage is guaranteed issue. She said employees that decline coverage during open enrollment can enroll at a later date but will have to submit evidence of insurability. She said members that are not full-time employees or are not actively at work are usually subject to full underwriting. She said the average issue age for true group LTCI is lower than that for individual LTCI. She said the combination of lesser benefits and lower issue ages results in lower average premiums for true group compared to individual LTCI.

Ms. Graeber said rate increases for group LTCI may be lower than those in the individual market due to absence of inflation protection and lifetime benefits in group coverage. She said the lower average issue age for group affords more time for a rate increase to offset ultimate claims experience, resulting in lower rate increases for group.

Ms. Graeber said multi-life LTCI uses individual policies that are issued to members, and there is no contract between the insurer and the plan sponsor. She said the plan sponsor can be an employer or an association, such as the AARP. She said multi-life plan coverage and assumptions are more similar to individual market offerings than true group. She said if the plan sponsor is an employer where the member’s actively-at-work status can be verified, underwriting may be less stringent than that seen in the individual market. She said underwriting for an association plan is similar to individual underwriting. She said multi-life plan premiums reflect a discount from similar individual premiums, due to group administrative efficiencies.

Mr. Lombardo asked if, in a true group setting, an employee applies for enhanced benefits, is the application fully underwritten. Ms. Graeber said the increase is typically fully underwritten. Mr. Lombardo asked what percentage of employees purchase enhanced benefits, and for employees that do purchase enhanced benefits, is the total set of benefits comparable to individual market benefits. Ms. Graeber said she can ask ACLI members for percentages of employees selecting enhanced benefits. She said the richness of total benefit packages available to employees varies by employer.

Mr. Lombardo asked if there is any concern that group policies that use simplified underwriting may present an actual risk profile that differs from that assumed in initial pricing. Ms. Graeber said in the case of true group that uses an actively-at-work
underwriting provision, the limited nature of the underwriting is accounted for in initial pricing. She said that multi-life plans, where there is no actively-at-work provision, use underwriting that is similar in intensity to that for individual market plans. Dave Plumb (John Hancock) said insurers typically assume higher claims costs for true group plans, given the limited underwriting in place. He said the risk profile for a true group member at a later attained age is similar to that of a fully-underwritten individual policyholder of the same attained age.

Mr. Lombardo asked if the experience associated with true group or multi-life group members that leave the employer or association, but elect coverage under a continuation or portability policy, stays with the original true group or multi-life block, or if this experience is transferred to the insurer’s individual pool. Ms. Graeber said for true group where the employer pays at least part of the premium, terminating employees that continue with the same coverage by paying the entirety of the premium are treated as any other member of the group for experience purposes. Mr. Plumb said he agrees with this. Ms. Graeber said for associations, the policy is already an individual policy, so the policy is completely portable. She said if the association dissolves, association members may be given the option to convert to a new individual policy, and the new policy experience may be placed in a new pool. Mr. Lombardo asked if insurers anticipate that employees who terminate from their employer, but elect to continue coverage, present a different risk profile than an insured who is still working for the employer. Ms. Graeber said she does not think insurers distinguish between the two classes of certificate holders in their pricing but rather consider the group’s experience as a whole when setting rates.

Mr. Lombardo said during the Subgroup’s July 11 conference call, Bonnie Burns (California Health Advocates—CHA) said she was told by a group LTCI company that it has a high percentage of claims that last less than one year. She said the explanation given was the low average age of the company’s block of insureds. Mr. Lombardo asked what reasons there could be that explain this difference. Ms. Graeber said that if there is such a difference, it is likely due to the event that triggered the claim, such as a car accident where long-term care (LTC) is needed during recovery from the accident, rather than conditions more prevalent in older age groups that result in longer-duration claims. Mr. Plumb said he thinks that recovery rates for younger attained ages will be higher than older attained ages for both individual and group coverage. Mr. Lombardo asked if group insurers have enough claims experience for older attained ages to accurately predict claims at older ages, or if they assume that incidence, morbidity and claim continuance for group insureds are the same as for individual insureds at older ages. Mr. Plumb said some group policies allow for family members of the employee to also be insured, which can create differences in group experience.

Mr. Lombardo asked allowing family members of the employee to also be insured may increase the average age of group contracts. He asked about the prevalence of insurers offering coverage to family members of employees and if there are estimates of how frequently family members of employees enroll for LTCI when this is an option. Mr. Plumb said his experience has been that the volume of family members insured is low and has little impact on the average age of an insurer’s block. Ms. Graeber said ACLI members have reported that in only 5% to 6% of cases do employers offer coverage to family members, and of these 5% to 6%, roughly only 1% of employees add coverage for a family member.

Mr. Lombardo asked Mr. Plumb if he thinks group pricing should be similar to individual pricing. Mr. Plumb said this is true for older ages but not necessarily for younger ages. Mr. Plumb said for a given younger age, group lapse rates are higher than individual, and group morbidity is lower. He said that these assumptions generally converge at older ages.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.
Below is a request for information related to companies’ long-term care insurance (LTC) asset adequacy testing that is being sent to each company filing an Actuarial Guideline 51 (AG 51) Memorandum. The request is related to a Valuation Analysis Review Group of the National Association of Insurance Commissioners project to review AG 51 reserve analysis. For each of the items below, please provide an answer or point to the section and page in the AG 51 filing where the item is addressed. The same confidentiality standards will apply to this information as applied to the AG 51 memorandum. The response should be sent as separate section of the AG 51 filing on the AG 51 filing due date.

I. Inforce

a. Provide charts containing the distribution of business (number of lives) by issue age band, issue year, coverage type, inflation protection, benefit period, and premium payment period. For premium payment period, distinguish between inforce policyholders with lifetime premium periods, inforce policyholders with limited-pay premium periods but still paying premiums, and inforce policyholders no longer paying premiums. In these charts, please exclude policyholders on claim.

II. Morbidity

In this context, morbidity refers to claim incidence rates, length of claim, and claim utilization.

a. Provide the year of the most recent morbidity study applied to support the company’s morbidity assumptions and provide the data period covered in the study. Explain which aspects of morbidity assumptions are reviewed on an annual basis and which are reviewed on a less frequent basis.

b. Discuss the general trend in morbidity experience and expectations over the past year and past several years at the company. If the trend has been in the direction of higher morbidity overall or in certain attained-age ranges, explain the extent to which this finding is reflected in updated assumptions. Also, if the company uses a claims-cost model (as opposed to a first-principles model), explain how company and/or industry trends in incidence and length-of-claim are tracked and reflected in updated assumptions.

c. Discuss the relevance of outside morbidity data applied to support the company’s morbidity assumptions, along with how that data was adjusted to fit the company’s circumstance and how the fit was determined to be appropriate. Explain how validation to historical company experience was performed.

d. Discuss whether and how the morbidity assumptions were compared with industry-average morbidity rates. Is there a reason for company assumptions to be higher or lower than industry average experience, such as benefits provided, policy provisions, underwriting standards, or claims practices? Note that the most recent Society of Actuaries’ (SOA) morbidity study is based on 2000-2011 data and may understate future morbidity in many instances. If the SOA table is relied upon, provide information on how morbidity assumptions used by the company are based on updated experience.
e. Discuss how morbidity assumptions for attained ages 85 and over were set in light of potential gaps in availability, credibility, and relevance of supporting data.

f. Discuss whether the company expects changes in morbidity assumptions in upcoming years as older-age experience develops. Describe how the company added margin to the morbidity assumption to address a potential increase in morbidity expectations. Also, please express a confidence interval of claim-cost-related assumptions for attained ages 90 and 95, including how the interval was determined. Does any sensitivity testing of the impact of adverse developments in morbidity appropriately address the level of potential older-age morbidity assumption increase?

g. Discuss assumed morbidity improvement (if applicable) and the basis for that assumption. Is the assumption supported by company experience? Does justification go beyond studies performed on the population as opposed to studies performed on insureds? Also, explain if the morbidity improvement and mortality improvement assumptions were determined separately. If not, please state the rationale.

h. Where applicable, provide an overview of changes in morbidity assumptions from those used in the previous AG 51 filing, including the basis for any changes.

i. Discuss assumed benefit utilization, including the cost-of-care inflation assumption. Provide the current average daily maximum benefit for policies with 5% compound inflation protection, policies with other inflation protection, and policies with no inflation protection.

j. Discuss the assumed underwriting wear-off pattern, duration in years of the wear-off, and the impact on beyond-select period morbidity assumptions. For policy durations 5, 10, and 20, provide the range of incidence rates for the best and worst underwriting classes for unmarried policyholders.

k. Explain whether incidence rates are determined using a denominator that is based on total lives or active lives. If the projections use a different denominator than the studies used to determine the incidence rate assumptions, please explain how adjustments are made to reconcile the difference and provide an example of this reconciliation, if possible. (If the company uses a total claim cost model, please address this question assuming that “incidence rates” were replaced with “claim costs”).

l. To help in understanding the morbidity assumption, calculate the present value of future benefits as of policy duration 10 of the following set of policies, each with $150 initial daily benefits, 2 ADL or severe cognitive impairment trigger, and 85- to 105-day elimination period:
   i. Female, issue age 55, lifetime benefits, 5% compound inflation
   ii. Female, issue age 55, 3-year benefits, no inflation
   {these cells were retained to provide context for the more-detailed calculation in m.; other 2018 cells are excluded}

For each calculation, use the following pricing assumptions for the following factors:
   - Ultimate, annual voluntary lapse of 0.5%
- 2012 IAR mortality applied to active lives [Clarification sent 1/9/19]
- 4% discount rate
- Assume the most preferred underwriting classification that contains at least 30% of the lives
- Assume a single female with no partner discount.

Use the company’s assumptions on claims’ incidence, length of claim, benefit utilization, and any other morbidity-related aspect.

m. This request is intended to help in the understanding of differences in companies’ morbidity assumptions underlying the present value amounts calculated in association with item II.l immediately above.

For the present value calculation associated with two cells:
   i) female, issue age 55, lifetime benefits, 5% compound inflation and
   ii) female, issue age 55, 3-year benefits, no inflation,
please provide the following durational information used in the present value calculation for each cell:

For attained ages 65, 70, 75, 80, 85, 90, 95, and 100:
   - 1-year incidence rate assumption
   - Maximum Annual Benefit, equal to 365 times Maximum Daily Benefit, inflated at 5% per year for the 5% compound inflation cell
   - Utilized Annual Benefit
   - Length of stay assumption over an entire claim for a claim starting at the specified attained age
   - Total Claim Cost for a claim started at the specified attained age

A preferred format of this information is shown below (Submissions in Excel are preferred):

<table>
<thead>
<tr>
<th>Attained Age</th>
<th>1-year Incidence rate</th>
<th>Maximum Annual Benefit $ = 365 * max. daily benefit, inflated at 5% per year</th>
<th>Utilized Annual Benefit %</th>
<th>Length of Stay in years over entire claim</th>
<th>Total Claim Cost for claim started at the specified attained age $</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>0.5%</td>
<td>$ 90,000</td>
<td>100%</td>
<td>1.5</td>
<td>$ 675</td>
</tr>
<tr>
<td>70</td>
<td>1.0%</td>
<td>$ 110,000</td>
<td>95%</td>
<td>2.5</td>
<td>$ 2,613</td>
</tr>
<tr>
<td>75</td>
<td>2.0%</td>
<td>$ 150,000</td>
<td>90%</td>
<td>3.0</td>
<td>$ 8,100</td>
</tr>
<tr>
<td>80</td>
<td>4.0%</td>
<td>$ 190,000</td>
<td>90%</td>
<td>3.0</td>
<td>$ 20,520</td>
</tr>
<tr>
<td>85</td>
<td>7.0%</td>
<td>$ 240,000</td>
<td>85%</td>
<td>3.0</td>
<td>$ 42,840</td>
</tr>
<tr>
<td>90</td>
<td>10.0%</td>
<td>$ 300,000</td>
<td>80%</td>
<td>2.5</td>
<td>$ 60,000</td>
</tr>
<tr>
<td>95</td>
<td>15.0%</td>
<td>$ 390,000</td>
<td>75%</td>
<td>2.0</td>
<td>$ 87,750</td>
</tr>
<tr>
<td>100</td>
<td>20.0%</td>
<td>$ 490,000</td>
<td>70%</td>
<td>1.5</td>
<td>$ 102,900</td>
</tr>
</tbody>
</table>

The assumptions above should only be provided for one year associated with the specified attained ages, not as the sum or average over a quinquennial range.

It is anticipated that the final column will be the product of the four preceding columns. If this is not the case, then please provide a narrative description of any adjustments.
It is preferred that any adjustments to incidence rates, including morbidity improvement, underwriting, spousal discount, etc., be embedded in the incidence rates in the table.

If the company uses a total claim cost model, please provide the total claim cost data column as well as any other data columns that are available.

Also, if there are any other factors not included in the table above that you believe could potentially lead the company’s present value amounts to be lower or higher than industry averages, then please include a narrative description. Identify if, for any of the cases in the two cells above, you believe the results are impacted by more conservative morbidity assumptions having been selected due to lower-than-average company credibility for that specific issue age and/or benefit type. Please identify whether the company morbidity assumptions used for this exercise were best estimate assumptions or included margins. Also identify if the morbidity assumptions used by the company and reflected in the calculations are unisex or gender-specific. Please explain if the attained age values shown in the table are for total lives or active lives.

In addition, please identify the type of product used as the basis for the calculation, in particular whether it was an expense reimbursement product, an indemnity (also known as cash) product, or another type. If there are other significant product aspects that are unique, please include a description. Identify whether the product is individual or group.

III. Reinsurance treaty information

a. Provide information on any new LTC-related reinsurance transactions or significant changes to existing LTC-related treaties that occurred in 2019.

IV. Sensitivity Tests

If the company performed cash-flow testing, provide the present value of ending surplus in a level interest-rate scenario using baseline assumptions. If the company performed a gross premium valuation, provide the resulting value using baseline assumptions. Also, provide the same values using all baseline assumptions except:

a. No morbidity improvement and no mortality improvement.

b. No morbidity improvement but with mortality improvement.

c. No future, non-approved premium rate increases.

d. Net yield pickup on existing and reinvestment assets capped at 150 basis points above Treasury yields at the time the asset was purchased or will be purchased. This cap applies as an average over the entire portfolio supporting the LTC block.
e. 80% benefit utilization of the projected total daily benefit amounts for products with higher-than 3% annual inflation protection.

AG 51 provides uniform guidance for the asset adequacy testing applied to a company’s LTC block of contracts, and is effective for reserves reported with respect to the Dec. 31, 2017, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 3B of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 14A of Model #820 provides that actuarial opinions and related documents, including an asset adequacy analysis, are confidential information, while Section 14B provides that such confidential information may be shared with other state regulatory agencies and the NAIC. The asset adequacy analyses required under AG 51 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements, and continue to remain confidential in nature.
Purpose & Background

- HHS-RADV:
  - Serves as an audit of the information used in establishing an enrollee’s risk score for purposes of calculating the issuer’s plan liability risk score (PLRS) under the risk adjustment (RA) program
  - Uses a multi-step process called error estimation to calculate error rates that are used to adjust outlier issuers’ risk scores and RA transfers for the applicable state market risk pool(s)

RADV Updates

<table>
<thead>
<tr>
<th>Recent Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 31, 2019</td>
<td>Released the first error rate summary report (for 2017 HHS-RADV)</td>
</tr>
<tr>
<td>August 1, 2019</td>
<td>Released the first HHS-RADV adjustments to transfers summary report (for 2017 HHS-RADV)</td>
</tr>
<tr>
<td>July-August, 2019</td>
<td>Conducted a series of HHS-RADV listening sessions</td>
</tr>
<tr>
<td>December 6, 2019</td>
<td>RADV White Paper with comment period</td>
</tr>
</tbody>
</table>

Purpose & Background

- White Paper Purpose: is to outline and seek feedback on certain HHS-RADV issues:
  - Enrollee Sampling
  - Outlier Detection
  - Error Rate Calculation
  - Application of HHS-RADV Error Rates
- Comments on the options outlined in this paper will help inform potential future rulemaking
**Enrollee Sampling**

Goals for HHS-RADV sample size refinement:
- Ensure samples accurately represent issuer enrollee populations
- Increase the number of samples that meet the 10 percent precision target for a two-sided 95 percent confidence interval
- Minimize the administrative and financial burden on issuers

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**Outlier Detection**

- **Issue 1:** The current methodology determines an issuer’s outlier status based on national, static, confidence intervals common to all issuers
  - Examines alternative methodologies to more precisely identify which issuers have failure rates that are very different from the national average
- **Issue 2:** The current methodology allows for HCC hierarchies in RA to be split across HCC failure rate groupings in HHS-RADV
  - Examines alternative methodologies to address the influence of HCC hierarchies

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**Error Rate Calculation**

- The RADV White Paper:
  - Examines alternative adjustment thresholds for calculating error rates for issuers that are just outside of the acceptable range of variation (the “payment cliff” or “leap frog effect”)
  - Examines a potential approach to mitigate the impact of HHS-RADV adjustments due to negative error rate issuers with negative failure rates

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**Application of HHS-RADV results**

- HHS currently uses an issuer’s HHS-RADV error rate from the prior year to adjust the issuer’s risk score in the current transfer year (with the exception of exiting issuers)
  - Considers options to transition to an approach that applies HHS-RADV results to the same RA benefit year PLRS and transfers for all issuers (e.g., 2021 HHS-RADV results applied to 2021 RA PLRS and transfers)
RADV Updates

• Next Steps
    • Comments should be submitted to CCHIACARADataValidation@cms.hhs.gov with the subject line of “December 2019 HHS-RADV White Paper.”
  – White HHS-RADV Paper Education Webinar is scheduled for December 18 at 2pm (ET) – Register at: Registrar@REGTA info.
  – Potential Future Rulemaking (TBD)

• Other Upcoming Activities
  – Proposed 2021 Payment Notice
  – Complete 2018 BY RADV
Health Practice Council Presentation to NAIC Health Actuarial Task Force (HATF)
December 6, 2019
Talking Points: Recent Work

Since the last HATF meeting, the Academy’s Health Practice Council (HPC) has continued to actively engage policymakers and regulators. The HPC has held a number of meetings with various federal agencies and Congressional committees on the topics of long-term care (LTC), social determinants of health, wellness programs, short-term limited duration insurance plans, and health savings accounts. Various committees within the HPC continue to work on publications within these areas. Furthermore, members of the LTC Reform Subcommittee continued discussions with a federal LTC Interagency Task Force organized by the Department of the Treasury’s (Treasury) Federal Insurance Office (FIO) regarding their experience and expertise in the LTC insurance (LTCI) space, including pricing, product development, and regulation. The Task Force participated in the Academy’s Annual Public Policy Forum on November 5-6 to update actuaries on a forthcoming report while staff from the Center for Consumer Information and Insurance Oversight (CCIIO) also participated in a separate session of the meeting to update attendees on recent and forthcoming regulatory changes. A third breakout session focused on examining the proposals to expand public health insurance plans while Commissioner Altman from Pennsylvania also participated as our plenary featured speaker.

Other recent work includes:

Affordable Care Act (ACA)
- The Individual and Small Group Markets Committee sent comments on October 3 to Centers for Medicare & Medicaid Services (CMS) on rules finalized in the 2020 Notice of Benefit and Payment Parameters (NBPP) concerning risk adjustment data validation (RADV)-related transfers.

Long-Term Care
- On August 30, members of the LTC Reform Subcommittee submitted comments following their discussion with the Federal Interagency Task Force on LTCI earlier this year. These comments reiterate and expand on their original discussion including addressing regulatory hurdles to innovation.
- This week, the LTC Practice Note was published in final form to provide information to actuaries on current and emerging practices in which their peers are engaged with respect to the considerations in the statutory, Generally Accepted Accounting Principles (GAAP) and tax valuation of long-term care combination products.

Health Care Delivery
- On September 25, Susan Pantely and Mick Diede of the Telehealth Work Group, presented on the topic of telehealth along with the debut of their new issue brief moderated by Cori Uccello, senior health fellow, to Capitol Hill staff. The brief explores the perspectives of the patients and providers, while analyzing the financial, legal and regulatory aspects associated with telehealth.
- The Health Practice Council released an issue brief on September 10, Surprise Medical
Bills: An Overview of the Problem and Approaches to Address It, providing an overview of the surprise-billing problem and insights on how to address it.

**NAIC**

- Two work groups presented detailed briefings to regulators following the NAIC’s national meeting in early August. The Long-Term Care Valuation Work Group presented updates on the mortality and lapse tables development on August 28, and the Group Life Waiver Valuation Table Work Group updated the Health Actuarial Task Force on group life waiver of premium mortality and recovery tables development on August 27.
- On September 4, the Health Solvency Subcommittee submitted comments to the NAIC Health Risk-Based Capital (HRBC) Working Group in response to comment letters received on the exposure of the Draft Bond Structure and Instructions.

**Reminders:**

- All of the materials mentioned are on the Academy's website, actuary.org in the Health section under the Public Policy tab, or contact David Linn, the Academy's Senior Health Analyst.
- *(If Joeff Williams has not already plugged)* Academy reception tonight at 5:30pm in Room 409 of the JW Marriott Austin.
REGULATORY FRAMEWORK (B) TASK FORCE

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Pharmacy Benefit Manager Regulatory Issues (B) Subgroup Aug. 15, 2019, Minutes
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The Regulatory Framework (B) Task Force met in Austin, TX, Dec. 7, 2019. The following Task Force members participated:

- Michael Conway, Chair (CO)
- Scott A. White, Vice Chair (VA)
- Lori K. Wing-Heier represented by Jacob Lauten (AK)
- Jim L. Ridling represented by Steve Ostlund (AL)
- Allen W. Kerr represented by Ryan James (AR)
- Stephen C. Taylor represented by Howard Liebers (DC)
- David Altmaier represented by James Dunn III (FL)
- Doug Ommen represented by Andria Seip (IA)
- Dean L. Cameron represented by Weston Trexler (ID)
- Vicki Schmidt (KS)
- Nancy G. Atkins represented by John Melvin (KY)
- Gary Anderson represented by Kevin Beagan (MA)
- Eric A. Cioppa represented by Robert Wake and Marti Hooper (ME)
- Steve Kelley (MN)
- Chlora Lindley-Myers represented by Angela Nelson (MO)
- Mike Chaney represented by Bob Williams (MS)
- Mike Causey represented by Ted Hamby (NC)
- Jon Godfread (ND)
- Bruce R. Ramge represented by Martin Swanson and Laura Arp (NE)
- John Elias represented by Maureen Belanger (NH)
- John G. Franchini represented by Paige Duhamel (NM)
- Glen Mulready represented by Ron Kreiter (OK)
- Andrew Stolfi represented by TK Keen and Rick Blackwell (OR)
- Jessica Altman represented by Michael Humphreys and Katie Dzurec (PA)
- Raymond G. Farmer represented by Kendall Buchanan (SC)
- Larry Deiter represented by Jill Kruger (SD)
- Kent Sullivan represented by Doug Danzeiser (TX)
- Todd E. Kiser represented by Tanji Northrup (UT)
- Mike Kreidler represented by Molly Nollette (WA)
- Andrew Stolfi represented by Nathan Houdek and Jennifer Stegall (WI)
- and James A. Dodrill represented by Erin K. Hunter (WV).

1. **Adopted its Oct. 2 and Summer National Meeting Minutes**

The Task Force met Oct. 2 and Aug. 3. During its Oct. 2 meeting, the Task Force adopted its 2020 proposed charges.

Mr. Trexler made a motion, seconded by Mr. Swanson, to adopt the Task Force’s Oct. 2 (Attachment One) and Aug. 3 (see NAIC Proceedings – Summer 2019, Regulatory Framework (B) Task Force) minutes. The motion passed unanimously.

2. **Adopted its Subgroup and Working Group Reports**

Mr. Keen made a motion, seconded by Commissioner Godfread, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Nov. 25 (Attachment Two), Nov. 19 (Attachment Three), Nov. 4 (Attachment Four), Oct. 28 (Attachment Five), Oct. 7 (Attachment Six) and Sept. 16 (Attachment Seven) minutes; the ERISA (B) Working Group (Attachment Eight); the HMO Issues (B) Subgroup, including its Nov. 21 (Attachment Nine) and Sept. 16 (Attachment Ten) minutes; and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its Oct. 3 (Attachment Eleven), Aug. 29 (Attachment Twelve), Aug. 22 (Attachment Thirteen) and Aug. 15 (Attachment Fourteen) minutes. The motion passed unanimously.

3. **Heard an Update on the CHIR’s Work Related to the ACA**

Justin Giovannelli (Center on Health Insurance Reforms—CHIR, Georgetown University Health Policy Institute) provided an update on the CHIR’s work related to the federal Affordable Care Act (ACA) and other issues of interest to state insurance regulators. He highlighted a forthcoming CHIR report, supported by the Commonwealth Fund, concerning state oversight of health care sharing ministries. He explained how health care sharing ministries are treated under the ACA. Mr. Danzeiser said the National Council of Insurance Legislators (NCOIL) has a draft model on health care sharing ministries, the Health Care Sharing Ministry Registration Model Act.

Mr. Giovannelli discussed the CHIR’s work regarding multiple employer welfare arrangements (MEWAs). He said the CHIR recently published thousands of pages of the U.S. Department of Labor’s (DOL) investigative records concerning MEWAs that it obtained in response to a 2018 Freedom of Information Act (FOIA) request. He said the CHIR has posted the materials and a summary of those materials on the CHIR website at [http://chirblog.org/the-mewa-files/](http://chirblog.org/the-mewa-files/). The CHIR anticipates providing additional analysis of these materials soon. He said the CHIR will continue to track and analyze state regulatory approaches to MEWAs and short-term, limited-duration plans (STLDPs) in the wake of recent federal rule changes with respect to these products.

Mr. Giovannelli also discussed the CHIR’s work related to state reforms affecting the individual market, including state actions involving the ACA’s section 1332 waiver program and state actions to improve the affordability of comprehensive coverage. He highlighted future CHIR research projects, including projects related to reinsurance, standardized health plans and state strategies concerning the Small Business Health Options Program (SHOP). He discussed the CHIR’s ongoing state technical
assistance regarding insurance regulatory matters with the support of the Robert Wood Johnson Foundation through its State Health and Value Strategies Program. He also highlighted the CHIR’s assistance, provided with the support by the Laura and John Arnold Foundation, to state and federal policymakers regarding regulatory approaches to balance billing.

Commissioner Conway asked about the CHIR’s timing for its reinsurance report. Mr. Giovannelli said the CHIR anticipates publishing a report in early Spring 2020. Commissioner Godfread asked Mr. Giovannelli if the CHIR has a position on provisions in the federal bills on balance billing that propose to use arbitration as the method for determining the out-of-network provider payment. Mr. Giovannelli said the CHIR has not taken any position on that issue, but its governing principle with respect to such legislation is that the consumer be held harmless.

4. **Heard a Presentation on the Implementation of a Consumer Purchasing Model in Summit County, CO**

Tamara Pogue-Drangstveit (Peak Health Alliance—Peak) provided an overview of the Peak community-based model for providing health insurance. She said this model provides existing community-based efforts with access to expertise and resources while maintaining local control. She said Peak is a non-profit purchasing cooperative governed by the local community. Peak also is a non-risk-bearing entity.

Ms. Pogue-Drangstveit described the traditional model used to provide health insurance benefits and Peak’s model. She highlighted the differences between the traditional model and Peak’s model. She described the process used to develop the Peak model, including the challenges encountered in developing such a model. She detailed how Peak set prices for certain services and procedures. She described Peak’s plan benefit designs, highlighting its plan benefit designs for mental health benefits.

Ms. Duhamel asked if Peak’s health benefit plans are sold on the ACA’s health insurance exchanges. Ms. Pogue-Drangstveit said Peak’s health benefit plans are sold both on and off the ACA’s health insurance exchanges. She also discussed the unintended consequences on the subsidized population because of Colorado’s reinsurance program and Peak’s successes. Mr. Humphreys asked how Peak’s model can be expanded to other states. Ms. Pogue-Drangstveit said Peak will only go into an area if it has a “sponsor” in order to have buy-in and creditability with the community and other stakeholders. Ms. Dzurec asked about Peak’s experience with rural hospitals and provider facilities and their lack of an ability to reduce prices due to their tight profit margins. Ms. Pogue-Drangstveit said Peak chose not to tackle prescription drug pricing during its first year. She said Peak plans to look at the data and prices for prescription drugs provided in facilities. She said Peak also plans to ask insurers how they can reduce prescription drug prices.

5. **Heard a Presentation on Health Care Cost Trends and Affordability**

Leanne Gassaway (America’s Health Insurance Plans—AHIP) discussed current health care cost trends and approaches to improving consumer affordability. She discussed three levers to lower premiums: 1) reducing the cost of health care; 2) offering premium savings; and 3) increasing participation to balance risk. She discussed AHIP’s suggested solutions to lower premiums for each lever.

To reduce health care costs, Ms. Gassaway suggested that curbing prescription drug costs is critical. She discussed the four themes that AHIP believes contribute to high prescription drug costs, including: 1) a broken and distorted pharmaceutical market; 2) excessive price increases on new and older drug therapies; and 3) high launch prices. She suggested that state solutions address this issue, including providing drug price transparency to consumers and providers.

Ms. Gassaway said another key to reducing health care costs is to reduce surprise medical bills. She said surprise medical bills raise costs. She also said private equity staffing firms are part of the reason for the increase in costs due to their exploitation of patients seeking care. She described how this is occurring. She also discussed state solutions to protect patients from surprise medical bills. She described how third-party payments are also driving up premiums. She highlighted California legislation addressing the issue.
Ms. Gassaway discussed how state reinsurance programs established under the ACA’s section 1332 waiver program can offer premium savings. She also discussed ways to increase participation to balance risk, including increasing consumer outreach and education about plan coverage options.

Commissioner Conway questioned whether market forces alone can address prescription drug costs. Ms. Gassaway said the states need to begin with providing prescription drug price transparently in order to obtain the necessary information to make more informed policy decisions. Commissioner Schmidt expressed concern that some of the information included in Ms. Gassaway’s presentation regarding prescription drug prices is out-of-date, and as such, it might not reflect the current situation. She also questioned why Ms. Gassaway did not mention pharmacy benefit managers (PBMs). Ms. Gassaway said AHIP views PBMs as partners in controlling prescription drug costs. She said pharmaceutical manufacturers set the prices, and AHIP does not view PBMs as driving up prescription drug costs.

Having no further business, the Regulatory Framework (B) Task Force adjourned.
The Regulatory Framework (B) Task Force met via conference call Oct. 2, 2019. The following Task Force members participated: Michael Conway, Chair (CO); Scott A. White, Vice Chair (VA); Lori K. Wing-Heier represented by Sarah Bailey and Jacob Lauten (AK); Jim L. Ridling represented by William Rodgers (AL); Allen W. Kerr represented by William Lacy and Mel Anderson (AR); Ricardo Lara represented by Sheirin Ghodoucy (CA); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Cynthia Banks Radke (IA); Dean L. Cameron represented by Fernanda Vallejo (ID); Vicki Schmidt represented by Julie Holmes (KS); Gary Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Steve Kelley represented by Candace Gergen (MN); Chlora Lindley-Myers represented by Carrie Couch and Jessica Schrimpf (MO); Mike Chaney represented by Bob Williams (MS); Mike Causey represented in the Ted Hamby (NC); Jon Godfread represented by Ross Hartley (ND); Bruce R. Ramge represented by Martin Swanson (NE); Glen Mulready represented by Ron Kreiter (OK); Andrew Stolfi represented by Gayle Woods (OR); Jessica Altman (PA); Raymond G. Farmer represented by Kendall Buchanan (SC); Larry Deiter represented by Jill Kruger (SD); Kent Sullivan represented by Doug Danzeiser (TX); Todd E. Kiser represented by Jaakob Sundberg and Heidi Clausen (UT); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek and Jennifer Stegall (WI); James A. Dodrill represented by Ellen Potter and Joylynn Fix (WV); and Jeff Rude (WY).

1. **Adopted its 2020 Proposed Charges**

Commissioner Conway said that prior to the conference call, NAIC staff distributed the Task Force’s 2020 proposed charges. He explained that the proposed charges generally are unchanged from the Task Force’s 2019 charges. He said the main substantive change is in the Accident and Sickness Insurance Minimum Standards (B) Subgroup’s charge deleting the reference to the *Accident and Sickness Insurance Minimum Standards Model Act* (#170) because the Subgroup completed its work on Model #170 earlier this year (which included changing the title to *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*).

Mr. Lauten suggested a technical change to the Task Force’s charge 1E. He suggested revising the charge’s language for consistency with the language in the Task Force’s charge 1F. There was no objection.

Ms. Nollette made a motion, seconded by Mr. Danzeiser, to adopt the Task Force’s 2020 proposed charges (Attachment One-A). The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.
2020 PROPOSED CHARGES

REGULATORY FRAMEWORK (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products and Services

1. The Regulatory Framework (B) Task Force will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2019-2020.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the ERISA (B) Working Group, monitor, analyze and report developments related to association health plans (AHPs).
   F. Monitor, analyze and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.

2. The Accident and Sickness Insurance Minimum Standards (B) Subgroup will:
   A. Review and consider revisions to the Accident and Sickness Insurance Minimum Standards Model Act (#170) and its companion regulation, the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171).

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

4. The HMO Issues (B) Subgroup will:
   A. Revise provisions in the Health Maintenance Organization Model Act (#430) to address conflicts and redundancies with provisions in the Life and Health Insurance Guaranty Association Model Act (#520).

5. The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will:
   A. Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.

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

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The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Nov. 25, 2019. The following Subgroup members participated: Melinda Domzalski-Hansen, Co-Chair (MN); Glen Mulready, Co-Chair, represented by Buddy Combs (OK); Eric Unger (CO); Chris Struk (FL); Frank Opelka (LA); Camille Anderson-Weddle (MO); Martin Swanson (NE); Gayle Woods (OR); Katie Dzurec (PA); Glynda Daniels (SC); Rachel Bowden and Sean Fry (TX); Heidi Clausen and Jaakob Sundberg (UT); Emily Brown (VT); Andrea Philhower and Michael Bryant (WA); and Jennifer Stegall (WI).

1. Continued Discussion of the July 30 Comments on Sections 1–5 of Model #171

Ms. Domzalski-Hansen said the purpose of today’s conference call is for the Subgroup to continue its discussion section-by-section of the comments received by the July 30 public comment deadline on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), beginning with Section 5L, the definition of “preexisting condition.” However, before starting that discussion, she said the Subgroup needs to complete its discussion of Section 5K, the definition of “physician.”

Ms. Domzalski-Hansen reminded the Subgroup of its discussion of Section 5K during its Nov. 19 conference. She said during this discussion, Ms. Philhower had agreed to rewrite the provision for clarity. Ms. Philhower said that following the Subgroup’s Nov. 19 call, she reviewed the provision and decided that Section 5K does not belong in Section 5—Policy Definitions; it should be moved to Section 7—Accident and Sickness Minimum Standards for Benefits because it is more of a substantive provision than a definition. After discussion, the Subgroup agreed to move Section 5K’s provisions to Section 7.

The Subgroup next discussed Section 5L, the definition of “preexisting condition.” Ms. Domzalski-Hansen said the Subgroup received comments on Section 5L from America’s Health Insurance Plans (AHIP), the Missouri Department of Insurance (DOI), the Washington DOI, and the NAIC consumer representatives. Chris Petersen (Arbor Strategies, LLC), speaking on behalf of AHIP, said AHIP’s comments suggest that the Subgroup consider different definitions of “preexisting condition” for supplementary products and short-term, limited-duration plans (STLDPs) because of the differences in the type of coverage. He said that for supplementary products, AHIP believes the definition of “preexisting condition” in Section 5L should remain unchanged. He said the NAIC consumer representatives’ suggested revisions for the term are not appropriate for supplementary products because they are excepted benefits, and they are not required to comply with the requirements under the federal Affordable Care Act (ACA) for comprehensive health insurance products. He said he also believes that the provisions in the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170), the companion model to Model #171, would prohibit such changes. He said that if the Subgroup believes changes for this definition need to be made for STLDPs, then the Subgroup should include those changes in the provisions in Model #171 applying only to STLDPs.

The Subgroup discussed whether to delete the specific timeframes in the definition and include specific timeframes in the specific sections for each product covered under Model #171. The Subgroup also discussed whether there should be a general definition of this term in Section 5 or if the definition should be removed and included in Section 7 for each product described in that section. After additional discussion, the Subgroup decided to move Section 5L to Section 7 without a timeframe and include a timeframe for each product described in Section 7.

The Subgroup discussed the Missouri DOI’s suggestion to remove language in the definition concerning the prudent layperson standard. Sarah Lueck (Center on Budget and Policy Priorities—CBPP) pointed out that the NAIC consumer representatives made a similar suggestion. She explained that the NAIC consumer representatives suggest such a revision because the prudent layperson standard is hard for consumers to understand when completing an application with respect to previous or current health conditions, and the suggested revised language is easier for consumers to understand.

J.P. Wieske (Horizon Government Affairs) expressed concern with the NAIC consumer representatives’ suggested revision, particularly with respect to disability income protection coverage. He said the potential revision would make it easier for consumers to game the system. He said consumers could delay seeing a physician, apply for coverage knowing that they have a medical condition; and because there are no waiting periods, they could receive coverage under the policy immediately. Ms. Lueck said the NAIC consumer representatives’ suggested revision adds transparency to the definition and as such, should be
beneficial to insurers. The Subgroup discussed the NAIC consumer representatives’ suggested revision. Ms. Stegall asked Ms. Lueck if she knew of any state’s definitions of “preexisting condition” that strike the appropriate balance with respect to consumer understanding while not contributing to the ability of consumers to game the system. Ms. Lueck said she did not. However, she agreed to research it. Katie Keith (Out2Enroll) agreed to send the Subgroup information on the subject compiled by the Kaiser Family Foundation (KFF). Mr. Petersen asked if the KFF’s information relates to major medical coverage. Ms. Keith said it did. Mr. Petersen suggested that the Subgroup needed to receive information related to supplementary coverages. After discussion, the Subgroup agreed that any information it receives on this issue would be valuable to the Subgroup as it continues its discussions of the term.

The Subgroup next discussed the Washington DOI’s suggestion to delete language in Section 5L’s drafting note seemingly related to post-claims underwriting when an insurer reviews an insured’s health history and as a result of that review decides to exclude a specific condition. Ms. Philhower said she is concerned about the discriminatory aspects of such language. Mr. Wieske said he believes that this language is a holdover from Model #171’s provisions when it included comprehensive health insurance coverage. The Subgroup discussed removing the language. Ms. Bowden suggested that regardless of whether it is removed, language should be added to Section 8—Required Disclosure Provisions alerting consumers about the importance of completing applications as accurately as possible, particularly as to the consumer’s health history. Ms. Lueck questioned whether state insurance regulators should permit post-claims underwriting. She questioned why insurers cannot perform pre-claims underwriting, which is more transparent to the consumer than post-claims underwriting. The Subgroup discussed Ms. Lueck’s comments and acknowledged her concerns. However, given the ability of consumers to game the system, post-claims underwriting occurs and is needed. The Subgroup noted, however, that state insurance regulators must monitor insurers to ensure that they do not abuse the post-claims underwriting process. After additional discussion, the Subgroup accepted the Washington DOI’s suggestion to delete the language in Section 5L’s drafting note and discuss the issue raised in the language when the Subgroup discusses Section 8.

Ms. Domzalski-Hansen said she expects the Subgroup to meet next via conference call after the Fall National Meeting.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Nov. 19, 2019. The following Subgroup members participated: Melinda Domzalski-Hansen, Co-Chair (MN); Debra Judy (CO); Howard Liebers (DC); Chris Struk (FL); Robert Wake (ME); Camille Anderson-Weddle and Carrie Couch (MO); Martin Swanson (NE); Katie Dzurec (PA); Shari Miles (SC); Rachel Bowden (TX); Anna Van Fleet (VT); Andrea Philhower and Michael Bryant (WA); and Nathan Houdek and Jennifer Stegall (WI).

1. Continued Discussion of the July 30 Comments on Model #171, Sections 1–5

Ms. Domzalski-Hansen said the purpose of today’s conference call is for the Subgroup to continue its discussion section-by-section of the comments received by the July 30 public comment deadline on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), beginning with Section 5I, the definition of “partial disability.” She said, however, before starting that discussion, the Subgroup needs to complete its discussion of Section 5I, the definition of “one period of confinement.”

Ms. Domzalski-Hansen reminded the Subgroup that during its Nov. 4 conference call, the Subgroup discussed Section 5I and whether its use of the word “means” was appropriate given the language used in other definitions in Section 5, such as “may be defined” or “shall be defined.” She said the Subgroup decided to change “means” to “shall be defined.” She said the Subgroup also discussed how the term is used in policy forms, and after discussion, the Subgroup decided to seek additional information from stakeholders to answer this question. Ms. Domzalski-Hansen said she sent an email to stakeholders asking for a response to these questions: 1) What type of policies currently use this language?; 2) How is this language currently used in the policies?; and 3) Do your policies use this language for one event for each period of time or for multiple events in one period of time? She said she received comments from AFLAC; the Health Benefits Institute and the Missouri Department of Insurance (DOI).

Ms. Domzalski-Hansen discussed AFLAC’s comments. She said that in its comments, AFLAC said it uses the term “period of hospital confinement” in its hospital indemnity policies. She said AFLAC noted that its short-term disability income policies include provisions discussing one event for each time period versus multiple events in a time period.

Ms. Domzalski-Hansen discussed the Missouri DOI’s comments from Mary Mealer (MO). She said Ms. Mealer said she searched for the term “confinement” in recent health filings in the System for Electronic Rate and Form Filing (SERFF). She said Ms. Mealer found that the term “confinement” is only used in comprehensive health filings and describing benefits. The term was not defined in these policies nor used as “one period of confinement.” She said Ms. Mealer found language concerning “successive period of coverage stays” in hospital indemnity policy filings.

J.P. Wieske (Horizon Government Affairs), representing the Health Benefits Institute, said the Health Benefits Institute believes that the definition of “one period of confinement” in Section 5I is used by insurers in at least two policy forms—supplemental accident benefits and fixed indemnity products. He said it is likely that this term is used in other policy forms, but for policies that would not be covered under Model #171. Mr. Wieske said it is important that the Subgroup understand that the policies using this language will be using the language in multiple ways, with some insurers paying on a per incident basis and others on a per service basis, and may apply separate cost-sharing per incident. He provided examples of how benefits could be paid using Section 5I’s definition of the term when multiple hospital visits are necessary arising from the same injury or sickness. He also described from a consumer’s viewpoint how a narrow and broad definition of the term could affect benefits.

Mr. Wieske said the Health Benefits Institute suggests modifying Section 5I as follows: “One period of confinement” means one or more consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time defined in the policy but not more than [ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.]

Drafting Note: This language is used in multiple policy forms that may pay benefits differently [e.g. on per incident or per service basis]. States may want to establish minimum policy standards that differ based on how the benefit is to be paid by the insurer and the type of policy.
The Subgroup discussed the Health Benefits Institute’s suggested revisions to Section 5I. Mr. Bryant questioned the language in Section 5I concerning the maximum number of days and asked if there was a way to simplify the language. Ms. Domzalski-Hansen questioned the addition of the brackets noting that including brackets would add variability to the language instead of establishing minimum standards for insurers with respect to the policies covered under Model #171. After additional discussion, the Subgroup decided to delete Section 5I and move its provisions to Section 7—Supplementary and Short-Term Health Minimum Standards for Benefits.

The Subgroup next discussed Section 5J, the definition of “partial disability.” Sarah Lueck (Center on Budget and Policy Priorities—CBPP) discussed the NAIC consumer representatives’ comments, which suggest that the Subgroup consider revising Section 5J(2) to add the language “including compensation in the form of goods and services.” She said the NAIC consumer representatives are suggesting this language to address situations when an individual is partially disabled and is employed in work not compensated through wages or profits. She explained that the Subgroup discussed the NAIC consumer representatives’ comments during its Nov. 4 conference call, but during that discussion, she neglected to tie the suggested revisions for Section 5J(2) to the NAIC consumer representatives’ suggested revisions for Section 5O, the definition of “total disability.”

Mr. Wieske reiterated his concern on whether an insurer would be able to determine the compensation to be provided to the insured in such a situation because of the difficulty in determining the value of goods and services. Chris Petersen (Arbor Strategies LLC) expressed concern with the possibility of disputes arising related to the valuation of the goods and services. Some Subgroup members agreed with Mr. Wieske’s and Mr. Petersen’s concerns. After discussion, Ms. Lueck agreed to withdraw the NAIC consumer representatives’ suggested revisions for Section 5J.

The Subgroup next discussed Section 5K, the definition of “physician.” Ms. Domzalski-Hansen said the Washington DOI submitted comments asking for clarification of Section 5K’s existing language. Ms. Philhower said her comments concerned whether the language in Section 5K(1) is an “any-willing provider” provision or something else. The Subgroup discussed her concern and decided the language was not an “any-willing provider” provision, but language requiring an insurer, for a provider contracted with the insurer, to permit the provider to the extent of its contractual obligations to provide the services within the scope of the provider’s licensed authority and applicable laws. Ms. Philhower said she also has questions about the language in Section 5K(2). She said it is unclear what the language “definition or concept” means. She also asked about the language “an owner or assignee.” Mr. Wake cautioned the Subgroup that the term “assignee” could be the physician in some cases. Mr. Bryant suggested changing the language to “policyholder or beneficiary.” Ms. Van Fleet said she believes the problem is Section 5K(2)’s construction. After discussion, Ms. Philhower volunteered to revise Section 5K for clarity for the Subgroup’s review during a future conference call.

Ms. Domzalski-Hansen said she believes the Subgroup could complete its review of the comments received on Sections 1–5 with two more conference calls. She said she would like the Subgroup to meet prior to the Fall National Meeting. The Subgroup expressed support for Ms. Domzalski-Hansen’s plan.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
Attachment Four
Regulatory Framework (B) Task Force
12/7/19

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Draft: 11/8/19

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Nov. 4, 2019. The following Subgroup members participated: Glen Mulready (OK); Melinda Domzalski-Hansen (MN); Adam Boggess (CO); Chris Struk (FL); Frank Opelka (LA); Mary Mealer (MO); Gayle Woods (OR); Rachel Bowden (TX); Tanji Northrup and Jaakob Sundberg (UT); Phil Keller and Anna Van Fleet (VT); Andrea Philhower and Michael Bryant (WA); and Jennifer Stegall (WI).

1. Continued Discussion of the July 30 Comments on Model #171, Sections 1–5

Ms. Domzalski-Hansen said the purpose of today’s conference call is for the Subgroup to continue its discussion section-by-section of the comments received by the July 30 public comment deadline on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), beginning with Section 5I, the definition of “one period of confinement.” She reminded the Subgroup that during its Oct. 28 conference call, the Subgroup discussed this provision and whether its use of the word “means” was appropriate given the language used in other definitions in Section 5, such as “may be defined” or “shall be defined.” She said that as the Subgroup requested, NAIC staff reviewed Section 5’s legislative history with respect to the definitions and found that there was nothing in the legislative history discussing the drafters’ intent in using “means,” “may be defined,” or “shall be defined.”

Ms. Domzalski-Hansen said that given this, she surveyed the Subgroup members on the issue. She said the responses she received indicated that in order to determine the appropriate language, the Subgroup would need to determine the intent of the provision, such as whether it is permissive or mandatory. She said the Subgroup has two options to consider related to the issue: 1) defer discussion on the issue until the Subgroup reviews Model #171’s substantive provisions where the terms are used; or 2) not defer the discussion and resolve the issue while the Subgroup is discussing Section 5.

The Subgroup discussed Ms. Domzalski-Hansen’s options. Ms. Philhower suggested that the Subgroup not defer the discussion and beginning with Section 5I review each definition as to its intent to decide whether the language should be “means,” “may be defined,” or “shall be defined.” She said because there has been no discussion prior to Section 5I on this issue, the Subgroup should not go back and review the definitions in Section 5 that it has already discussed. The Subgroup accepted Ms. Philhower’s suggestion.

The Subgroup discussed whether Section 5I should say “means,” “may be defined,” or “shall be defined.” Mr. Keller asked for clarification on how the Subgroup plans to use the term “one period of confinement” in policy forms. The Subgroup discussed Mr. Keller’s question, but it reached no conclusion. The Subgroup next discussed changing “means” to “may be defined” and the substantive implications of such a change. After discussion, the Subgroup decided to change “means” to “shall be defined.” Ms. Domzalski-Hansen said she would send out a question to stakeholders on how the term “one period of confinement” is used in policy forms. She said the Subgroup would return to this discussion during its next conference call Nov. 19.

The Subgroup next discussed Section 5J, the definition of “partial disability.” Sarah Lueck (Center on Budget and Policy Priorities—CBPP) discussed the NAIC consumer representatives’ comments, which suggest that the Subgroup consider revising Section 5J(2) to add the language “including compensation in the form of goods and services.” She said the NAIC consumer representatives are suggesting this language to address situations when an individual is partially disabled and is employed in a work not compensated through wages or profits. J.P. Wieske (Horizon Government Affairs) questioned whether an insurer would be able to determine the compensation to be provided to the insured in such a situation because of the difficulty in determining the value of goods and services. The Subgroup discussed the NAIC consumer representatives’ suggested revision and decided to defer making a decision. The Subgroup requested that the NAIC consumer representatives submit additional comments on the issue for the Subgroup to consider during its next conference call Nov. 19. The Subgroup next discussed Section 5K, the definition of “physician.” Ms. Domzalski-Hansen said the Washington Department of Insurance (DOI) submitted comments asking for clarification of Section 5K’s existing language. The Subgroup deferred discussion of the Washington DOI’s comments until its next conference call Nov. 19.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Oct. 28, 2019. The following Subgroup members participated: Glen Mulready, Co-Chair, represented by Buddy Combs (OK); Melinda Domzalski-Hansen, Co-Chair (MN); Chris Struk (FL); Frank Opelka (LA); Mary Mealer (MO); Martin Swanson (NE); Katie Dzurec (PA); Kendall Buchanan (SC); Jaakob Sundberg and Heidi Clausen (UT); Phil Keller and Anna Van Fleet (VT); Michael Bryant (WA); and Nathan Houdek (WI).

1. Continued Discussion of the July 30 Comments on Model #171, Sections 1–5

Ms. Domzalski-Hansen said the purpose of today’s conference call is for the Subgroup to continue its discussion section-by-section of the comments received by the July 30 public comment deadline on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) beginning with Section 5D, the definition of “hospital.” She reminded the Subgroup that during its Oct. 7 conference call, the Subgroup began discussion of the comments received on Section 5D, but it did not complete its discussion.

Sarah Lueck (Center on Budget and Policy Priorities—CBPP) discussed the NAIC consumer representatives’ comments, which suggest the Subgroup consider revising Section 5D(2)(b) and deleting Section 5D(2)(c) to remove obsolete language and for consistency with other Subgroup proposed revisions. Chris Petersen (Arbor Strategies LLC) expressed concern with deleting Section 5D(2)(c) because its deletion could be inconsistent with various state laws defining “hospital.” J.P. Wieske (Horizon Government Affairs) said Section 5D(2), if permitted under state law, allows plans to exclude the facilities listed as a type of hospital facility from a plan’s policy provisions. Some Subgroup members expressed concern with deleting the provision. After discussion, the Subgroup decided to leave Section 5D unchanged except for adding the Missouri Department of Insurance’s (DOI) clarifying revisions.

The Subgroup next discussed the comments received on Section 5E, which defines the term “injury.” Ms. Mealer said the Missouri DOI suggests deleting Section 5E(4) because “disability” has nothing to do with a definition of “injury.” She said the Missouri DOI also suggests deleting Section 5E(5) because there is most likely a better way to ensure the policy does not pay for workers’ compensation claims or claims under medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts. Ms. Lueck suggested the Subgroup delete the language “independent of disease or bodily injury” in Section 5E(1) because of the language’s potential to limit the types of claims that could be made. The Subgroup discussed whether to delete the language “or bodily injury” in Section 5E(1). The Subgroup discussed the interaction of Section 5E(1) and Section 5E(2). Jolie H. Matthews (NAIC) explained that this definition is new and was most likely derived from a similar definition in the Interstate Insurance Product Regulation Commission’s (Compact) disability income standards. Ms. Buchanan suggesting deleting Section 5E(2) because it appears to be duplicative of Section 5E(1). The Subgroup agreed to delete Section 5E(2). The Subgroup also decided to delete the language “or bodily injury” in Section 5E(1).

Mollie Zito (UnitedHealthcare) discussed UnitedHealthcare’s suggestion to add the following sentence to Section 5E(1): “All injuries due to the same accident are deemed to be one injury.” Ms. Lueck asked if an “injury” only results from an “accident.” She pointed out that the definition of “accident” in the former Section 5B was deleted. Ms. Zito said UnitedHealthcare is proposing a new definition of “accident.” The Subgroup discussed issues related to “intentional” and/or “self-inflicted” accidents and the definition of “injury.” After additional discussion, the Subgroup deferred making a decision on UnitedHealthcare’s suggested revision.

The Subgroup next discussed Section 5G, which defines the term “mental or nervous disorder.” Ms. Mealer said the Missouri DOI’s suggested revision to Section 5G updates the definition to reflect current terminology. Mr. Petersen asked if the Missouri DOI’s language is consistent with how the term is used and defined in recent NAIC models. Ms. Matthews said she would review the NAIC models for consistency. The Subgroup agreed to accept the Missouri DOI’s suggested revision to Section 5G subject to any changes NAIC staff may make for consistency with similar language and definitions used in recent NAIC models.

The Subgroup next discussed Section 5H, which defines the term “nurse.” Ms. Lueck said the NAIC consumer representatives suggest revising Section 5H to include a reference to “advance practice nurse.” She said this additional language is consistent with current terminology. The Subgroup agreed to accept the suggested revision.
The Subgroup next discussed Section 5I, which defines the term “one period of confinement.” Ms. Mealer said the Missouri DOI suggests deleting the term because it is not used in the proposed revised model. Ms. Matthews said she did a search and found the term is no longer used because provisions in the model using the term are to be deleted. Mr. Petersen said if this term is used in policies, it should not be deleted. After discussion, the Subgroup agreed to retain the term. The Subgroup discussed whether it is appropriate for the definition to use the word “means” instead of the language used in other definitions in Section 5, such as “may be defined” or “shall be defined.” After additional discussion, the Subgroup requested NAIC staff to review the legislative history for the terms in Section 5 to determine if the drafters had any specific intent for the differing language. Ms. Domzalski-Hansen said she would also survey the Subgroup members prior to the Subgroup’s Nov. 4 conference call to see if the Subgroup members had specific suggestions to address this issue.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Oct. 7, 2019. The following Subgroup members participated: Glen Mulready, Co-Chair (OK); Melinda Domzalski-Hansen, Co-Chair (MN); Eric Unger (CO); Chris Struk (FL); Jeff Zewe (LA); Robert Wake (ME); Mary Mealer and Molly White (MO); Gayle Woods (OR); Katie Dzurec and Michael Humphreys (PA); Kendall Buchanan (SC); Jakob Sundberg and Heidi Clausen (UT); Anna Van Fleet (VT); Andrea Philhower (WA); and Julie Walsh (WI).

1. Continued Discussion of the July 30 Comments on Model #171, Sections 1–5

Ms. Domzalski-Hansen said the purpose of today’s conference call is for the Subgroup to continue its discussion section-by-section of the comments received by the July 30 public comment deadline on Sections 1–5 of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). She said prior to the Subgroup continuing those discussions, as discussed during the Subgroup’s Sept. 16 conference call, she developed the following language for the Subgroup’s review for revising Section 5A—Policy Definitions: “A. A supplementary health insurance policy; a short-term health insurance policy; a limited scope dental insurance policy; or a limited scope vision insurance policy delivered or issued for delivery to any person in this state shall contain definitions respecting the matters set forth below that comply with the requirements of this section, if the policy contains one of the terms or definitions below.”

Ms. White suggested revising the suggested language to state “one of the terms and/or definitions below.” Barbara Klever (Blue Cross and Blue Shield Association—BCBSA) suggested adding the word “certificate” with respect to a short-term health insurance policy in order to ensure it applies to association coverage. The Subgroup discussed whether it was appropriate to add “certificate” given Section 5’s scope and the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170). After additional discussion, the Subgroup decided to defer making a decision until it discusses the substantive sections in Model #171.

The Subgroup next discussed whether to delete Section 5C, which defines “disability” or “disabled.” Ms. Domzalski-Hansen reminded the Subgroup that during its Sept. 16 conference call, the Subgroup discussed the Washington Department of Insurance’s (DOI) suggestion to delete Section 5C but deferred making a decision until NAIC staff could research why the definition was added. She explained that NAIC staff found that this definition is derived from the Interstate Insurance Product Regulation Commission’s (Compact) disability income standards, but the definition in Section 5C does not match the Compact’s definition for the term. She said the Subgroup has at least two options: 1) delete the definition for the term; or 2) revise it to match the Compact’s definition for the term. The Subgroup discussed the options. After additional discussion, the Subgroup decided to defer making a decision until it discusses the substantive sections in Model #171.

The Subgroup next discussed the comments received on Section 5D, which defines “hospital.” Ms. Domzalski-Hansen said America’s Health Insurance Plans (AHIP), the Missouri DOI and the NAIC consumer representatives submitted comments on Section 5D. Chris Petersen (Arbor Strategies LLC), representing AHIP, said AHIP suggests adding “facilities existing primarily to provide psychiatric services” to Section 5D(2) because these types of facilities are not hospitals. Some Subgroup members expressed concern with adding the suggested language.

The Subgroup discussed the Missouri DOI’s suggested revisions to Section 5D(2). Ms. White said the Missouri DOI’s suggested revisions are meant to clarify the language. After discussion, the Subgroup agreed to accept the Missouri DOI’s suggested revisions. The Subgroup discussed whether it could accept AHIP’s suggested language because it accepted the Missouri DOI’s suggested revisions. The Subgroup deferred making a decision on AHIP’s suggested language. Sarah Lueck (Center on Budget and Policy Priorities—CBPP) discussed the NAIC consumer representatives’ comments, which suggests the Subgroup consider revising Section 5D(2)(b) and deleting Section 5D(2)(c) to remove obsolete language. The Subgroup deferred discussion of the NAIC consumer representatives’ suggested revisions until its next conference call on Oct. 28.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup met via conference call Sept. 16, 2019. The following Subgroup members participated: Glen Mulready, Co-Chair, and Tyler Laughlin (OK); Melinda Domzalski-Hansen, Co-Chair (MN); Mary Grover (CO); Chris Struk and Shannon Doheny (FL); Frank Opelka (LA); Robert Wake (ME); Mary Mealer (MO); Martin Swanson and Laura Arp (NE); Gayle Woods (OR); Michael Humphreys (PA); Kendall Buchanan (SC); Tanji Northrup (UT); Anna Van Fleet (VT); Michael Bryant (WA); and Nathan Houdek (WI).

1. Discussed July 30 Comments on Model #171, Sections 1–5

Ms. Domzalski-Hansen said the purpose of today’s conference call is for the Subgroup to begin its review of and discuss section-by-section the comments received by the July 30 public comment deadline on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171). She said no comments were received on Model #171’s title or its table of contents.

Ms. Domzalski-Hansen said the Missouri Department of Insurance (DOI) submitted comments on Section 1—Purpose suggesting adding the word “renewal.” Ms. Mealer said the Missouri DOI suggests adding this word because the model’s provisions should apply to renewals, as well as the initial purchase. Ms. Domzalski-Hansen suggested also adding the word “continuation” because in some situations, the coverage may not be “renewed” but “continued.” Chris Petersen (Arbor Strategies LLC), representing America’s Health Insurance Plans (AHIP), said the word “purchase” is interpreted to include “sale and renewal.” The Subgroup discussed whether to add these references and at the end of the discussion, it decided to add the language “renewal and continuation.”

No comments were received on Section 2—Authority.

Ms. Domzalski-Hansen said the Missouri Department of Insurance (DOI) submitted comments on Section 3A—Applicability and Scope. Jeremy Crandall (BCBSA) said the BCBSA suggests revising Section 3A to include the language “regardless of the situs of the delivery of the contract” to ensure it is clear Model #171 applies to short-term, limited-duration coverage issued through out-of-state group trusts or associations and is consistent with the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (formerly the Accident and Sickness Insurance Minimum Standards Model Act) (#170). After discussion, the Subgroup agreed to accept the BCBSA’s suggested revisions.

Ms. Mealer said the Missouri DOI suggests deleting the word “also” in its comments on Section 3A because the word is unnecessary. The Subgroup agreed to accept the suggested revision. Mr. Bryant said the Washington DOI suggests adding the word “supplementary” to the term “hospital indemnity or other fixed indemnity” because Model #171 does not apply to all hospital indemnity plans, such as comprehensive hospital indemnity plans. Mr. Petersen said that based on the revisions to Model #170, Model #171 has been restructured to apply to supplementary plans. He said that in addition, Model #170 does not define “supplementary hospital indemnity.” After discussion, Mr. Bryant withdrew the Washington DOI’s comment.

The Subgroup next discussed the Missouri DOI’s suggested revision to Section 3B to delete the words “shall apply” and replace it with “applies.” Ms. Mealer said the Missouri DOI’s suggested revision is clarifying. The Subgroup agreed to accept the suggested revision. No comments were received on Section 3C or Section 3D.

No comments were received on Section 4—Effective Date.

The Subgroup next discussed the comments received on Section 5A—Policy Definitions. Mr. Crandall said the BCBSA’s suggested revisions to Section 5A are intended to track the definition of “short-term, limited-duration health insurance” in Model #170. Ms. Mealer said the Missouri DOI’s suggested revisions are meant to reduce redundancy and provide precision and consistency. The Subgroup discussed the suggested revisions, including whether to use the word “policy” or “coverage.” Mr. Petersen said the Subgroup will have to decide what terminology to use throughout Model #171 to refer to these plans. The Subgroup also discussed whether it was appropriate to add the word “certificate.” Mr. Laughlin pointed out that “policy” is...
defined in Model #170. He suggested merging the BCBSA and the Missouri DOI suggested revisions. Ms. Domzalski-Hansen said she would develop language for the Subgroup to discuss during its next conference call Oct. 7.

The Subgroup next discussed the comments received on Section 5B. Ms. Mealer said the Missouri DOI’s comments to Section 5B(2) are intended to be clarifying. The Subgroup agreed. Sarah Lueck (Center on Budget and Policy Priorities—CBPP) discussed the NAIC consumer representatives’ comments. She explained that the suggested revisions update the language by deleting and revising outdated terminology. Jolie Matthews (NAIC) asked if the suggested revision to delete the language “drug addicts and alcoholics” and replace it with “individuals with a substance-related disorder” is correct. She suggested that the language should be “substance use disorder.” After discussion, the Subgroup agreed to accept the NAIC consumer representatives’ suggested revisions to Section 5B except for the language “substance-related disorder.” The Subgroup agreed that this should be “substance use disorder.” The Subgroup also agreed to allow NAIC staff to update any obsolete, outdated language throughout Model #171.

The Subgroup next discussed the Washington DOI’s suggestion to delete Section 5C, which defines “disability” or “disabled.” Mr. Bryant said the Washington DOI suggests Section 5C is not necessary because Model #171 defines “partial disability,” “residual disability” and “total disability” with respect to the inability to work. The way “disability” or “disabled” is defined in Section 5C is confusing because it is not defined with respect to the inability to work. Mr. Petersen expressed support for the Washington DOI’s comments. Mr. Laughlin suggested the Subgroup defer deleting Section 5C until it could determine why it was added. NAIC staff agreed to search the Subgroup’s 2016 minutes to find this information for discussion during the Subgroup’s Oct. 7 conference call.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The ERISA (B) Working Group of the Regulatory Framework (B) Task Force met in Austin, TX, Dec. 7, 2019. The following Working Group members participated: Robert Wake, Chair (ME); Ryan James (AR); Kate Harris (CO); Howard Liebers (DC); Andria Seip (IA); Craig Van Aalst (KS); Frank Opelka (LA); Grace Arnold and Steve Kelley (MN); Angela Nelson (MO); Laura Arp and Martin Swanson (NE); Laura Miller (OH); Ron Kreiter (OK); Jill Kruger (SD); Doug Danzeiser (TX); Tanji Northrup (UT); Toni Hood (WA); and Richard Wicka (WI). Also participating were: Paige Duhamel (NM); Tashia Sizemore (OR); and Sarah Neil (RI).

1. **Adopted its Summer National Meeting Minutes**

Mr. Wicka made a motion, seconded by Ms. Kruger, to adopt the Working Group’s Aug. 3 minutes (see **NAIC Proceedings – Summer 2019, Regulatory Framework (B) Task Force, Attachment Four**). The motion passed unanimously.

2. **Discussed MEWAs and AHPs**

Mr. Wake asked for information on state activities regarding multiple employer welfare arrangements (MEWAs) and association health plans (AHPs) since the District Court for the District of Columbia issued its opinion in *New York v. U.S. Department of Labor*, vacating critical portions of the U.S. Department of Labor’s (DOL) final rule on AHPs. Mr. James said Arkansas has issued Rule 119, which establishes requirements for licensing and operations of self-funded MEWAs and explains registration requirements for fully insured MEWAs. He said the rule is scheduled to take effect next week. Ms. Seip said that Iowa has seen increased interest in forming MEWAs in Iowa and that there are two new MEWAs for 2020 and a handful of applications pending. Ms. Arp said that in Nebraska, there is a fully insured MEWA that formed, but it included self-employed individuals, so in order to be able to keep operating, it has reorganized to provide two consecutive term, short-term limited duration (STLD) plans, using an association product sold to individuals.

William F. Megna (MEWA Association of America—MAA) said his organization is holding its first annual meeting on Dec. 9 at the Hyatt Place Austin hotel in Austin, TX, to discuss the development of uniform standards for regulation and solvency protections for self-funded MEWAs. He said the MAA would like to work with state insurance regulators on these standards and that everyone is welcome to attend.

Justin Giovannelli (Georgetown Center for Health Insurance Reform—CHIR) has started to research federal oversight of MEWAs. He said CHIR made a Freedom of Information Act (FOIA) request to the U.S. Department of Labor (DOL) and has received several thousand pages of DOL investigative records regarding MEWAs, including AHPs. Information continues to be released and is available to the public at [http://chirblog.org/the-mewa-files/](http://chirblog.org/the-mewa-files/). Analysis of this information by CHIR is planned.

Amber Rivers (DOL Employee Benefits Security Administration—EBSA) explained that the DOL has recently undergone a reorganization. Ms. Rivers is currently the Acting Director of the Office of Health Plan Standards and Compliance Assistance, within EBSA, which is the position formerly occupied by Amy Turner, who is now the Deputy Assistant Secretary for Regional Office Operations within EBSA. Colleen McKee is the head of the Office of Health Investigations within the Office of Enforcement within EBSA. While there have been some internal changes, Ms. Rivers assured the Working Group that there should not be any discernable difference for the NAIC; the DOL continues to want to partner with the NAIC in areas of shared jurisdiction.

Having no further business, the ERISA (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals), and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.
The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Nov. 21, 2019. The following Subgroup members participated: Don Beatty, Chair (VA); Dayle Axman (CO); Toma Wilkerson (FL); Ryan Gillespie (IL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson (NE); Ron Pastuch (WA); Jennifer Stegall (WI); and Joylynn Fix (WV).

1. Discussed and Agreed Upon Recommendations for Revising Model #430

Mr. Beatty said that prior to the conference call, NAIC staff had distributed a cover memorandum (Attachment Nine-A) and Virginia’s revised recommendations for revising the Health Maintenance Organization Model Act (#430) for consistency with the revised Life and Health Insurance Guaranty Association Model Act (#520) (Attachment Nine-B). He discussed the recommendations, explaining that Virginia’s approach is to leave Model #430 unchanged because leaving it unchanged will provide the states that have not included health maintenance organizations (HMOs) as members under their life and health guaranty association’s statute, and those states that have not yet adopted the revised Model #520, with the guidance provided in the model they have come to rely on. He said those states that have adopted the revised Model #520 and currently have provisions in their laws or regulations based on Model #430 will have the guidance provided in the proposed drafting notes for the relevant sections in Model #430 in order for them to determine if they should amend their laws and regulations.

Mr. Wake explained that Maine’s approach (Attachment Nine-C) to revising Model #430 is substantially the same approach taken in Virginia’s revised recommendations. He said the main difference is that Maine’s approach is to revise Model #430 to reflect the states that have adopted the revised Model #520 rather than Virginia’s approach to leave Model #430 unchanged for those states that have not adopted the revised Model #520.

The Subgroup discussed the both recommendations. Chris Petersen (Arbor Strategies, LLC) expressed concern with the drafting note language in the Virginia Insurance Bureau’s recommendation to have the states consider repealing provisions in their laws or regulations concerning Section 19—Hold Harmless Provision Requirements for Covered Persons. He also expressed similar concerns about Section 14—Continuation of Benefits. He noted that he had submitted a comment letter previously to the Subgroup from a coalition of health insurers (Coalition)—Aetna, Anthem, Cigna, Health Care Service Corporation (HCSC) and UnitedHealthcare expressing those same concerns with weakening or eliminating these important consumer protections. He expressed support for Maine’s recommendations. Bonnie Burns (California Health Advocates) also expressed concern with repealing Section 19. Jeremy Crandall (Blue Cross and Blue Shield Association—BCBSA) also expressed support for Maine’s recommendations. Bob Ridgeway (America’s Health Insurance Plans—AHIP) noted that AHIP had submitted previous comments to the Subgroup suggesting the Subgroup take the approach to revising Model #430, as the Virginia Insurance Bureau’s revised recommendations reflect, because of the number of states that have adopted the revised Model #520. He expressed support for the Virginia Insurance Bureau’s revised recommendations and Maine’s suggested approach for revising Section 19.

The Subgroup discussed whether Section 19 should be deleted. After discussion, the Subgroup decided that Section 19 should be retained and that no drafting note revisions are needed.

Mr. Wake made a motion, seconded by Mr. Swanson, to have the Subgroup accept Maine’s recommendations for revising Model #430, except for the recommendations for Section 19. The motion passed unanimously.

Mr. Beatty said he anticipated the Subgroup holding its next conference call sometime after the Fall National Meeting to review an initial draft of revisions to Model #430 based on Maine’s recommendations.

Having no further business, the HMO Issues (B) Subgroup adjourned.
TO: Jolie H. Matthews  
Senior Health and Life Policy Counsel  
National Association of Insurance Commissioners

FROM: Virginia Bureau of Insurance

DATE: November 12, 2019

RE: HMO Issues (B) Subgroup  
Potential Revisions to the HMO Model Act #430

Upon review of the status of States’ adoption of the 2017 version of the Life and Health Insurance Guaranty Association Model Act (Model Act #520), the discussion during the HMO Issues (B) Subgroup’s September 16, 2019 conference call, and the comments received from America’s Health Insurance Plans (AHIP) and the National Organization of Life and Health Insurance Guaranty Associations regarding Virginia’s proposed revisions to the HMO Model Act (Model Act #430), we offer the following for consideration by the Subgroup.

We propose leaving the current requirements in the HMO Model Act as-is but recommend adding several Drafting Notes applicable to States that have adopted the Model Act #520 HMO requirements. Leaving the HMO Model Act as-is will provide States that may not include HMOs as member insurers under their Life and Health Insurance Guaranty Associations statute, and those States that have not yet adopted the 2017 Model Act revisions, with the guidance they have come to rely on. States that have adopted Model Act #520, and currently have provisions in their laws/regulations based on Model Act #430, will need to review the Sections of Model Act #430 that contain the new Drafting Notes to determine if they should amend their laws/regulations.

The Drafting Notes have been added to the following Sections:

Section 3 - Definitions:
- Subsection HH – “Uncovered Expenditures”

Section 14 – Continuation of Benefits
Section 19 – Hold Harmless Provision Requirements for Covered Persons
Section 20 – Uncovered Expenditures Deposit
Section 21 – Open Enrollment and Replacement Coverage in the Event of Insolvency

No changes have been proposed to:
- Section 5B(16) – Establishment of Health Maintenance Organizations
- Section 18 – Deposit Requirements
- Section 31 – Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations

Virginia’s Proposed Revisions to the
NAIC’s Health Maintenance Organization Model Act (#430)

Section 3. Definitions

A. “Adverse determination” means a determination by a health maintenance organization or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health maintenance organization’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.

B. “Basic health care services” includes the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment.

C. “Capitated basis” means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

D. “Coinsurance” means the percentage amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.

Drafting Note: States that do not allow HMOs to impose a coinsurance requirement should not adopt this definition nor include the term when it is referenced throughout the model.

E. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of health maintenance organizations lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

F. “Copayment” means a specified dollar amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.

G. “Covered benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.

H. “Covered person” means any person eligible to receive covered benefits under the terms of a health benefit plan.

I. “Deductible” means the amount a covered person is responsible to pay out-of-pocket before the health maintenance organization begins to pay the covered expenses associated with treatment.

J. “Enrollee” means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

K. “Evidence of coverage” means a statement that sets out the coverage and other rights to which the covered person is entitled under the health benefit plan and that may be issued by the health maintenance organization or by the group contract holder to an enrollee electronically or, upon request, in writing.

L. “Extension of benefits” means the continuation of coverage under a particular benefit provided under a contract following termination with respect to a covered person who is totally disabled on the date of termination.
M. “Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

N. “Grievance” means a written complaint submitted by or on behalf of a covered person regarding:

1. The availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

2. Claims payment, handling or reimbursement for health care services; or

3. Matters pertaining to the contractual relationship between a covered person and a health maintenance organization.

O. “Group contract” means a contract for health care services, which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

P. “Group contract holder” means a person, other than an individual, to which a group contract has been issued.

Q. “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

R. “Health care professional” means a physician or other health care practitioner license, accredited or certified to perform specified health services consistent with state law.

S. “Health care provider” or “provider” means a health care professional or facility.

T. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

U. “Health carrier” or “carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, managed care organization, health maintenance organization, a nonprofit hospital or medical service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

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

Drafting Note: The term “hospital or medical service corporation,” as used in the model act, is intended to apply to any nonprofit health, hospital or medical service corporation or similar organization. In order to include such organizations in this section, which are also commonly referred to as “Blue Cross Blue Shield-type” plans, each state should identify these organizations in accordance with its statutory terminology for such plans or by specific statutory citation. Some states also may have to amend other laws to bring these organizations within the scope of this section since the portions of state law applicable to these organizations may provide that no other portion of the insurance code applies to these organizations without a specific reference to the other provision.

V. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for a covered person’s responsibility for copayments, coinsurance or deductibles.

W. “Individual contract” means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the enrollee.

X. “Insolvent” or “insolvency” shall mean that the health maintenance organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.
Y. “Intermediary organization” means a person, other than an individual, authorized to negotiate and execute provider contracts with health maintenance organizations on behalf of a group of health care providers or on behalf of a network, but does not include a provider or group of providers negotiating on its own behalf.

Z. “Network” means the group of participating providers providing services to a health maintenance organization.

AA. “Net worth” means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

BB. “Participating provider” means a provider that, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than copayments, coinsurance or deductibles, from the health maintenance organization or other organization under contract with the health maintenance organization to provide payment in accordance with the terms of the contract.

CC. “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or a combination of the foregoing.

DD. “Policyholder” means, for individual contracts, the individual in whose name the contract is issued, and for group contracts, the group contract holder.

EE. “Qualified actuary” means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the commissioner may require.

FF. “Replacement coverage” means the benefits provided by a succeeding carrier.

GG. “Risk bearing entity” means an intermediary organization that is at financial risk for services provided through contractual assumption of the obligation for the delivery of specified health care services to covered persons of the health maintenance organization.

HH. “Uncovered expenditures” means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which a covered person may also be liable in the event of the health maintenance organization’s insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner.

Drafting Note: Subsection HH is not applicable to States that have adopted the 2017 version of the Life and Health Insurance Guaranty Association Model Act (#520), including the requirement that Health Maintenance Organizations be member insurers of the Life and Health Guaranty Association. States that have adopted the 2017 version of Model Act #520 and currently have provisions in their laws/regulations based on Subsection HH, should consider repealing/deleting such provisions.

Drafting Note: Subsection HH defines uncovered expenditures for use in Section 20. They will vary in type and amount, depending on the arrangements of the health maintenance organization. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the covered person even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.

II. “Utilization review” means a set of formal techniques utilized by or on behalf of the health maintenance organization designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Section 14. Continuation of Benefits

A. The commissioner shall require that each health maintenance organization have a plan for handling insolvency that provides for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to covered persons who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.
B. In considering such a plan, the commissioner may require:

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider, after the health maintenance organization’s insolvency, to provide covered services through the period for which premium has been paid to the health maintenance organization on behalf of the covered person or until the covered person’s discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency will continue until their confinement in an inpatient facility is no longer medically necessary;

(3) Insolvency reserves;

(4) Acceptable letters of credit; or

(5) Any other arrangements to assure that benefits are continued as specified above.

Drafting Note: In the event of an insolvency for States that have adopted the 2017 version of the Life and Health Insurance Guaranty Association Model Act (#520), including the requirement that Health Maintenance Organizations (HMO) be member insurers of the Life and Health Guaranty Association, benefits and coverages will be provided pursuant to [insert reference to state’s guaranty association statute based on Sections 2B and 8B(2) of the Model Act]. States that have adopted the 2017 version of Model Act #520 and currently have provisions in their laws/regulations based on Section 14, should consider repealing/deleting such provisions.

Section 19. Hold Harmless Provision Requirements for Covered Persons

A. Except for coinsurance, deductibles or copayments as specifically provided in the evidence of coverage, in no event, including but not limited to nonpayment by the health maintenance organization, insolvency of the health maintenance organization or breach of contract among the health maintenance organization, risk bearing entity or participating provider, shall a risk bearing entity or participating provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization) acting on behalf of the covered person to collect sums owed by the health maintenance organization.

B. All contracts among health maintenance organizations, risk bearing entities, and participating providers shall include a hold harmless provision specifying protection for covered persons. Any attempted waiver or amendment in a manner materially adverse to the interests of covered persons of a hold harmless provision shall be null and void and unenforceable.

C. The requirement of Subsection B shall be met by including a provision substantially similar to the following:

“Provider agrees that in no event, including but not limited to nonpayment by the health maintenance organization or intermediary organization, insolvency of the health maintenance organization or intermediary organization, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization or intermediary organization) acting on behalf of the covered person for covered services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, copayments or services in excess of limits, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons.”

D. (1) Any statement sent to a covered person shall clearly state the amounts billed to the health...
maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.

(2) All contracts among health maintenance organizations, risk bearing entities, and participating providers shall require that all statements sent to covered persons clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.

(3) The notice requirements in this subsection shall be met by including in the statement to covered persons a provision substantially similar the following:

NOTICE: YOU ARE NOT RESPONSIBLE FOR ANY AMOUNTS OWED BY YOUR HEALTH MAINTENANCE ORGANIZATION

E. Any violation of the provisions of this section shall constitute an unfair trade practice pursuant to [insert reference to state insurance fraud statute] and shall subject the health care provider to monetary penalties in accordance with [insert reference to state insurance fraud statute] and notification to the [insert reference to appropriate licensing entity for type of provider].

Drafting Note: For States that have adopted the 2017 version of the Life and Health Insurance Guaranty Association Model Act (#520), including the requirement that Health Maintenance Organizations (HMO) be member insurers of the Life and Health Guaranty Association, health care providers will be protected against loss due to an impairment or insolvency of an insurer (HMO) pursuant to Section 3B(1) of the Model Act. States that have adopted the 2017 version of Model Act #520 and currently have provisions in their laws/regulations based on Section 19, should consider repealing/deleting such provisions.

Drafting Note: States that do not authorize insurance departments to take action against providers should not adopt Subsection E and should consider other options such as contacting the state attorney general’s office or other appropriate state official.

Drafting Note: States with consumer protection acts that provide covered persons with a private right of action should consider including a reference in Subsection E.

Section 20. Uncovered Expenditures Deposit

A. If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, with an organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of 120 percent of the health maintenance organization’s outstanding liability for uncovered expenditures for covered persons in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

B. The deposit required under this section is in addition to the deposit required under Section 18 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.

C. (1) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:

(a) A substitute deposit of cash or securities of equal amount and value is made;

(b) The fair market value exceeds the amount of the required deposit; or
(c) The required deposit under Subsection A is reduced or eliminated.

(2) Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.

D. The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of covered persons of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

E. The commissioner may by regulation prescribe the time, manner and form for filing claims under Subsection D.

F. The commissioner may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports deemed necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

Drafting Note: Section 20 is not applicable to States that have adopted the 2017 version of the Life and Health Insurance Guaranty Association Model Act (#520), including the requirement that Health Maintenance Organizations be member insurers of the Life and Health Guaranty Association. States that have adopted the 2017 version of Model Act #520 and currently have provisions in their laws/regulations based on Section 20, should consider repealing/deleting such provisions.

Section 21. Open Enrollment and Replacement Coverage in the Event of Insolvency

A. Enrollment Period

(1) In the event of an insolvency of a health maintenance organization, upon order of the commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group’s last regular enrollment period shall offer the group’s enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(2) If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group covered persons of the insolvent health maintenance organization, then the commissioner shall allocate equitably the insolvent health maintenance organization’s group contracts for these groups among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization’s service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer the group or groups the health maintenance organization’s existing coverage that is most similar to each group’s coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization’s existing rating methodology and in accordance with state law.

(3) The commissioner shall also allocate equitably the insolvent health maintenance organization’s nongroup enrollees that are unable to obtain other coverage among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization’s service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall
offer the nongroup enrollees the health maintenance organization’s existing coverage for individual or conversion coverage as determined by the enrollee’s type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization’s existing rating methodology. Successor health maintenance organizations that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

B. Replacement Coverage

(1) “Discontinuance” shall mean the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.

(2) A health maintenance organization providing replacement coverage hospital, medical or surgical expense or service benefits within a period of sixty (60) days from the date of discontinuance of a prior health maintenance organization, shall immediately cover all covered persons who were validly covered under the previous health maintenance organization at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding health maintenance organization, regardless of any provisions of the contract relating to active employment, hospital confinement or pregnancy.

Drafting Note: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in the group market, a succeeding carrier, including a health maintenance organization, is prohibited from including any nonconfinement rules in its plan of benefits and any actively-at-work rules provided in the succeeding carrier’s plan of benefits must provide that absence from work due to any health status-related factor be treated as being actively-at-work.

(3) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier’s contract or policy, no provision in a succeeding health maintenance organization’s contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier’s contract shall be applied with respect to those covered persons validly covered under the prior carrier’s contract or policy on the date of discontinuance.

Drafting Note: Section 21 is not applicable to States that have adopted the 2017 version of the Life and Health Insurance Guaranty Association Model Act (#520), including the requirement that Health Maintenance Organizations be member insurers of the Life and Health Guaranty Association. States that have adopted the 2017 version of Model Act #520 and currently have provisions in their laws/regulations based on Section 21, should consider repealing/deleting such provisions.
Maine Comments on Revisions to HMO Model Act

November 18, 2019 (Corrected Version)

In August, the Virginia Bureau of Insurance proposed some revisions to the HMO Model Act (# 430) to bring it into conformance with the current version of the Life & Health Insurance Guaranty Association Model Act (# 520), which no longer excludes HMOs from the guaranty association. Comments on the proposed revisions pointed out that not all states have updated their guaranty find laws to include HMOs. In response, Virginia has proposed a new approach, which would leave the HMO Model Act unchanged but add drafting notes describing the revisions that would be necessary for those states that no longer exclude HMOs from guaranty association membership.

While we agree that the revisions to the Model need to recognize that at least at this time, adoption of the model guaranty fund amendments has not been uniform, we believe the current proposal sends an unfortunate message, by treating the previous exclusion of HMOs as the default and recognizing the inclusion of HMOs in the guaranty association as an optional alternative some states might choose. We believe it should be the other way around – the text of the HMO Model should conform to the current version of the Guaranty Association Model, and there should be drafting notes describing what states should do if they choose to retain the prior version.

Also, NOLHGA observed that the proposed replacement for Section 14 does not accurately describe the responsibilities of the guaranty association to provide replacement coverage. While policies would remain in place for a brief period of time after the date of insolvency, backed by the guaranty association, long-term replacement coverage will be available from any solvent insurance carrier through a “special enrollment period.” This is the case whether or not there is guaranty association coverage. In general, in states that have adopted the 2017 amendments to the Guaranty Association Model, insolvent HMOs are treated like any other insolvent insurance carrier under the guaranty association laws, the health insurance laws, and the receivership laws. Therefore, there is no longer any need for the HMO laws to include an insolvency plan section that is unique to HMOs, and Section 14 should simply be repealed, not replaced.

Accordingly, we recommend the following substitute:

I. Preserve the prior numbering for ease of reference.

II. Repeal Subsection 3(HH), which currently defines the term “uncovered expenditures.” Amend the drafting note that will now follow Subsection 3(GG) to read as follows:

Drafting Note: Sections 3(HH), 14 and 20 have been repealed to bring this Model Act into conformity with the Life and Health Insurance Guaranty Association Model Act (Model #520), which was amended in 2017 to make health maintenance organizations members of the guaranty association. States that continue to exclude health maintenance organizations from guaranty association membership should retain former Subsection HH, which defined the term “uncovered expenditures.” These are costs that could be the responsibility of consumers if a health maintenance organization became insolvent without guaranty association protection for use in Section 20. They will vary in type and amount, depending on the arrangements of the health maintenance organization. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the covered person even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.

III. Repeal Section 14, and replace it with the following drafting note:

Drafting Note: States that exclude health maintenance organizations from guaranty association membership should retain former Section 14, which required HMO-specific insolvency planning procedures to facilitate continuation of benefits after an insolvency.

IV. Consider amending the new drafting note after Section 19 to read as follows:

Drafting Note: Pursuant to Section 3B(1) of the Life and Health Insurance Guaranty Association Model Act (Model #520), both enrollees and health care providers will be protected against loss due to an impairment or insolvency of an insurer (HMO) a health maintenance organization, in states that have adopted the current version of Model #520.
This section has been retained because its primary purpose is no longer protecting consumers against insolvency, but protecting consumers against unfair billing practices. Many states now also require similar protections for consumers covered by other types of health carriers.

V. Repeal Section 20, and replace it with the following drafting note:

**Drafting Note:** States that exclude health maintenance organizations from guaranty association membership should retain former Section 20, which required health maintenance organizations to post uncovered expenditures insolvency deposits if their uncovered expenditures, as defined in former Section 3(HH), exceeded 10% of total health care expenditures.

VI. Repeal Section 21. No replacement drafting note is necessary, as open enrollment in replacement coverage is now governed by the ACA and state guaranteed-issue laws and is no longer an HMO-specific concern.
HMO Issues (B) Subgroup
Conference Call
September 16, 2019

The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Sept. 16, 2019. The following Subgroup members participated: Don Beatty, Chair, and Raquel Pino (VA); Dayle Axman (CO); Toma Wilkerson (FL); Eric Anderson (IL); Robert Wake (ME); Chlora Lindley-Myers and Mary Mealer (MO); Martin Swanson (NE); Ron Pastuch (WA); Nathan Houdek and Jennifer Stegall (WI); and Joylynn Fix (WV).

1. Exposed the Virginia Insurance Bureau’s Recommendations for Revising Model #430

Mr. Beatty said that prior to the conference call, NAIC staff had distributed a cover memorandum and the Virginia Insurance Bureau’s (Bureau) recommendations for revising the Health Maintenance Organization Model Act (#430) for consistency with the revised Life and Health Insurance Guaranty Association Model Act (#520). Ms. Pino went through the suggested recommendations. She said the Bureau recommends deleting the definition of “uncovered expenditures” in 3HH because if a health maintenance organization (HMO) is treated as an insurer in the event of an insolvency, then the insolvency protections in Model #430 related to this definition are no longer needed. Chris Petersen (Arbor Strategies LLC), representing a coalition of health insurers (Coalition), suggested the Subgroup defer specific discussion of this recommendation because of the open issue of whether Section 20—Uncovered Expenditures Deposit, where this defined term is used, should be deleted as the Bureau recommends. The Subgroup agreed.

Ms. Pino discussed Section 14—Continuation of Benefits. She said this section establishes a mechanism for providing continuation of benefits for enrollees in the event of an insolvency. She said such a provision would not be necessary because the guaranty association would be responsible for obtaining replacement coverage for an insolvent HMO’s enrollees. She said the Bureau recommends deleting Section 14’s current language and replacing it with language stating that the guaranty association would be responsible for continuation of benefits and coverages in the event of an insolvency. Mr. Petersen explained that in the Coalition’s comment letter, it suggests retaining Section 14 because it provides a significant consumer protection to ensure consumers can continue to receive health care services. He explained that Section 14 does not address who will pay for that care. Under Model #520, the guaranty association would assume responsibility for paying claims, and under Section 14, providers are required to continue to provide health care services to the insolvent HMO’s enrollees. The Subgroup discussed whether Section 14 should be retained and amended to clarify its provisions as continuation of benefits in the event of an insolvency requiring providers to continue to provide health care services to the insolvent HMO’s enrollees. After additional discussion, the Subgroup deferred making a decision.

Ms. Pino said the Bureau recommends retaining Section 19—Hold Harmless Provision Requirements for Covered Persons and adding a drafting note stating that health care providers are protected against losses due to insolvency or impairment of an HMO under Model #520. She said the Bureau recommends deleting Section 20—Uncovered Expenditures Deposit. She said the uncovered expenditures insolvency deposit authorized by Section 20 is in addition to the deposit required under Section 18—Deposit Requirements. She said that because HMOs are now members of the life and health insurance guaranty associations and subject to assessments of failed long-term care insurance (LTCI) insurers, this additional deposit does not appear to be necessary. Ms. Pino said the Bureau recommends deleting Section 21—Open Enrollment and Replacement Coverage in the Event of an Insolvency. She said Section 21 establishes a mechanism for providing replacement coverage for enrollees in the event of an insolvency, which is no longer needed because the guaranty association would be responsible for obtaining replacement coverage for an insolvent HMO’s enrollees.

Bob Ridgeway (America’s Health Insurance Plans—AHIP) said that approximately 26 states to date have adopted the revised Model #520 adding HMOs as members of the life and health insurance guaranty associations. He asked if the Subgroup is contemplating adding a drafting note to alert those states that have not adopted the revised Model #520 to not adopt the revisions to Model #430. Mr. Beatty said he does not believe such a drafting note is necessary or appropriate because he is not sure it is an issue.

The Subgroup exposed the Bureau’s recommendations for a public comment period ending Oct. 15.

Having no further business, the HMO Issues (B) Subgroup adjourned.
The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Oct. 3, 2019. The following Subgroup members participated: TK Keen, Chair, and Jesse O'Brien (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Chris Murray and Sarah Bailey (AK); William Rodgers (AL); Ryan James (AR); Lan Brown (CA); Andria Seip and Cynthia Banks Radke (IA); Vicki Schmidt (KS); Nancy G. Atkins and Patrick O'Connor (KY); Jeff Zewe (LA); Mary Kwei (MD); Chad Arnold (MI); Andrew Kleinendorst (MN); Chlora Lindley-Myers and Molly White (MO); Derek Oestreicher (MT); Gale Simon (NJ); Renee Blechner (NM); Michael Humphreys (PA); Rachel Jade-Rice (TN); Don Beatty (VA); Jennifer Kreitler (WA); Jennifer Stegall (WI); and Denise Burke (WY). Also participating were: Fleur McKendell (DE); and Robert Wake (ME).

1. **Heard a Presentation on the Kentucky PBM License Process**

Mr. Keen said that during the Subgroup’s August conference calls, it heard from several stakeholders. He said the purpose of this conference call is to hear from one of the last major stakeholders, the states: Arkansas, Kentucky, Montana, New Mexico and Oregon. He said following this conference call, he anticipates surveying the Subgroup members to determine the Subgroup’s next steps, particularly if the Subgroup should hear from additional stakeholders before beginning its work to develop an NAIC model regulating pharmacy benefit managers (PBMs).

Mr. O’Connor provided an overview of Kentucky’s PBM licensing process. He explained that during the 2016 legislative session, the Kentucky legislature passed Senate Bill 117 (S.B. 117), giving the Kentucky Department of Insurance (DOI) the authority to license PBMs; prior to the legislation’s passage, depending on their function, PBMs were licensed as third-party administrators (TPAs). He said S.B. 117 had two primary areas of concentration: 1) creating a framework for a separate PBM license in Kentucky with the Kentucky DOI and to subject PBMs to civil penalties; and 2) pharmacy reimbursement transparency requirements and reimbursement appeal process to the PBM and the Kentucky DOI. He said that in 2018, the Kentucky legislature passed S.B. 5, enhancing PBM reporting requirements and heightening penalties for PBM violations.

Mr. O’Connor said that due to the broad definition of PBM, the Kentucky DOI has licensed more entities than it originally anticipated. He said that for 2019, Kentucky has 45 active PBM licenses. He said that during the licensing process, the Kentucky DOI found that many PBMs did not have documented policies and procedures for provisions in the Kentucky law concerning the maximum allowable cost (MAC) appeals process and transparency requirements, which resulted in delays in the licensing process. He noted that the Kentucky DOI has had personnel expertise and resource challenges in implementing the PBM law.

Mr. Keen asked about staffing resources. Mr. O’Connor said the Kentucky DOI has two staffers. Mr. Murray asked about the number of MAC appeals the Kentucky DOI has received. Mr. O’Connor said during the law’s first year, it had no appeals, but since then, the Kentucky DOI has received approximately 3500 appeals. However, the number of appeals has decreased over time.

2. **Heard a Presentation on the Arkansas PBM Law**

Mr. James discussed the Arkansas PBM licensure law. He said the law was enacted in 2018 and is like the Kentucky licensing law. He said Arkansas currently licenses 17 PBMs. He said the law served as a guidepost for the National Council of Insurance Legislators’ (NCOIL) Pharmacy Benefits Manager Licensure and Regulation Model Act. He explained that provisions in the law related to MAC pricing were passed in 2015 but were immediately challenged and are currently on appeal. Mr. James discussed other provisions in the law, including its gag clause provisions. He said in the recently concluded 2019 legislative session, the Arkansas law was tweaked with respect to spread pricing and claw backs. He also said provisions related to MAC pricing were revised, making the National Average Drug Acquisition Cost (NADAC) the minimum floor reimbursement threshold instead of the MAC.

Mr. Ryan said that to implement the law, the Arkansas DOI established a new position, PBM coordinator, carved out from its legal division. He discussed the challenges the Arkansas DOI has encountered with respect to the MAC complaints. He also discussed possible future Arkansas legislation involving pharmacy services administrative organizations (PSAOs).
Ms. McKendell asked if the Arkansas DOI handled the MAC complaints or some other state agency. Mr. Ryan said the Arkansas DOI handles the complaints in-house. He said appeals related to the NADAC could be handled differently. Mr. Wake asked Mr. Ryan if he could provide a copy of the Arkansas PBM regulation with the Subgroup and interested state insurance regulators. Mr. Ryan said he would send a link to NAIC staff for distribution.

3. **Heard a Presentation on the Montana PBM law**

Mr. Oestreicher discussed the history, purpose and provisions of S.B. 71 to address issues related to PBMs, which passed in Montana but was ultimately vetoed. He noted that the National Academy for State Health Policy (NASHP) adopted S.B. 71 as model legislation, and Maine recently enacted legislation, L.D. 1504, which is based on S.B. 71.

Mr. Oestreicher said that before drafting S.B. 71, the Montana DOI considered two factors: 1) why prescription drug costs are so high; and 2) what state insurance departments can do to combat rising drug costs. He discussed the broken mechanisms in the prescription drug supply chain most likely contributing to high prescription drug costs. He said the Montana DOI considered different approaches to address the broken system, but ultimately, it decided to develop a bill using the DOI’s current regulatory authority over health insurers to address the issue. He said S.B. 71 comprised a list of best practices for insurers to include in their PBM contracts: 1) prohibit spread pricing; 2) require that all rebates be passed through the insurer; and 3) use rebate savings to directly lower premiums. He also discussed continuing legal and regulatory actions against the Montana DOI. He said the Montana DOI anticipates re-introducing the legislation during Montana’s 2021 legislative session.

Mr. Keen asked if S.B. 71 would have required additional staffing resources. Mr. Oestreicher said the Montana DOI did not anticipate having to hire additional staff because S.B. 71 relied on its regulatory authority over health insurers to enforce its PBM-related requirements. He said the bill’s fiscal note was $600 for the cost of the Montana DOI to promulgate rules. Ms. Seip asked about Maine’s law. Mr. Wake said the Maine law mirrors S.B. 71. Mr. Oestreicher pointed out that Maine’s law included a unique approach to spread pricing by permitting an insurer to allow spread pricing while requiring the insurer to account for the “spread” as an administrative cost for the purposes of the federal Affordable Care Act’s (ACA) medical loss ratio (MLR).

4. **Heard a Presentation on the New Mexico PBM Legislation**

Ms. Blechner discussed PBM legislation in New Mexico. She said legislation enacted in 2014 required minimum information from PBMs, but in 2019, legislation was enacted amending the law to allow the New Mexico DOI to establish PBM licensing requirements by regulation. She said PSAOs are required to register with the New Mexico DOI.

Ms. Blechner discussed the reimbursement provisions in New Mexico’s law, which includes provisions: 1) requiring objective and verifiable resources for drug pricing; 2) requiring the disclosure of derivative sources for formulating MAC prices for a particular provider on request; 3) prohibiting a PBM from paying a pharmacy less than it pays an affiliate; 4) allowing a pharmacy to appeal reimbursement disputes directly to the PBM or its PSAO; and 5) requiring PBMs to provide access to the MAC list to the New Mexico DOI and all network pharmacies.

Ms. Blechner discussed the provisions in New Mexico’s law involving contracts between pharmacies and PBMs. She said the New Mexico law prohibits PBMs from recouping monies, known as “claw backs,” from pharmacies as a result of low sales of certain drugs or patient noncompliance. She said the law also prohibits gag orders on pharmacists informing patients about lower cost options.

5. **Heard a Presentation on the Oregon Law**

Mr. O’Brien discussed PBM regulation in Oregon. He said Oregon enacted legislation in 2013 requiring PBMs to register. The legislation set a $50 registration fee and included restrictions on pharmacy audits and MAC pricing and appeals. He said the legislation was problematic due to its low registration fee and unclear enforcement mechanisms.

Mr. O’Brien said in 2017, the legislature passed legislation to address some of the issues with the 2013 law. He said the legislation: 1) allowed the Department of Financial Regulation (DFR) to set an annual registration fee by rule; 2) empowered the DFR to revoke or suspend a registration for misconduct; and 3) established a complaints process. During Oregon’s 2019 legislative session, the legislature enacted additional PBM-related legislation that: 1) prohibits gag clauses; 2) prohibits PBMs from requiring consumers to use mail-order; 3) strengthens existing MAC pricing requirements; and 4) establishes stronger rulemaking authority for the DFR. Mr. O’Brien said the DFR is currently working on promulgating rules but anticipates the
rules will focus on defining key terms, such as “specialty drug/pharmacy,” “ancillary service” and “generally available to purchase.” He said currently, there are 52 PBMs registered in Oregon.

Mr. O’Brien also discussed Oregon’s Prescription Drug Price Transparency program (Program). He explained that in 2018, the Oregon legislature passed House Bill 4005 (H.B. 4005) to increase prescription drug price transparency. The Program’s goal is to provide accountability for prescription drug pricing through transparency of specific cost and price information from pharmaceutical manufacturers and health insurers. Mr. O’Brien said Oregon’s next steps could include efforts to increase PBM transparency.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.
Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Conference Call
August 29, 2019

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via
conference call Aug. 29, 2019. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson and
Laura Arp, Vice Chairs (NE); Sarah Bailey and Jacob Lauten (AK); William Rodgers and Anthony L. Williams (AL); Marjorie
Farmer (AR); Bruce Hinze (CA); Howard Liebers (DC); Cynthia Banks Radke and Johanna Nagel (IA); Vicki Schmidt (KS);
John Melvin (KY); Jeff Zewe (LA); Mary Kwet (MD); Chad Arnold (MI); Andrew Kleinendorst (MN); Mary Mealer and
Molly White (MO); Derek Oestreicher (MT); Gale Simon (NJ); Renee Blechner (NM); Katie Dzurec, Karen M. Feather and
Sandra L. Ykema (PA); Vicki Trice (TN); Eric Lowe (VA); Ron Pastuch (WA); Nathan Houdek and Jennifer Stegall (WI);
Joylynn Fix and Ellen Potter (WV); and Denise Burke (WY). Also participating was: Matthew Veno (MA).

1. Heard a Presentation on Managing Prescription Drug Benefits from the PCMA and Horizon Government Affairs

April Alexander (Pharmaceutical Care Management Association—PCMA) and J.P. Wieske (Horizon Government Affairs)
discussed the history, role, and services that pharmacy benefit managers (PBMs) provide in managing prescription drug benefits.
Ms. Alexander discussed how payer strategies regarding prescription drug benefits evolved over time, increasing the role PBMs
play in the provision of prescription drug benefits by plans. She noted, however, that no plan is required to use a PBM. She
provided a snapshot of the current PBM marketplace, explaining that competition in the PBM marketplace is strong. She said
there are 66 PBMs in the U.S. Ms. Alexander acknowledged that, currently, three PBMs cover 75% of the marketplace, but she
said this is changing due to market consolidation, vertical integration and new market entrants. She said that PBMs’ net profit
is the lowest among those entities in the prescription drug supply chain.

Ms. Alexander discussed the services PBMs provide, including services that save plans money. She said PBMs provide other
important services unrelated to cost savings, such as drug utilization review programs and programs to address opioid use
issues.

Ms. Alexander discussed the contracting process between PBMs and plans. She explained that as part of the contracting process,
PBMs offer various plan design models depending on a plan’s specific needs. She said plan sponsors always have the final say
when creating a prescription drug benefit plan. The PBM does not determine benefit design, cost sharing levels, deductibles or
other benefit design elements. The PBM is agnostic with respect to such decisions.

Ms. Alexander provided an example of a “negative” spread where the PBM can lose money on a drug or class of drugs using
spread pricing. Mr. Wieske described spread pricing as a way a PBM hedges its risk in its contract with a plan.

Ms. Alexander discussed how PBMs drive savings and quality by using their ability to bring volume to drug manufacturers
and the use of rebates. Mr. Wieske discussed how rebates help reduce premiums and cost-sharing and how the revenue is
included in the medical loss ratio (MLR) calculation and reported in a plan’s MLR filing.

Ms. Alexander discussed how pharmacy networks developed by PBMs play a role in driving savings and quality. She described
PBMs’ contracting process with a variety of pharmacies, typically through pharmacy services administrative organizations
(PSAOs), to ensure a robust network for plan enrollees to access. She noted that PBMs have no insight into private contract
terms between PSAOs and pharmacies.

Mr. Wieske discussed the NAIC’s work to date related to PBMs and prescription drug benefits. He highlighted the provisions
in the Health Carrier Prescription Drug Benefit Management Model Act (#22). He explained that the focus of the NAIC’s
work on Model #22 was on the consumer, not PBMs. He said that Model #22 regulates entities such as PBMs through a plan’s
contract with the entity and does not directly regulate these entities. He said the Subgroup should look at Model #22’s provisions
to decide its next steps.

Ms. Alexander described a world without PBMs. She said that without PBMs to manage the prescription drug benefit, plans
would most likely incur 40% to 50% more in costs for a variety of reasons, including lack of competition between drug
manufacturers, less efficient claims processing and less utilization of generic drugs.
Commissioner Schmidt asked about Ms. Alexander’s example illustrating “negative” spread. She questioned whether PBMs actually reimburse pharmacies based on the National Average Drug Acquisition Cost (NADAC) price as shown in the example. Ms. Alexander said the NADAC price is used as a proxy. She said this same data is used to show “positive” spread. Commissioner Schmidt suggested Ms. Alexander provide the Subgroup with the complete report, which includes this table. Ms. Alexander agreed to provide the information.

2. Heard a Presentation on the Community Pharmacy Industry Perspective Regarding PBMs and Managing Prescription Drug Benefits from the NCPA

Anne Cassity (National Community Pharmacists Association—NCPA) and Matthew Magner (NCPA) discussed the community pharmacy industry’s perspective regarding PBMs and managing prescription drug benefits. Ms. Cassity provided a profile of community pharmacists. She said 80% of community pharmacists are located in areas with populations of less than 50,000. She described the types of services that full-line, independent community pharmacists provide, such as medication therapy management; same-day, in-person delivery; immunizations; and blood pressure monitoring. Ms. Cassity explained that when the medication is covered by insurance, the consumer’s price for a drug is set by the PBM, not the pharmacy. If it is a cash transaction, then the pharmacy sets the price. Ms. Cassity said what community pharmacies charge consumers and are reimbursed is often determined by a competitor. She explained that PBMs own or are affiliated with competing retail, mail-order and/or specialty pharmacies. PBMs often require or incentivize consumers to use the PBM-owned pharmacy.

Ms. Cassity discussed how the lack of PBM oversight and regulation has had a negative impact on community pharmacies. She highlighted how this situation affects community pharmacies particularly in contracting with PBMs. She discussed how PBM steering to PBM-owned retail, mail-order and specialty pharmacies have caused consumers to lose access to trusted pharmacy providers. Between 2003 and 2018, 1,231 independent pharmacies closed in rural areas.

Mr. Magner discussed how PBMs have affected patient and payer costs. He said PBMs have no fiduciary duty to anyone but their shareholders. He said this results in a lack of accountability. He suggested the following solutions to address this issue: 1) reimbursement transparency; 2) accountability through licensure; and 3) ensuring patient access through anti-mandatory mail-order provisions, network adequacy requirements and limits on conflicts of interest.

Ms. White asked Mr. Magner about his comments concerning PBMs moving away from maximum allowable cost (MAC) lists towards generic effective rate reimbursement methodologies with respect to states enacting reimbursement transparency laws as a solution to PBMs’ lack of accountability. Mr. Magner said he made the comment to alert states that may be thinking of enacting such reimbursement transparency laws to not make the law too narrow. He said Arkansas and Maryland recently revised their laws to address this issue.

Mr. Veno asked Mr. Magner if the community pharmacy has a direct relationship with the PBM through the pharmacy’s contract with the PSAO. Mr. Magner said the community pharmacy would only have a direct relationship with the PBM if it contracted directly with the PBM. Mr. Veno questioned why PSAOs must “take it” or “leave it” with respect to the contract with the PBM if 80% of community pharmacies contract with PSAOs, which in turn contract with PBMs. Mr. Magner said because of antitrust laws, PSAOs may not decline a contract on behalf of a pharmacy. Mr. Veno questioned the value to community pharmacies of contracting with PSAOs because of this situation.

3. Heard a Presentation on the Consumer Perspective of PBMs from Families USA

Claire McAndrew (Families USA) discussed the effect of PBMs and prescription drug costs on consumers. She said consumers are struggling with high prescription drug costs. She discussed how consumers have dealt with this by not taking a medicine as prescribed or declining other medical tests or procedures or delaying doctors’ visits. Ms. McAndrew suggested that the entire drug supply chain has contributed to this rise in prescription drug costs. She discussed some state mechanisms for addressing prescription drug costs, such as price transparency, PBM regulations, anti-price gouging and drug importation.

Ms. McAndrew said PBMs present concerns for consumers due to their: 1) lack of transparency in pricing and the effect of rebates on prescription drug costs; 2) lack of accountability; 3) incentives to select high-cost drugs; and 4) potential to lead to higher prescription drug costs at the pharmacy counter for consumers with insurance. She discussed ways these concerns can be addressed, such as PBM registration and imposing a fiduciary duty on PBMs to plans.
4. **Heard a Presentation on PBMs and their Impact on Access and Affordability from the NASTAD**

Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) discussed PBMs and their impact on consumer access and affordability of prescription drugs. Ms. Killelea said PBMs play an outsized role in prescription drug access due to their involvement in formulary development, utilization management and pharmacy network design. She said the NAIC’s work on Model #22 and the *Health Benefit Plan Network Access and Adequacy Model Act* (#74) addressed some of these activities, but not all.

Ms. Killelea discussed how the lack of transparency regarding prescription drugs costs and the impact of rebates on these costs have affected consumers. She said that with respect to affordability, PBMs play a significant role in the ultimate prescription drug cost passed on to the consumer. She said rebates generated are generally used to defray premiums, but not used to reduce consumer prescription drug cost-sharing. She discussed how plan copay accumulator policies put the consumer in the middle between the plan and the drug manufacturer and how such policies are not a substitute for sound prescription drug pricing reforms.

Ms. Killelea outlined certain considerations for the Subgroup as it works to complete its charge, which included:
1) strengthening and reinforcing the applicability of relevant formulary and access protections included in Model #22;
2) strengthening conflict of interest standards to ensure that formulary and access decisions are based on clinical justifications and not PBM self-dealing;
3) reviewing network adequacy standards in Model #74 and ensuring that pharmacy network nuances are addressed;
4) developing transparency standards for PBM practices; and
5) ensuring rebates are used to defray consumer prescription drug cost-sharing, not just to defray premiums.

Mr. Keen said he anticipates the Subgroup meeting via conference call sometime in September to hear from the states on their work related to PBMs.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.
The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Aug. 22, 2019. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Chris Murray and Sarah Bailey (AK); Jerry Workman and Anthony L. Williams (AL); Ryan James (AR); Bruce Hinze (CA); Andria Seip (IA); Vicki Schmidt (KS); Patrick O’Connor (KY); Jeff Zewe (LA); Mary Kwei (MD); Joseph Stoddard (MI); Melinda Domzalski-Hansen and Krisi Bohn (MN); Molly White (MO); Marilyn Bartlett (MT); Gale Simon (NJ); Renee Blechner (NM); Katie Dzurec, Karen M. Feather and Sandra L. Ykema (PA); Michael Humphreys (TN); Don Beatty and Yolanda Tennyson (VA); Jennifer Kreitler (WA); Nathan Houdek and Jennifer Stegall (WI); and Joylynn Fix and Ellen Potter (WV). Also participating were: Matthew Veno (MA); and Jesse O’Brien (OR).

1. **Heard a Presentation on PBM Economics from the University of Southern California**

Neeraj Sood (Sol Price School of Public Policy, University of Southern California) discussed the role pharmacy benefit managers (PBMs) play in the pharmaceutical supply chain. He described the flow of services and the PBM’s relationship with other supply chain participants. He said PBMs are true middlemen; they play no role in the physical distribution of prescription drugs to consumers. Dr. Sood also discussed how PBMs make money describing how rebates and spread pricing play a role in PBM income.

Dr. Sood discussed how the PBM market functions and how rebates can create misaligned incentives for the PBM in choosing certain drugs for a health plan’s formulary, potentially resulting in higher premium and increased costs for consumers. He also discussed how the lack of competition in the supply chain and a consolidated PBM market also play a role in costs. Dr. Sood discussed how the new wave of vertical consolidation in the supply chain might further curtail competition and how it could result in misaligned incentives for the PBM. He provided two examples of such misaligned incentives when: 1) a PBM owns a pharmacy; and 2) a PBM owns a health plan. He also noted the high barriers to entry for new entrants in the drug supply chain.

Dr. Sood presented potential policy solutions to address issues he discussed in the drug supply chain. He recommended the following: 1) improve drug price transparency throughout the supply chain; 2) move from a rebate system to a discounts model; 3) mandate pass-through of rebate to consumers; 4) outlaw unfair business practices of PBMs; and 5) reduce barriers to entry in the PBM market.

Ms. Arp asked if vertical integration could address the misaligned incentive with respect to rebates. Dr. Sood agreed that vertical integration could address some of those issues, but he pointed out the issues with vertical integration.

Ms. White asked about drug pricing. Dr. Sood explained that market dynamics hinder lower drug prices. He said drug manufacturers typically set high drug prices to maximize profit for their shareholders, but not to limit consumer access to those drugs. He said that to address this, the pricing model needs to be changed.

Mr. O’Brien asked if spread pricing in the situation where a PBM contracts with a health plan to pay a set price for a drug benefits the health plan. Dr. Sood explained how in some scenarios, such a contract would not benefit the health plan even if the plan’s risk is limited due to the set drug price.

Mr. Veno asked Dr. Sood why he recommends limiting the use of spread pricing and rebates instead of prohibiting their use to address issues in the drug supply chain. Dr. Sood said PBMs are providing a service and need to make money for providing that service in some way. He said that if a state prohibits PBMs from using rebates or spread pricing to make money, then PBMs could receive payment by charging administrative fees. Dr. Sood said, however, that he does not have strong feelings on which approach policy makers should take to address these issues. Ms. Seip said the federal Affordable Care Act (ACA) requires health plans to maintain a certain medical loss ratio (MLR) to help to ensure that plans are providing value to enrollees. She asked if Dr. Sood thinks a similar requirement would work for PBMs. Dr. Sood said it is possible that an MLR requirement could provide similar benefits. He said the challenge would be making sure PBMs do not circumvent the requirement.
2. **Heard a Presentation on Prescription Drug Costs from PhRMA**

Saiza Elayda (Pharmaceutical Research and Manufacturers of America—PhRMA) described the evolution of medicine over time from medicines made of chemical compounds to medicines made from living cells. She discussed the biopharmaceutical research and development process, explaining that from drug discovery through U.S. Food and Drug Administration (FDA) approval, developing a medicine on average takes 10 to 15 years. She said the competitive U.S. market provides patients with access to innovative medicines faster. She also said more medicines are available to U.S. patients than in other countries, such as the United Kingdom (UK), Canada and France.

Ms. Elayda explained how competition drives down costs. She also explained how medicine cost growth is declining, noting that after discounts and rebates, brand drug medicine costs grew just 0.3% in 2018. She said that spending on retail and physician-administered medicines continues to represent just 14% of U.S. health care spending. She said prescription drug spending is projected to grow in line with health care spending through the next decade, while growth in other health care services will be five times total medicine spending growth through the next decade.

Ms. Elayda discussed the pharmaceutical supply chain and how the pharmaceutical distribution and payment system shapes the prices of brand name medicines. She provided examples. She said the current system needs to evolve to better reward results and ensure patients more directly benefit from the significant price negotiations between PBMs and biopharmaceutical companies. Ms. Elayda discussed drug access and affordability. She said that when drug coverage is subjected to a large combined (medical and drug) deductible, on average, patients pay a higher share of their drug costs compared with their other health care services costs. She explained the impact of drug coupon use on patient out-of-pocket spending on brand name drugs.

Ms. Elayda discussed market-based reforms that could make medicines more affordable and accessible, which included: 1) modernizing the drug discovery and development process; 2) promoting value-driven health care; 3) empowering consumers; and 4) addressing market distortions. She provided three key takeaways from her presentation: 1) after accounting for discounts and rebates, brand name drugs average net price increased just 1.9% in 2017; 2) in 2016, biopharmaceutical companies paid out $127 billion in rebates and discounts to government and private payers, but these rebates and discounts were typically not shared with patients at the pharmacy counter; and 3) 90% of all prescriptions filled in 2016 were generics, with projections that $140 billion of U.S. brand name drug sales will face competition from generics of biosimilars between 2017 and 2021. There is no similar type of cost containment for other health care services.

Mr. Swanson asked Ms. Elayda about the price increases for insulin over the past few years. He asked who controls such cost increases—the drug manufacturer or the PBM. Ms. Elayda said that PhRMA, as a trade association, does not have insight on this issue. She discussed factors drug manufacturers consider in making drug pricing decisions. Mr. Swanson asked if PhRMA could support an MLR requirement. Ms. Elayda said it is something PhRMA would take under consideration. She explained that PhRMA, as a trade association of drug researchers and developers, asks its members to return a majority of its profits back into research and development.

Commissioner Schmidt asked Ms. Elayda if she had a breakdown of the $140 billion brand name drug sales amount she referenced in her presentation. Ms. Elayda said she did not currently have the information but would follow up.

Mr. Keen said that if anyone had additional questions for the presenters, send them to NAIC staff.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.
The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Aug. 15, 2019. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Chris Murray (AK); Yada Horace, Steve Ostlund and William Rodgers (AL); Ryan James (AR); Bruce Hinze (CA); Johanna Nagel and Andria Seip (IA); Vicki Schmidt (KS); Nancy G. Atkins and Patrick O’Connor (KY); Jeff Zewe (LA); Mary Kwei (MD); Chad Arnold (MI); Melinda Domzalski-Hansen and Krisi Bohn (MN); Chlora Lindley-Myers, Mary Mealer, Amy Hoyt and Molly White (MO); Derek Oestreicher and Marilyn Bartlett (MT); Gale Simon (NJ); Renee Blechner (NM); Michael Humphreys, Lorrie Brouse and Rachel Jade-Rice (TN); Eric Lowe and Yolanda Tennyson (VA); Jennifer Kreitler (WA); Nathan Houdek and Jennifer Steggall (WI); Joylynn Fix (WV); and Denise Burke (WY). Also participating were: Barbara D. Richardson (NV); and Marie Ganim (RI).

1. Heard Presentations

Mr. Keen said the purpose of the Subgroup’s conference call is to hear presentations from Jane Horvath (Horvath Health Policy and Research Faculty, Georgetown University) and Leanne Gassaway (America’s Health Insurance Plans—AHIP) concerning the pharmaceutical market and its regulatory framework and pharmacy benefit managers (PBMs) and their business practices.

   a. Horvath Presentation: “Basics of the Pharmaceutical Market & PBMs”

Ms. Horvath provided an overview of the regulatory and legal framework for the pharmaceutical industry. She explained the role of the U.S. Food and Drug Administration (FDA), the federal Centers for Medicare & Medicaid Services (CMS), and the states in regulating this industry. She provided a general overview of the basics of the product supply chain and the role pharmaceutical manufacturers, wholesalers, PBMs, insurers and pharmacies play in this supply chain. She explained the difference between prescription drug discounting and rebates. She noted that discounts are provided “up front” at the point of sale, and they are transparent. However, unlike discounts, rebates are not very transparent, and they occur after the sale of a product.

Ms. Horvath discussed stakeholder concerns with some PBM business practices, including concerns that these business practices: 1) disadvantage independent and regional pharmacy chains; 2) result in inappropriate patient pay and access policies; and 3) result in the lack of transparency to health plan clients. She discussed state responses to these concerns, including state legislative and regulatory activity. She pointed out trends in this activity resulting in more review of PBM business practices toward pharmacies, health plan clients, and enrollees. She discussed the increase in state legislation banning gag clauses.

Ms. Horvath discussed the different approaches the states have taken to regulate PBMs and their business practices, such as: 1) indirect regulation through the state insurance department’s existing regulatory authority over health insurers; 2) enacting specific PBM statutes regulating the contract between the pharmacies and health plans; and 3) requiring PBM licensure or registration. She discussed state policy approaches with respect to Medicaid and state employee health benefit plans to address PBM business practices concerning transparency and spread pricing. She discussed how the states have used reverse auctions to address rising prescription drug costs.

Ms. White asked Ms. Horvath about the timing of the reverse auctions with respect to the data given to PBMs to use in developing their bids. Ms. Horvath explained that a state would look at the data from previous years to determine which prescription drug classes and/or categories are the significant cost drivers. Then, the state would develop a request for proposals (RFP) using the reverse auction process. Mr. Keen asked about the diversity of formularies in the commercial market. Ms. Horvath said she does not believe there is great diversity, but there could be more diversity with respect to tiers.

   b. AHIP Presentation: “Pharmacy Benefit Managers Overview & Background”

Ms. Gassaway provided an overview of the prescription drug supply chain, and she discussed how insurers utilize PBMs and potential next steps for the Subgroup to consider related to its work in developing a new NAIC model regulating PBMs. Specifically, she discussed the supply flow and money flow for brand name drugs and generic drugs among the various entities in the supply chain, such as the drug manufacturers, wholesalers, PBMs, insurers and pharmacies. She discussed how rebates
play a role with respect to brand name drugs. She said insurers utilize PBMs to provide a variety of services, such as: 1) negotiating with drug manufacturers on price; 2) processing drug claims; 3) managing drug formularies; and 4) drug utilization review. She said insurers pay for these services in various ways: 1) administrative fees; 2) spread pricing; and 3) shared savings.

Ms. Gassaway discussed how drug rebates work as shared savings between the PBM and health benefit plan and how they work at the point of sale. She also discussed why AHIP does not believe rebates are the issue by pointing out that from the 300 million medications prescribed annually, 82% are generic and 18% are brand name. She also said only 2.4% of brand name drugs would be eligible for a point-of-sale rebate.

In discussing next steps, Ms. Gassaway said the Health Carrier Prescription Drug Benefit Management Model Act (#22) and the Health Benefit Plan Network Access and Adequacy Model Act (#74), taken together, establish a robust regulatory framework for the administration of prescription drug benefits. She outlined AHIP’s suggestions for regulating PBMs, including those provisions that should and should not be considered in any potential regulations and NAIC model.

Ms. Gassaway said she included two articles in her presentation related to issues relevant to the Subgroup’s discussions: 1) Milliman Analysis: Prescription Drug Rebates and Part D Drug Costs; and 2) Copay Coupons, Informational Explanation of How Drug Copay Coupons Work.

Mr. Oestreicher asked Ms. Gassaway for examples in which PBMs experienced net losses in arrangements involving spread pricing where the health plan pays the PBM a set price for a drug and the PBM pays the pharmacy more for the dispensed drug than the price set with the plan. Ms. Gassaway said because AHIP is an association, for legal reasons, it does not have this specific plan information. However, AHIP plan members have told Ms. Gassaway about their experiences and this scenario. Mr. Oestreicher said from his experience, particularly given the leverage PBMs have in contracting with affected parties, he was not sure how such a scenario would ever occur. April Alexander (Pharmaceutical Care Management Association—PCMA) said she believes there is data involving the Medicaid program where there are instances of both a positive and negative spread. She said she would provide this information to the Subgroup.

Mr. Keen asked Ms. Gassaway about the dollar numbers for the amount of money spent annually on brand name drugs versus generic drugs. Ms. Gassaway said she would provide the dollar numbers to the Subgroup, but she noted that specialty drugs and brand name drugs are driving the spending.

Mr. Swanson asked if AHIP has seen any difference in pricing to consumers in those states enacting legislation affecting PBM business practices. Ms. Gassaway said AHIP is beginning to gather data from its member plans related to spending, overall costs, dispensing fees, pharmacy participation and pharmacy networks. She said she believes it will take at least another six months before AHIP would be able to discern any trends and develop a report.

Mr. Oestreicher highlighted Montana’s experience with reducing prescription drug costs in its state employee health plan. He also mentioned Montana’s Senate Bill 71 (SB71), which was developed to address issues related to PBM business practices. SB71 passed, but it was ultimately vetoed. Mr. Oestreicher expressed his concern with information about SB71 that AHIP disseminated to state insurance regulators at the Summer National Meeting. He requested that the Subgroup allow him and Ms. Bartlett to provide a response to the AHIP information during a future Subgroup meeting. The Subgroup took Mr. Oestreicher’s request under advisement.

Ms. Seip asked Ms. Gassaway to clarify whether rebates were available only for brand name drugs. Ms. Gassaway confirmed that rebates are, for the most part, limited to brand name drugs. Ms. Seip asked about limiting the length of a drug manufacturer’s drug patent, extensions and evergreening that could have any impact on costs. Ms. Gassaway said there has been debate in the U.S. Congress (Congress) on this issue.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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SENIOR ISSUES (B) TASK FORCE

Senior Issues (B) Task Force Dec. 7, 2019, Minutes .......................................................... 7-173
Senior Issues (B) Task Force Oct. 16, 2019, Minutes (Attachment One) ........................................ 7-175
  Senior Issues (B) Task Force Letter to the Federal Centers for Medicare & Medicaid Services (CMS) Regarding its New Medicare Plan Finder, Oct. 16, 2019 (Attachment One-A) .......................................................... 7-176
Senior Issues (B) Task Force Sept. 24, 2019, Minutes (Attachment Two) ........................................ 7-178
  Senior Issues (B) Task Force 2020 Proposed Charges (Attachment Two-A) .................................. 7-179
  California Health Advocates (CHA) Paper Titled, “Medicare, COBRA and Implied Coverage: A False Equivalency” (Attachment Three) .......................................................... 7-180
Draft: 12/10/19

Senior Issues (B) Task Force
Austin, Texas
December 7, 2019

The Senior Issues (B) Task Force met in Austin, TX, Dec. 7, 2019. The following Task Force members participated: Lori K. Wing-Heier, Chair (AK); Marlene Caride, Vice Chair (NJ); Jim L. Ridling represented by Steven Ostlund (AL); Allen W. Kerr represented by Bill Lacy (AR); Andrew N. Mais represented by Paul Lombardo (CT); Trinidad Navarro represented by Fleur McKendell (DE); David Altmaier represented by James Dunn (FL); John F. King (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Wes Trexler (ID); Robert H. Muriel represented by Mike Chrysler (IL); Stephen W. Robertson represented by Alex Peck (IN); Vicki Schmidt (KS); James J. Donelon represented by Ron Henderson (LA); Gary Anderson represented by Kevin Beagan (MA); Al Redmer Jr. represented by Paula Keen (MD); Eric A. Cioppa represented by Marti Hooper (ME); Anita G. Fox represented by Kevin Dyke (MI); Steve Kelley represented by Grace Arnold (MN); Chlora Lindley-Myers represented by Angela Nelson (MO); Mike Chaney represented by Daniel Bradshaw (MS); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Bruce R. Ramge represented by Martin Swanson (NE); John G. Franchini represented by Margaret Pena (NM); Barbara D. Richardson represented by Dave Cassetty (NV); Jillian Froment represented by Laura Miller (OH); Glen Mulready represented by Ron Kreiter (OK); Andrew Stolfi represented by Tashia Sizemore (OR); Jessica Altman (PA); Larry Deiter represented by Jill Kruger (SD); Hodgen Mainda represented by Brian Hoffmeister (TN); Kent Sullivan represented by Raja Malkani (TX); Todd E. Kiser represented by Shelley Wiseman (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Mike Bryant (WA); Mark Afable represented by Jennifer Stegall (WI); and James A. Dodrill represented by Ellen Potter (WV).

1. Adopted its Oct. 16, Sept. 24 and Summer National Meeting Minutes

Mr. Ostlund made a motion, seconded by Commissioner Caride, to adopt the Task Force’s Oct. 16 (Attachment One), Sept. 24 (Attachment Two) and Aug. 3 (see NAIC Proceedings – Summer 2019, Senior Issues (B) Task Force) minutes. The motion passed.

2. Heard a Federal Legislative Update

David Torian (NAIC) provided an update on federal funding for the State Health Insurance Assistance Program (SHIP) and informed the Task Force about a draft legislative proposal by U.S. Sen. Pat Toomey (R-PA) based on one of the policy option recommendations adopted by the Task Force. Mr. Torian said the draft legislation would allow for retirement account dollars to be used to buy long-term care insurance (LTCI) so families can better plan for long-term services and supports (LTSS) needs. Mr. Torian said Sen. Toomey’s office would be happy to receive recommendations and comments to the draft proposal from Task Force members and stakeholders.

3. Discussed Other Matters

Bonnie Burns (California Health Advocates—CHA) discussed conflicts between Medicare, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and the Coordination of Benefits Model Regulation (#120) (Attachment Three).

Ms. Burns pointed out that too many workers do not know that they must enroll in Medicare even if they are continuing to work past the age 65. She said these conflicts have left some Medicare-eligible individuals subject to Medicare premium penalties and delays in coverage, mistakes in benefit payment and claims for recovery of mistakenly paid COBRA benefits.

Ms. Burns cited an example of a woman receiving a demand from her COBRA carrier for repayment of $150,000 for health care expenses the carrier had paid after she stopped working. The carrier alleged that while she was still working, she became eligible for Medicare on her 65th birthday and should have enrolled for Medicare benefits. The carrier alleged that Medicare should have been her primary health coverage once she stopped working and COBRA should have paid secondary benefits, not the $150,000 the carrier had paid for primary coverage. This demand for repayment of primary benefits was based on her eligibility to enroll in Medicare or “implied coverage.”

Director Wing-Heier asked Ms. Burns what the path would be for the state insurance regulator in this matter, as it seems that this an issue at the federal level. Ms. Burns replied that insurers follow Model #120, noting that the language in the model needs to be made clearer.

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Ms. Nelson said not all states have adopted the newest version of Model #120, noting that she shares Director Wing-Heier’s sentiment that this may be more of a federal matter.

Ms. Sizemore said Oregon is having trouble with this issue, noting that insurers cannot assume people are on Medicare; they must know and ask.

Director Wing-Heier said each state should check its own laws and suggested the Task Force look at this matter in the new year.

Having no further business, the Senior Issues (B) Task Force adjourned.
The Senior Issues (B) Task Force conducted an e-vote that concluded on Oct. 16, 2019. The following Task Force members participated: Lori K. Wing-Heier, Chair (AK); Marlene Caride, Vice Chair (NJ); Jim L. Ridling represented by Steve Ostlund (AL); Allen W. Kerr (AR); Michael Conway (CO); Andrew N. Mais represented by Paul Lombardo (CT); Trinidad Navarro represented by Susan Jennette (DE); David Altmaier (FL); John F. King (GA); Doug Ommen represented by Andria Seip (IA); Dean Cameron represented by Kathy McGill (ID); Vicki Schmidt represented by Julie Holmes (KS); James J. Donelon represented by Ron Henderson (LA); Al Redmer Jr. represented by Joy Hatchette (MD); Eric A. Cioppa represented by Marti Hooper (ME); Anita G. Fox represented by Karen Dennis (MI); Steve Kelley represented by Melinda Domzalski-Hansen (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Bruce R. Ramge represented by Martin Swanson (NE); Barbara D. Richardson (NV); Jillian Froment represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew Stolfi represented by Gayle Woods (OR); Jessica Altman represented by Michael Humphreys (PA); Larry Deiter represented by Jill Kruger (SD); Kent Sullivan represented by Doug Danzeiser (TX); Todd E. Kiser (UT); Scott A. White (VA); Mike Kreidler represented by Michael Bryant (WA); Mark Afable represented by Jennifer Stegall (WI); and Jeff Rude (WY).

1. **Adopted a Letter to CMS Regarding its New Medicare Plan Finder**

The Task Force conducted an e-vote to consider the adoption of a letter from the Task Force to the federal Centers for Medicare & Medicaid Services (CMS) regarding concerns with CMS’ new Medicare Plan Finder.


Having no further business, the Senior Issues (B) Task Force adjourned.
October 16, 2019

Hon. Seema Verma -- Administrator
Centers for Medicare and Medicaid Services
Department of Health & Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Administrator Verma:

The membership of the National Association of Insurance Commissioners’ (NAIC) Senior Issues Task Force (SITF) write to support the concerns expressed by state regulators, consumer advocacy groups and industry representatives regarding the new Medicare Plan Finder (Finder).

For many people with Medicare, evaluating health care and prescription drug coverage options can be a daunting task. While the Finder can be a helpful tool, this new updated version raises problems. The SITF shares many of the concerns expressed by many interested parties that this new Finder has serious inaccuracies and errors that have the potential to affect consumers, carriers and state insurance regulators.

Some examples of concerns, errors and omissions are:

- There is no Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) notice with respect to newly eligible beneficiaries on individual Medigap Plan C, Plan F and Plan High Deductible F.

- The cost comparison between Medicare Advantage (MA) and Medicare with a Medigap plan does not capture out of pocket costs – only premiums. This gives the false sense that Medigap is much more expensive overall than an MA plan.

- The total yearly estimated cost for Original Medicare and a Medigap Plan (particularly Plan F) is unreasonably high.

- The description of the Medicare Savings Program (MSP) is inaccurate since not every MSP pays for cost-sharing, which the description implies.

- General searches will not save prescription drug entries, so repeated entries will be required as needed when not doing a personalized search.
The new Finder should allow users to sort drug plans by the “total drug and premium cost” for the plan year, as was possible with the previous version of the Finder.

The drug plan summary lists the costs for mail order pharmacies but there is no ability to compare the mail order and retail cost of a drug, as was possible with the previous version of the Finder.

The new Finder should add formulary information in the summary view and the ability to sort or filter plans according to this data point.

There is no longer an option for selecting that a person gets a drug once per year, which is a common scenario for people with Medicare, as was possible with the previous version of the Finder.

The Drug Cost information section should include a monthly cost chart, including the bar graph, which includes premiums and out-of-pocket expenses, as was possible with the previous version of the Finder.

We also encourage CMS to work with the NAIC on some of the functionality issues with the Finder when CMS updates the Finder for next year. Some of the concerns include not allowing for general searches to be saved without the creation of an account and not including an email option for consumers to view and review their comparisons, rather than the current cumbersome print option. This email option was available on the previous version of the Finder.

Coming out with a new Finder on the heels of open enrollment that has errors and omissions may discourage Medicare beneficiaries from taking advantage of reviewing their drug/medical plans. We encourage you to carefully and seriously review the concerns expressed in this letter and in the letters already sent to CMS by concerned parties and make the necessary corrections, edits and changes so that the Finder can be the truly useful tool for consumers as intended.

Sincerely,

Lori K. Wing-Heier
Chair, Senior Issues (B) Task Force
Director, Alaska Division of Insurance

cc:  Brady Brookes, Deputy Administrator and Deputy Chief of Staff
     Kimberly Brandt, Principal Deputy Administrator for Policy & Operations
     Demetrios L. Kouzoukas, Principal Deputy Administrator of CMS and Director of the Center for Medicare
     Kathryn Anne Coleman, Director, Medicare Drug & Health Plan Contract Administration Group
     Jerry Mulcahy, Director, Medicare Enrollment and Appeals Group
The Senior Issues (B) Task Force met via conference call Sept. 24, 2019. The following Task Force members participated: Lori K. Wing-Heier (AK), Chair; Marlene Caride (NJ), Vice Chair; Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Tyler McKinney (CA); David Altmaier represented by Craig Wright (FL); John F. King represented by Martin R. Sullivan Jr. (GA); Dean L. Cameron represented by Kathy McGill (ID); Stephen W. Robertson represented by Bobbi Henn (IN); Vicki Schmidt represented by Julie Holmes (KS); Nancy G. Atkins represented by Stephanie McGaughy-Bowker (KY); Al Redmer Jr. represented by Joy Hatchette (MD); Eric A. Cioppa represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell (MI); Steve Kelley represented by Kristi Bohn (MN); Chlora Lindley-Myers (MO); Mike Causey represented by David Yetter (NC); Jon Godfread represented by Chrystal Bartuska (ND); Bruce R. Ramge represented by Martin Swanson (NE); Barbara D. Richardson represented by Jack Childress (NV); Glen Mulready represented by Ron Kreiter (OK); Andrew Stolfi represented by Gayle Woods (OR); Carter Lawrence represented by Brian Hoffmeister (TN); Kent Sullivan represented by Dewayne Matthews (TX); Todd E. Kiser represented by Tomasz Serbinowski and Jaakob Sundberg (UT); Scott A. White represented by Yolanda Tennyson (VA); Mike Kreidler represented by Michael Bryant (WA); Mark Afable represented by Jennifer Stegall (WI); and Jeff Rude (WY). Also participating was: Martin Wojcik (NY).

1. Discussed a Technical Change to Model #642

   David Torian (NAIC) announced a technical change to the Limited Long-Term Care Insurance Model Act (#642). Mr. Torian said Section 6B(3) references Section 6C(1) and Section 6C(2) but should actually reference Section 6B(1) and Section 6B(2). He said Section 6B(4) twice references Section 6C(2) but should actually reference Section 6B(2).

2. Adopted its 2020 Proposed Charges

   Director Wing-Heier asked if anyone had any comments to the Task Force’s 2020 proposed charges. None were heard.

   Director Lindley-Myers made a motion, seconded by Mr. Swanson, to adopt the Task Force’s 2020 proposed charges (Attachment Two-A). The motion passed.

Having no further business, the Senior Issues (B) Task Force adjourned.
2020 PROPOSED CHARGES

SENIOR ISSUES (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: David Torian
Medicare, COBRA and Implied Coverage: A False Equivalency

Conflicts between Medicare and COBRA rules have led to confusion about which system, and which set of rules governs eligibility for coverage and how responsibility for payment of health care benefits for eligible individuals is determined. These conflicts have left some Medicare eligible individuals subject to Medicare premium penalties and delays in coverage, mistakes in benefit payment, and claims for recovery of mistakenly paid COBRA benefits.

Example: Mary Smith received a demand from her COBRA carrier for repayment of $150,000 for health care expenses the carrier had paid after she stopped working. The carrier alleged that while she was still working she became eligible for Medicare on her 65 birthday and should have enrolled for Medicare benefits. The carrier alleged that Medicare should have been her primary health coverage once she stopped working and COBRA should have paid secondary benefits, not the $150,000 the carrier had paid for primary coverage.

This demand for repayment of primary benefits was based on her eligibility to enroll in Medicare or “implied coverage.” Several recovery actions like this one have been reported to a California advocacy program, and the number of these actions has been steadily increasing over the last several years as more people continue working past their 65th birthday when they first become eligible for Medicare.

This paper discusses current conflicts in federal enrollment rules, and the quandary faced by individuals who fall into this quagmire of conflicts.

Implied Coverage and Recovery of Paid Benefits

COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1996, prohibits carriers from refusing or terminating coverage on the basis that an individual is eligible for Medicare as long as enrollment for benefits occurred prior to their COBRA coverage. If enrollment occurs after COBRA has begun COBRA can be terminated.

Implied coverage is a concept that insurers and health plans are using to recoup primary payment of health care expenses from former employees who were eligible for Medicare but not yet enrolled in Medicare. However, being eligible for Medicare does not constitute having activated those benefits. And, a Medicare eligible individual is not compelled to enroll in Medicare when eligible to do so. In fact, a Medicare eligible individual working for an employer that is subject to Medicare’s Secondary Payer rules is protected from application of late enrollment premium penalties while employed and during an 8-month window of eligibility following separation from employment.

Background

Medicare eligibility begins at age 65 unless a person qualifies for benefits earlier as a result of a disabling physical or medical condition. And, for decades, Social Security eligibility for full retirement benefits also began at age 65. However, beginning in 1983, the age of eligibility for full Social Security retirement benefits has increased by two months each year and will end at age 67 in the year 2027. As a result, the ages of eligibility for Medicare and full Social Security retirement benefits no
longer match. While an individual can enroll for early reduced Social Security retirement benefits at age 62, they will not be eligible to enroll in Medicare until age 65.

Because of the disconnect between the age of eligibility for Medicare and the age of eligibility for full Social Security retirement benefits an employed person turning 65 often has no knowledge about when or why to sign up for Medicare. Many employees pass their 65th birthday without even knowing they are eligible for Medicare benefits before they are eligible for full Social Security benefits.

Even when an employed individual knows they are eligible for Medicare there is no reason to sign up since they have employer health benefits. Signing up for Medicare benefits while working would require payment of an additional premium and Medicare would only provide secondary coverage to their employer benefits.

**Transitioning to COBRA**

Medicare Secondary Payer rules prohibit employers from treating a Medicare eligible employee differently than other employees in regard to group health benefits or continued employment at age 65. Under federal law an employer group health plan is primary to Medicare when the employer has 20 or more employees and a Medicare eligible individual is 65 or older (100 or more employees when the Medicare eligible individual is eligible for Medicare due to a disabling condition). When an individual has permanent kidney failure known as ESRD an employer plan of any size is required to be primary during a 30-month coordination of benefit period.

The Department of Labor’s Model COBRA Notice does not mention Medicare eligibility, Medicare eligibility or enrollment, or any effect that Medicare has on COBRA benefits in regard to primary and secondary coverage. Employer HR personnel rarely understand the interaction between Medicare and COBRA, and are often only aware of the requirement to pay primary benefits when a Medicare beneficiary has permanent kidney failure (ESRD) and is enrolled for Medicare benefits. Neither Medicare nor Social Security notifies a person when they become eligible for Medicare benefits at age 65.

When a Medicare eligible individual transitions into COBRA coverage, their health care benefits are generally the same as when they were employed. While these former employees have to pay the full premium plus an administrative fee for their COBRA benefits, the only coverage change they are aware of is an increase in their premium payment. Often they don’t know that they will no longer meet the federal requirement of active employment for primary coverage of their former employer’s health benefits, or that if they aren’t already enrolled in Medicare that they must enroll now and activate that primary coverage.

**Enrollment Rules**

There is no Medicare premium penalty imposed for delayed enrollment while an eligible individual is actively employed and covered by a group health plan. Once active employment ends however the former employee has an eight month special enrollment window to sign up for Medicare Part B without incurring a late enrollment premium penalty, and 60 days to sign up for Part D unless COBRA coverage provides equivalent prescription drug coverage as the Medicare benefit. After this Part B special enrollment window closes an annual late enrollment premium penalty begins to accrue and the window to enroll shrinks to an annual 3-month period, January thru March. Benefits are delayed until July of the same year of enrollment.

Since most Medicare beneficiaries are eligible for premium free Medicare Part A no delayed enrollment penalty for that part of Medicare is imposed. There is no late enrollment penalty for Part D as long as current coverage provides equivalent prescription drug coverage as the Medicare benefit.

**Order of Payment Rules**

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5. Federal law does not impose a late enrollment penalty Medicare Part B when an eligible individual is “actively employed” under the IRS definition, regardless of the size of the employer, or into Medicare Part D when employer sponsored insurance is providing Medicare equivalent prescription drug benefits.

6. Approximately 35% of employers offer a Medical Savings Account (MSA). A Medicare eligible individual could face tax penalties if they sign up for Medicare and continue contributions to their MSA.
The National Association of Insurance Commissioners (NAIC) Coordination of Benefits (COB) Model Regulation explains the order of health insurance benefits payments when an individual or a covered spouse or dependent is or could be eligible for health benefits under more than one health benefit plan. Federal Medicare Secondary Payer rules do not require employer health plans to pay primary benefits when an employer has fewer than 20 employees (or fewer than 100 employees in the case of a disabling condition).

The NAIC Model Regulation prohibits insurers from reducing benefits when an individual is covered or could have been covered under another health benefit plan, except in certain very restricted circumstances. One of those restricted circumstances, amended into the Model in 1984-85, is in regard to Medicare Part B benefits.7

The NAIC language allows insurers to reduce health plan benefits when a Medicare eligible individual “is or could have been” covered by Medicare Part B. There is no mention of Medicare Part A, nor any explanation for this one very focused exception. Most states have adopted the NAIC Coordination of Benefits Model Law language or similar language.

**Application of Implied Coverage**

There are currently three situations in which insurers have applied this concept of implied coverage.

- The first is when a Medicare eligible individual is eligible for COBRA coverage following a qualified event.8
- The second is when a Medicare eligible employee is covered under the health plan of an employer with fewer than 20 employees (or fewer than 100 when the Medicare eligible individual has a disability).
- The third is when a former employee is covered by the health benefits of an employer or union plan and becomes eligible for Medicare years later.

In each of these three situations the Medicare Secondary Payer (MSP) rules do not require the employer’s health plan to provide primary payment of benefits, and the NAIC COB Model allows secondary payment.9

**COBRA Coverage vs Medicare**

COBRA provides continuation of employer or union health benefits upon separation from employment. When a covered employee transitions to COBRA they are no longer actively employed under federal law. If a former employee is also enrolled for Medicare benefits Medicare would become primary coverage. COBRA or employer or union group coverage would be secondary coverage under current rules.

A problem arises when a Medicare eligible individual does not understand the need to enroll for Medicare, and the COBRA carrier does not know the individual’s Medicare status.

In this situation a Medicare eligible individual loses or leaves employment and is covered by COBRA. Prior to leaving employment the Medicare eligible individual did not enroll in Medicare and relied solely on the employer plan health benefits. The individual transitions to COBRA and continues to ignore eligibility for Medicare since the employer’s health plan benefits haven’t changed under COBRA and the individual is paying the full premium.

In a variation of this situation a Medicare eligible individual while actively employed may have accepted Medicare Part A because this part of Medicare doesn’t require any premium payment, but declined Part B and Part D because both require additional monthly premium payments and appear to duplicate the employer’s existing health benefits.

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7 See: https://www.naic.org/store/free/MDL-120.pdf
9 None of these situations apply when an individual is eligible for Medicare due to permanent kidney failure (End Stage Renal Disease)
benefits. The individual then transitions to COBRA and continues to ignore eligibility for Medicare because they have no information regarding the consequences of that decision.

The COBRA notice does not alert the recipient to the need for Medicare, nor does it warn the Medicare eligible individual that any problems will result due to their eligibility for Medicare. More importantly the COBRA notice fails to inform the individual of the consequences of not enrolling in Medicare. These consequences include late enrollment premium penalties, delayed coverage, and the potential financial danger of future recovery actions by the COBRA carrier. There also is no notice from Medicare or Social Security that would alert a Medicare eligible beneficiary of the need to enroll for Medicare benefits or the consequences of not doing so.

In both of the situations described above the individual no longer meets the requirement of active employment once they transition to COBRA. At some point, if the COBRA carrier has paid primary benefits and later discovers an individual’s potential availability of Medicare benefits it may begin a recovery action for any COBRA benefits paid as primary benefits.

Small Employers With Less Than 20 Employees (or 100 if the Medicare eligible individual has a disability):

In this situation a Medicare eligible individual is covered by an employer group health plan and the employer plan has fewer than 20 or 100 employees. Medicare Secondary Payer rules do not require the health plan to pay primary benefits, and Medicare is primary if a beneficiary is enrolled for Medicare benefits.

Some health insurers have attempted recovery of benefit payments from Medicare eligible individuals who work for these small employers but who have NOT enrolled for Medicare benefits and instead use the employer plan as their primary health benefits.

Large Employer or Union Plans for Retirees:

In this situation former employees who are not yet Medicare eligible when they retire are covered by an employer or union retiree health plan. Later, when they become eligible for Medicare, often years after leaving employment, they may not know about the need to enroll in Medicare, and the plan administrator may not know when a member becomes eligible for Medicare and be able to advise them.

While plan documents may contain information related to Medicare eligibility the plan member may have no formal notice about when they become eligible for Medicare or understand the steps they must take as a result.

Plan administrators often do not have information to give plan members at the time they become eligible for Medicare. A review or an audit of the plan, or a change in the third party administrator may prompt a recovery action when the former employee has not enrolled in Medicare when eligible to do so.

Implied Coverage

The theory of implied coverage creates a “phantom benefit” that exposes Medicare eligible individuals to aggressive collection efforts by insurers and COBRA carriers. recovery action by insurers and COBRA carriers disregards federal criteria that eligibility does not constitute enrollment for Medicare when a Medicare eligible individual is eligible for Medicare but has not yet enrolled for benefits. Federal law clearly states: “A qualified beneficiary becomes entitled to Medicare benefits upon the effective date of enrollment in either part A or B, whichever occurs earlier. Thus, merely being entitled to enroll in Medicare does not constitute being entitled to Medicare benefits” (emphasis added).

If a Medicare eligible employee did not enroll in either Part A or Part B prior to applying for COBRA under current law the individual’s COBRA coverage cannot be terminated. However, in current practice, if a Medicare eligible individual leaves

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10 Has contributed the appropriate number of quarters to qualify for Social Security benefits and Medicare, or is eligible to pay some or all of the Medicare Part A premium and/or Medicare Part B premium
11 https://www.law.cornell.edu/cfr/text/26/54.4980B-7
employment without enrolling in either part of Medicare a COBRA carrier may insist that they enroll in that program to obtain primary coverage. If a Medicare eligible individual complies and does enroll while receiving COBRA benefits the COBRA carrier can terminate coverage on the basis that their enrollment occurred after their COBRA coverage was effective. This is a conflict that sets up a catch 22 for Medicare eligible employees and it must be resolved.

**Recommended Actions**

Conflicts between eligibility for Medicare and COBRA are certain to increase as more people work past the age of 65. The Bureau of Labor statistics show that the number of employed seniors today is the highest it’s been in 55 years. The Bureau estimates that 36 percent of 65- to 69-year-olds will be active participants in the labor market by 2024.12 Employers and COBRA carriers are unlikely to be prepared for the conflicts in coverage that are certain to accompany a growing number of Medicare eligible employees having employer coverage or transitioning to COBRA. As evidence of this trend, the California state health insurance counseling program HICAP (one of the federally funded SHIPs) has had an influx of clients with demands from COBRA carriers or insurance companies for repayment of primary benefits.13

Information about interaction between COBRA and Medicare coverage is non-existent from federal sources such as the Department of Labor (DOL) and the Centers for Medicare and Medicaid Services (CMS). While one can readily find information about eligibility criteria for COBRA or Medicare, nothing about the relationship between the two health benefit programs is available.

Recovery actions based simply on presumed coverage for Medicare without the requisite enrollment for benefits could potentially be the subject of legal action against the carrier or an insurer given the employer’s and the COBRA carrier’s failure to inform employees about the conflict between Medicare and COBRA, as well as any potential legal liability for recovery of the primary benefits paid by the COBRA carrier.

State regulators play an important role in balancing the needs of consumers with the financial oversight of insurance companies, enforcing consumer protections, and setting and enforcing regulatory rules that ensure fairness in the marketplace. There are a number of actions state regulators and federal governmental agencies should take to help employers and insurers accurately and fairly administer the benefits of overlapping health benefit programs.

The Department of Labor (DOL) should prohibit the application of implied coverage if a Medicare eligible individual has failed to enroll in Medicare, and prohibit recovery actions based on failure to enroll in Medicare. DOL should revise the Model COBRA Notice to ensure that all of the pertinent information and the dangers of interaction between Medicare and COBRA are clearly described to all COBRA applicants.

The DOL should review ERISA notification requirement to ensure that employers are meeting their responsibilities to accurately and timely notify employees and their dependents of any requirements and conflicts in regard to the relationship and coordination of overlapping health benefits.

The Centers for Medicare and Medicaid Services (CMS) should develop a Special Enrollment Period (SEP) with equitable relief for Medicare eligible individuals caught in this conflict. CMS should revise all their Medicare information and publications to reflect issues related to COBRA. Medicare eligible individuals need to understand how COBRA and Medicare benefits interact and conflict, as well as the consequences of not enrolling for Medicare benefits when eligible for COBRA. CMS should work with the state SHIPs to ensure their understanding of these issues when counseling Medicare beneficiaries who leave employment.

The National Association of Insurance Commissioners (NAIC) should revise the current language in the Association’s Coordination of Benefits Model Regulation. There is no justification for that language that penalizes people with Medicare who take advantage of COBRA protection. The current language expressly prohibits insurers from taking into consideration other coverage when determining coverage or denying a claim, and it prevents

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13 The Health Insurance Counseling Program (HICAP) California HICAP is part of a national network of State Health Insurance and Assistance Programs (SHIP). SHIP is a Federal grant program that helps States enhance and support a network of local programs, staff, and volunteers. The Centers for Medicare and Medicaid (CMS) administers the SHIP grant programs nationally.
insurers from refusing to pay or reducing benefits based on the availability of other coverage, except when that other coverage is Medicare Part B coverage.

The NAIC should ensure that issuers provide accurate information about coordination of health insurance benefits between Medicare, COBRA, and employer sponsored health plans, and that companies fairly administer overlapping benefits.

The NAIC Senior Issues Task Force should develop a compliance notice for insurance companies and agents and an educational notice for consumers. Both notices should accurately explain the relationship of COBRA coverage to Medicare and the difference between being eligible for Medicare and being enrolled for benefits.

State insurance regulators should examine their laws and regulations to ensure that insurers and COBRA carriers are in compliance with all state and federal laws and regulations, and that Medicare eligible individuals are not subjected to unfair recovery actions.

Additional Information

COBRA Q and A

§ 54.4980B-7 Duration of COBRA continuation coverage. 14

The following questions-and-answers address the duration of COBRA continuation coverage:

Q-3: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to the qualified beneficiary's entitlement to Medicare benefits?

A-3: (a) If a qualified beneficiary first becomes entitled to Medicare benefits under title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg) after the date on which COBRA continuation coverage is elected for the qualified beneficiary, then the plan may terminate the qualified beneficiary's COBRA continuation coverage upon the date on which the qualified beneficiary becomes so entitled. By contrast, if a qualified beneficiary first becomes entitled to Medicare benefits on or before the date that COBRA continuation coverage is elected, then the qualified beneficiary's entitlement to Medicare benefits cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.

A qualified beneficiary becomes entitled to Medicare benefits upon the effective date of enrollment in either part A or B, whichever occurs earlier. Thus, merely being eligible to enroll in Medicare does not constitute being entitled to Medicare benefits. (Highlight added)

The NAIC Coordination of Benefits Model Regulation (MDL-120)

The NAIC Coordination of Benefits Model Regulation (MDL-120) excludes Medicare Part B with the following language:

Section 5. Use of Model COB Contract Provision

D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

(1) Another plan exists and the covered person did not enroll in that plan;

(2) A person is or could have been covered under another plan, except with respect to Part B of Medicare; or

(3) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

14 https://www.law.cornell.edu/cfr/text/26/54.4980B-7

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[Author’s Note: Notice that exempting Medicare Part B allows the prohibited practice described in (1), and potentially the prohibited practice described in (3).]

Summary Of Situations Discussed In This Paper:

- Medicare eligible individuals not yet enrolled for benefits under Part A or Part B prior to becoming eligible for COBRA cannot be refused COBRA coverage
- Individuals enrolled in either Medicare Part A or Part B prior to becoming eligible for COBRA cannot be refused COBRA coverage
- Medicare eligible individuals who are eligible for Medicare while working but enroll after becoming eligible for COBRA can be terminated from COBRA coverage
- Medicare eligible individuals actively working for employers of less than 20 employee are not covered by Medicare Secondary Payer rules that require employer health care benefits to be primary to Medicare coverage
- COBRA covered individuals who are eligible for Medicare but not enrolled in Medicare Part A or Part B are penalized under both COBRA and Medicare law
- COBRA benefits and Medicare eligible individuals who are enrolled in either Medicare Part A or Part B are penalized under both COBRA and Medicare law
- Medicare Secondary Payment rules do not require COBRA coverage to be primary to Medicare
- The National Association of Insurance Commissioners (NAIC) Coordination of Benefits Model Regulation establishes the order of payments for health benefits and requires health benefits to be secondary to Medicare, regardless of whether Medicare benefits have been activated.
PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

Property and Casualty Insurance (C) Committee Dec. 9, 2019, Minutes ................................................................. 8-2
Property and Casualty Insurance (C) Committee Nov. 18, 2019, Minutes (Attachment One)................................. 8-8
Property and Casualty Insurance (C) Committee Sept. 10, 2019, Minutes (Attachment One-A) ......................... 8-10
Private Flood Insurance Data Call Template (Attachment One-A1) ................................................................. 8-12
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Cannabis Insurance (C) Working Group Oct. 10, 2019, Minutes (Attachment Two) ..................................................... 8-27
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    Update and 2020 Proposed Charges (Attachment Two-A) ........................................................................... 8-29
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Considerations for State Insurance Regulators in Building the Private Flood Insurance Market
    (Attachment Nine) ............................................................................................................................................... 8-70
The Property and Casualty Insurance (C) Committee met in Austin, TX, Dec. 9, 2019. The following Committee members participated: Elizabeth Kelleher Dwyer, Chair, and Matt Gendron (RI); Scott A. White, Vice Chair, and Don Beatty (VA); Jim L. Ridling represented by Sheila Travis (AL); Andrew N. Mais and George Bradner (CT); David Altmair (FL); Robert H. Muriel (IL); James J. Donelson represented by Warren Byrd (LA); Al Redmer Jr. and Robert Baron (MD); Marlene Caride (NJ); John G. Franchini and Anna Krylova (NM); Glen Mulready (OK); Larry Deiter (SD); Mark Afable represented by Rebecca Rebholz (WI); and James A. Dodrill represented by Gregory Elam (WV). Also participating was: Travis Grassel (IA).

1. **Adopted its Nov. 18 Minutes**

The Committee met Nov. 18 and took the following action: 1) adopted its Sept. 10 minutes, which included adoption of its Summer National Meeting minutes and adoption of documents related to the private flood insurance data call; 2) adopted additional documents related to the private flood insurance data call, including making the data publicly available; 3) discussed proposed blanks changes related to private flood insurance; and 4) discussed the upcoming Fall National Meeting.

Commissioner Dieter made a motion, seconded by Commissioner Caride, to adopt the Committee’s Nov. 18 minutes (Attachment One). The motion passed unanimously.

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

Commissioner Altmair made a motion, seconded by Mr. Byrd, to adopt the following task force and working group reports: the Casualty Actuarial and Statistical (C) Task Force; the Surplus Lines (C) Task Force; the Title Insurance (C) Task Force; the Workers’ Compensation (C) Task Force; the Cannabis Insurance (C) Working Group (Attachment Two); the Catastrophe Insurance (C) Working Group (Attachment Three); the Climate Risk and Resilience (C) Working Group (Attachment Four); the Lender-Placed Insurance Model Act (C) Working Group; the Pet Insurance (C) Working Group (Attachment Five); the Terrorism Insurance Implementation (C) Working Group (Attachment Six); and the Transparency and Readability of Consumer Information (C) Working Group. The motion passed unanimously.

3. **Adopted an Extension for Revisions to the Proposed Real Property Lender-Placed Insurance Model Act**

Commissioner Altmair made a motion, seconded by Commissioner Caride, to adopt an extension to the 2020 Spring National Meeting for revisions to the proposed Real Property Lender-Placed Insurance Model Act. The motion passed unanimously.

4. **Adopted its 2020 Charges**

Commissioner Caride made a motion, seconded by Director Dieter, to adopt the Committee’s 2020 charges (Attachment Seven). The motion passed unanimously.

5. **Adopted a Blanks Request Regarding Private Flood Insurance**

Superintendent Dwyer said the Committee discussed during its Nov. 18 conference call proposed revisions to the annual statement to include private flood insurance data. She said the Committee has drafted a proposal to the Blanks (E) Working Group that requests: 1) a new supplement that will separate residential from commercial private flood, as well as capture standalone/endorsement and first dollar/excess policy information for private flood policies; and 2) revisions to the Credit Insurance Experience Exhibit to collect lender-placed flood coverages including a split between first dollar and excess coverages.

Superintendent Dwyer said the proposed annual statement changes would not take effect until 2021, collecting 2020 data. She noted that states are currently in the process of issuing a data call that will collect 2018 private flood data early next year and 2019 data later in 2020.
Commissioner Mais made a motion, seconded by Commissioner Altmaier, to adopt the blanks request related to private flood insurance (Attachment Eight). The motion passed unanimously.


Mr. Bradner said a drafting group established by the Catastrophe Insurance (C) Working Group began working last year on a document to include strategies to encourage the development of the private flood insurance market. He said the drafting group sent its draft to the Catastrophe Insurance (C) Working Group on July 18, and the Working Group received comments through Aug. 22. He said changes were made to the document to reflect the comments received. He said comments were also received from the Reinsurance Association of America (RAA) on Dec. 4 and from the National Association of Mutual Insurance Companies (NAMIC) on Dec. 7.

Mr. Bradner said the document recognizes that the Property and Casualty Insurance (C) Committee has already begun to take steps to enhance the collection of private flood insurance data, including collecting more granular data through the annual statement and the Credit Insurance Experience Exhibit, as well as from the surplus lines market through the Surplus Lines (C) Working Group. He said the document also recognizes that a private flood insurance line will be implemented for the Market Conduct Annual Statement (MCAS). The document presents other considerations for the Property and Casualty Insurance (C) Committee, including:

- Considering ways to incorporate a conforming conditions clause in the form approval process.
- Referring state law conflicts relating to statute of limitations and cancellation/renewal provisions to the Government Relations (EX) Leadership Council to resolve at the federal level.

Mr. Bradner said the majority of the document provides state insurance regulators with concrete actions that can be or have been taken to assist with the development of the burgeoning private insurance market for residential flood insurance. He said the actions are split into several categories, including: 1) legislative and regulatory changes such as supporting private flood insurance legislation and products and tailoring rate and form requirements; 2) consumer information, such as consumer outreach and collecting residential private flood insurance data; and 3) agent and lender actions, such as implementing specific continuing education (CE) requirements for producers and conducting agent and lender education.

Mr. Bradner said the document also includes an appendix that would be more valuable with the addition of more state examples of actions states have taken. He recommended the Committee make the appendix a living document that can be updated on an ongoing basis.

Aaron Brandenburg (NAIC) said RAA had suggested adding the following paragraph to page 19 of the document:

> To avoid unintended consequences policymakers interested in facilitating a private flood insurance market should familiarize themselves with the requirements for residential customers with a federally backed mortgage to purchase flood insurance coverage and with the existing private insurance markets that provide coverage for flood damage, including coverage provided under: (a) commercial policies, (b) residential policies providing coverage in excess of required flood insurance coverage limits, (c) residential policies for those not mandated to purchase flood insurance, and (d) comprehensive auto policies. With such knowledge, legislative and regulatory changes can be tailored to accomplish the policy objectives without adversely impacting existing flood insurance markets.

Ms. Nelson asked if the word “policies” in “comprehensive auto policies” should read “coverages.” Dennis Burke (RAA) agreed with this change.

Mr. Brandenburg said NAMIC suggested adding language to page 21 to read:

> In Florida, the statute requires a 10-day cancellation for non-payment of premium. In Florida, to comply with the flood statute as other than Flexible or Supplement flood insurance, the insurer would have to give at least 45 days.

Commissioner Altmaier said he does not have a problem with this change. Mr. Bradner suggested the word “notice” be added after the phrase “at least 45 days.”

Mr. Brandenburg said RAA recommended moving the placement of a paragraph on page 22 and including a sentence:

> As a result, any flood insurance policy covering such properties is not required to be as broad as the NFIP policy.
Mr. Brandenburg said each of these changes is reflected in the current document before the Committee. Mr. Bradner made a motion, seconded by Commissioner Caride, to accept the edits recommended by the RAA and NAMIC, including the additional edits from Ms. Nelson and Mr. Bradner. The motion was adopted unanimously.

Mr. Bradner made a motion, seconded by Commissioner Caride, to adopt the newly revised Considerations for State Insurance Regulators in Building the Private Flood Insurance Market (Attachment Nine) and keep the appendix as a living document that can be updated with state activities. The motion passed unanimously.

7. Heard a Presentation from SBP on the Work it Does to Promote Resiliency and Mitigation Among Homeowners Pre- and Post-Disaster

Deirdre Manna (Zurich) said Zurich recognizes that flooding affects more people than any other disaster. She said in 2013, Zurich started a flood resilience program to link academic insights to humanitarian efforts and Zurich’s expertise. She said Zurich creates post-event reviews to shift the focus from post-disaster response to community resilience. She said $1 spent in prevention can save $5 in future losses. She said Zurich has conducted 16 post-event catastrophe reviews. In 2020, Zurich will launch a review of the 2017–2018 California wildfires. She said Zurich has collaborated with SBP in educating communities about disasters.

Mark Smith (SBP) explained SBP is a nonprofit founded in St. Bernard Parish, LA, after Hurricane Katrina. SBP has since built 18 homes in eight states and has operations in those states plus Puerto Rico and the Bahamas. He said the best way to help families is to increase resiliency before disasters and improve preparedness.

Mr. Smith said SBP recognizes that disaster survivors have breaking points determined by the amount of time recovery takes, the predictability of the recovery, and the vertical and horizontal resilience of each survivor. He said SBP’s mission is to prevent survivors from reaching their breaking point by shrinking the time between disaster and recovery. He said SBP strives to improve preparedness and provide tools before a disaster occurs. He said SBP’s strategic interventions have to do with building, sharing, preparing, advising and advocating. He said SBP prepares communities by identifying communities at high risk and advises governments about the best use of resources.

Mr. Smith said SBP partners with corporations such as Zurich to obtain additional resources in rebuilding homes. These corporate partnerships allow for the creation of disaster resilience and recovery labs, eLearning modules, government advisory and advocacy activities, and assisting communities with improving their Community Rating System score which can then improve the National Flood Insurance Program (NFIP) rates they receive.

Mr. Smith said SBP would like to partner with the NAIC before disasters to help communities better understand and mitigate risk ahead of disasters and partner after disasters to leverage SBP’s turnkey educational and advocacy materials to help survivors recover more quickly after disasters.

Superintendent Dwyer said Director Raymond G. Farmer (SC) recommended SBP make this presentation, and South Carolina has partnered with SBP.

Mr. Bradner said he co-chairs a statewide long-term recovery task force that helps communities to prepare and recover from disasters and that he would like to work with SBP in identifying resiliency needs. He said his group would like to work with SBP in helping communities improve their Community Rating System scores.

Mr. Smith said SBP often works with nonprofits in recovery programs.

Superintendent Dwyer said the NAIC’s Northeast Zone works on these issues, and she asked Mr. Bradner to leverage SBP in the work the Northeast Zone conducts.

8. Heard a Presentation Regarding Underinsurance Issues from the APCIA and NAMIC

Superintendent Dwyer reminded the Committee that Amy Bach (United Policyholders) spoke to the Committee during the Summer National Meeting about the problem of underinsurance.

Dave Snyder (American Property Casualty Insurance Association—APCIA) said he believes the top unresolved property/casualty (P/C) insurance issue is natural catastrophe risk and resiliency. He commended the NAIC for making this a top priority.
Mr. Snyder agreed with many of Ms. Bach’s points, including that more Americans need to be protected from natural disasters and that many property owners do not have enough coverage on their home. He said 75% of the losses from Hurricane Harvey were uninsured. He stressed property valuation is the responsibility of the property owner working with the insurer. He said the most significant protection gap is with flood damage.

Mr. Snyder said property valuation is difficult and is not the same as market value. He said actual cash value is the standard, but most policies are replacement cost. Insurers often offer extended replacement cost that provides up to an additional 25% in most cases to help address the underinsurance issues. He said this does not help if there are additions such as renovations or significant changes to the home. He said revised building codes also add to reconstruction costs.

Mr. Snyder said most insurers include inflation guard coverage to address increasing materials and labor costs. He said many insurers ask policyholders annually about substantial structural changes. Insurers also conduct insurance-to-value campaigns. He said insurers and policyholders need to work together to establish the correct value. He said balance is the key. Too much coverage creates a moral hazard, and too little coverage creates underinsurance issues.

Mr. Snyder said flooding is the most common disaster in the U.S. and can occur almost anywhere in the country. He said the NFIP has just more than 5 million policyholders. He noted CoreLogic estimates that 29 million homes have moderate to severe risk of flood loss. He said the biggest question for agents is still whether consumers have to buy flood insurance. People think of it as a binary decision; they are either required to purchase flood insurance or they are not. He said it should be stressed that where it rains, it can flood.

Mr. Snyder said the number of nonrenewals has crept up in areas with wildfire losses. He said this happens with other perils until the market is able to recover. He said development is often allowed where it should not be.

In terms of what the industry is doing, Mr. Snyder said the industry is supportive of NFIP Risk Rating 2.0, modernizing policy language, modernizing flood mapping, and the Federal Emergency Management Agency’s (FEMA) “moonshot” goal of doubling flood insurance as well as consumer education. He said 98% of all counties have had a flooding event. He said the APCIA has developed numerous educational materials and state and local mitigation programs.

Mr. Snyder stressed state insurance regulators should allow innovations such as revising anti-rebating laws and allowing parametric insurance. He said state insurance regulators should continue to help to develop the private flood insurance market, such as promoting ideas within the Considerations for State Insurance Regulators in Building the Private Flood Insurance Market.

Cate Paolino (NAMIC) said several inputs can affect underinsurance, including market changes, input challenges and post-catastrophe surge. She said insurers and agents should provide communications regarding how to actively manage risk, including available products such as inflation guard protection options. She said people improve their property, they need to share that information with insurers. Insurers often ask for additional information with a supplemental or renewal questionnaire. She said some individuals elect not to insure-to-value.

Ms. Paolino said rebuilding often costs more after a large catastrophe due to increases in labor, equipment and supplies. This demand surge can sometimes be 30% or higher. She said approximately 14 states have laws that prohibit policy limits from exceeding replaced cost estimates. She noted that over insurance should be avoided, as well as underinsurance.

Ms. Paolino said the industry wishes to work with state insurance regulators in encouraging the growth of the private flood insurance market. She said flood should be distinguished from property with respect to certain property regulations, such as weather-related loss limitations. She said the Build Strong Coalition was formed in 2011 to bring together a diverse group to respond to an increasing number of severe disasters. She said a primary focus of this group has been support of the federal Disaster Recovery Reform Act, which shifts the federal government approach to disaster recovery by incentivizing states to implement resiliency measures before natural disasters. She noted the Act provides monies to states and communities for pre-disaster mitigation measure. She said she would like to see state insurance regulators weigh in on the importance of mitigation efforts, especially improving building codes. NAMIC works with state legislators and others in promoting disaster mitigation and resiliency through a resiliency week.

Mr. Bradner said the International Residential Code (IRC) has upcoming building code changes that lower wind speed requirements because the code looks at historical averages of wind speeds. He is concerned that climate changes are not being considered.
Mr. Snyder said this is a source of concern and that there is opportunity for state insurance regulators to advise others in state
government about building codes and their effectiveness. He said the insurance industry also needs to provide information and
advocacy. He said new houses often are not built to withstand fire.

Mr. Bradner said he has worked with the construction industry on building codes, but state differences and lack of data make it difficult to get consensus. He said data is needed from the insurance industry to understand the effectiveness of mitigation steps.

Mr. Byrd said often repairs cost more to get up to code and that the insurer should have an incentive for the policyholder to take these steps to become a better risk. He wondered whether the insurer would pay some or all of these increased costs. Mr. Snyder said he would follow up on this issue.

Commissioner Mulready said Oklahoma recently experienced record flooding. He said maps have changed in areas where banks communicate with the homeowners that flood insurance is no longer required. He asked if the insurance industry had worked with the American Bankers Association (ABA) on educating consumers about flood risks.

Mr. Snyder said consumers often only consider whether the bank requires them to carry flood coverage. He said this decision-making process needs to change and that it will take work. He said research into communicating risks needs to continue. He said the insurance industry is trying to communicate these risks to policyholders.

Superintendent Dwyer said she also supervises banks in Rhode Island and said there is a lack of understanding by lenders on floods, earthquakes and other perils. She said banks say they are at a competitive disadvantage if they encourage the purchase of additional insurance.

Mr. Grassel said the key is pushing resiliency and mitigation efforts.

Superintendent Dwyer said she finds flood insurance to be difficult to buy if one is not required to purchase it.

Ms. Paolino said she is hopeful the growth of the private flood insurance market will help in the purchase process.

Tom Glassic (Wright National Flood Insurance Company) said it is becoming easier to purchase flood insurance, such as by going to the floodsmart.gov website. He said write-your-own (WYO) companies and FEMA are working to make the flood policy look like other policies.

Mr. Bradner said the states should think about how they can work more closely with the construction industry on mitigation steps, including sharing research conducted by the Insurance Institute for Business & Home Safety (IBHS). He said the states should also work with the construction sector on obtaining data on mitigation efforts.

Superintendent Dwyer said she will ask California to speak at the 2020 Spring National Meeting to discuss its experience with wildfire risks.

9. Heard an Update on Crop Insurance

Dave Miller (U.S. Department of Agriculture—USDA) said the federal crop insurance program was established in 1938. He said the private sector delivers the program through 14 insurance companies through sales, loss adjustment and underwriting. He said the standard reinsurance agreement is provided through the USDA.

Mr. Miller said the USDA works with states to share information about the market behavior and financial stability of the insurers. He said the USDA has worked with individual states recently with companies cancelling policies and leaving gaps in the marketplace. USDA’s compliance office has worked closely with state insurance regulators to deal with sales and rebating issues. He said the federal Crop Insurance Handbook was last updated in 2013 and should be looked at again based on new federal legislation. He also noted the NAIC’s federal relations staff has worked with the USDA as federal legislation arises. He said state data is available on the USDA website.

Tom Zacharias (National Crop Insurance Services—NCIS) said NCIS provides a unique suite of services to the crop insurance industry ranging from actuarial and analytical support to the development of crop loss adjustment standards and industry-wide training for both company staff and industry loss adjusters. He said NCIS is the only entity that fully supports both the state-regulated and federally regulated lines of the crop insurance business.
Dean Strasser (NCIS) noted the federal crop insurance program requires that adjusters be licensed in the state in which they service claims in order to be certified under the Standard Reinsurance Agreement (SRA) between the USDA Risk Management Agency (RMA) and the Approved Insurance Providers (AIPs). However, if a state’s licensing requirements are not crop insurance-specific or the state has no loss adjuster licensing requirements, RMA requires completion of a proficiency program to be certified. (Completing the Crop Adjuster Proficiency Program [CAPP] satisfies this requirement.) Several states that have crop adjuster license requirements do recognize CAPP as meeting their exam requirements for licensure.

Mr. Zacharias said NCIS files loss costs with states. He said crop-hail insurance has about $1 billion in premium, while federal crop insurance premiums are about $10 billion. Preventative planting claims were about $4 billion in 2019.

Director Ramge said it is important to maintain the working relationships with USDA and NCIS when issues arise with crop insurance companies.

Director Deiter said there have not been many issues in crop insurance lately, but he appreciates the presentation.

Superintendent Dwyer said she would like to continue these updates on an annual basis.

10. **Heard an Update on the Auto Insurance Report**

Superintendent Dwyer reported that state insurance regulators are currently reviewing private passenger auto state exhibits created from auto data collected from statistical agents. She said the Committee plans to release the private passenger auto report on its web page in the near future.

Having no further business, the Property and Casualty Insurance (C) Committee adjourned.
The Property and Casualty Insurance (C) Committee met via conference call Nov. 18, 2019. The following Committee members participated: Elizabeth Kelleher Dwyer, Chair (RI); Scott A. White, Vice Chair (VA); Jim L. Ridling (AL); Ricardo Lara represented by Ken Allen (CA); Andrew N. Mais represented by George Bradner (CT); David Altmaier and Robert Lee (FL); James J. Donelon (LA); Marlene Caride represented by Carl Sornson (NJ); John G. Franchini represented by Ashley Hernandez (NM); Glen Mulready (OK); Larry Deiter represented by Jill Kruger (SD); and Mark Afable (WI).

1. Adopted its Sept. 10 Minutes

The Committee met Sept. 10 and took the following action: 1) adopted its Summer National Meeting minutes; and 2) adopted a data call template to collect private flood data.

Commissioner Afable made a motion, seconded by Commissioner Donelon, to adopt the Committee’s Sept. 10 minutes (Attachment One-A). The motion passed unanimously.

2. Adopted Documents Related to the Private Flood Insurance Data Call

Superintendent Dwyer said the Committee adopted a private flood insurance data call template during its Sept. 10 conference call (Attachment One-A1), contingent on changes to make the data elements consistent with the annual financial statement and the Market Conduct Annual Statement (MCAS). She said NAIC staff made those changes, and the template—along with information related to data checks and filing the data—was distributed.

Superintendent Dwyer said one of the main purposes for the data call and subsequent blanks revisions is for state insurance regulators, the industry, consumers and others to have an accurate picture of the private flood insurance market, its growth and who the major carriers are. She noted that for data calls, the states often collect data under their examination laws because the data needs to be kept confidential. She said data within the data call will mirror what will be collected in 2021 on the annual financial statement. Data collected on the annual financial statement will be publicly available, as it normally is. Superintendent Dwyer said the data collected through the data call will be publicly available just as the data collected on the annual financial statement will be. She noted that to implement the data call, NAIC staff will be reaching out to all states asking them to indicate participation through a signed document.

Birny Birnbaum (Center for Economic Justice—CEJ) said the instructions say the data should be reported in a spreadsheet format, but later it lists input requirements referring to comma delimited format, which is a text format. Aaron Brandenburg (NAIC) said the instructions would be clarified.

Don Griffin (American Property Casualty Insurance Association—APCIA) asked why the data call would be public if state insurance regulators could just wait for the annual financial statement data to be submitted.

Superintendent Dwyer said 2020 data on private flood insurance would not be collected on the annual financial statement until 2021. She also said what is currently collected on the annual financial statement does not split residential policies from commercial policies. She said state insurance regulators and others desire to know which companies are writing what sort of policies. She also noted that writers of commercial general liability policies that do not exclude flood coverage cannot be distinguished from companies writing residential flood coverage.

Mr. Griffin said other lines of business, such as workers’ compensation or stop loss products, are not separated between first-dollar and excess.

Mr. Birnbaum said flood insurance data is fundamentally different, as it mixes commercial and residential coverages, noting that it is critical to distinguish primary from excess coverages in order to inform public policy issues. He said state insurance regulators should lead that discussion and they need to have the data to do so. He said the special data call just collects the annual financial statement data at an earlier time.
Commissioner Donelon agreed with and said state insurance regulators need to have residential policies separated from commercial policies in order to inform public policy discussions.

Superintendent Dwyer said state insurance regulators are often asked who is writing what coverages, and currently they cannot answer that.

Commissioner Mulready made a motion, seconded by Commissioner White, to adopt the supplemental documentation related to the private flood data call (Attachment One-B). The motion passed unanimously.

3. Discussed Proposed Blanks Changes Related to Private Flood Insurance

Superintendent Dwyer said the Committee had previously distributed a proposal to collect private flood insurance data through a new annual financial statement supplement that would collect residential and commercial private flood insurance data and through revisions to the Credit Insurance Experience Exhibit (CIEE) that would collect lender-placed flood coverage data. She said comments were received on the proposed changes from the APCIA, the National Association of Mutual Insurers (NAMIC) and the CEJ.

Mr. Lee asked why first-dollar and excess coverages would not be collected within the CIEE. He said the National Flood Insurance Program (NFIP) has a separate program for lender-placed policies.

Mr. Birnbaum said if flood is required and a policyholder is given a force-placed policy, it is on a first-dollar basis, but if a lender requires more than the maximum offered by the NFIP, there would also be force-placed excess coverage. He suggested that should be broken out on the CIEE.

Superintendent Dwyer said a revised version of the CIEE would be distributed prior to the Fall National Meeting, at which time the Committee might consider adoption of the blanks proposal.

Mr. Griffin said he is concerned that collecting first-dollar and excess coverages would require changes to the way companies collect data. He said he understands that state insurance regulators need to understand the market, but it will take a lot of time to report data in this manner. He said he does not see a need to determine primary from excess for lender-placed policies.

Mr. Birnbaum said lender-placed policies are usually written by the same insurer for primary and excess coverages, but this is not necessarily true in the voluntary market. He said there are likely different companies specializing in first-dollar and excess coverages. He said a distinction is needed between first-dollar and excess so that state insurance regulators can see who is writing the policies and whether there is different experience in the policies. He said the distinction between first-dollar and excess is being made on the MCAS and in the surplus lines flood data collection. He also said the blanks process allows companies to have ample time to make changes so they can report the data. He said first-dollar and excess will be written by companies on two different forms, so it should not be that difficult to report the data.

4. Discussed the Fall National Meeting

Superintendent Dwyer said that during the Fall National Meeting, the Committee hopes to consider adoption of a document from the Catastrophe Insurance (C) Working Group that describes steps the states can take to facilitate the growth of the private flood insurance market. She said the Committee will also consider adoption of its 2020 proposed charges. She said the Committee will continue a conversation from the Summer National Meeting on underinsurance by hearing from the APCIA and NAMIC. She said the Committee will also hear from SBP, which is a nonprofit organization that will speak about its mission to prepare citizens prior to and following disasters with mitigation and resilience steps.

Having no further business, the Property and Casualty Insurance (C) Committee adjourned.
The Property and Casualty Insurance (C) Committee met via conference call Sept. 10, 2019. The following Committee members participated: Elizabeth Kelleher Dwyer, Chair (RI); Scott A. White, Vice Chair (VA); Jim L. Ridling (AL); Ricardo Lara represented by Ken Allen (CA); David Altmair (FL); Robert H. Muriel represented by Reid McClintock (IL); James J. Donelon (LA); Marlene Caride represented by Carl Sornson (NJ); John G. Franchini represented by Anna Krylova (NM); Glen Mulready (OK); Larry Deiter represented by Dan Nelson (SD); and James A. Dodrill represented by Jamie Taylor (WV).

1. **Adopted its Summer National Meeting Minutes**

Commissioner Altmaier made a motion, seconded by Mr. Nelson, to adopt the Committee’s Aug. 5 minutes (**see NAIC Proceedings – Summer 2019, Property and Casualty Insurance (C) Committee**). The motion passed unanimously.

2. **Adopted a Data Template for a Private Flood Insurance Data Call**

Superintendent Dwyer said the Committee discussed the possibility of a data call to collect private flood insurance data during its July 18 conference call. She said the Committee has separately discussed collection of private flood data through the annual financial statement blank and that the data collected in each would be as similar as possible. She noted three comment letters were received on the blanks proposal and said those comments would be discussed on a future conference call.

Superintendent Dwyer said state insurance regulators, the Federal Emergency Management Agency (FEMA), the industry and consumers have struggled with defining just how big the private flood market is and how fast it might be growing. Private flood data collected through the annual financial statement does not distinguish between residential and commercial policies. She noted that insurance publications cite the largest writer of private flood insurance as a company that writes large corporations and does not exclude flood from its policies. The company is not issuing standalone residential policies, but this cannot be determined from the data found in the annual financial statement.

Superintendent Dwyer said new data received from a revision to the annual financial statement would not be received until 2021, so a data call would allow that data to be collected sooner. The draft data call proposes five main sections: four sections for residential coverages, including standalone first dollar, standalone excess, endorsements first dollar and endorsements excess; and one section for all commercial policies. Data collected at a state level would include direct written and earned premium, direct losses paid, direct losses case reserves, defense and cost containment paid, defense and cost containment case reserves, number of policies in force at the end of the year, number of claims reported, open claims and closed claims with payment, and percentage of polices written in a special flood hazard area (SFHA). Superintendent Dwyer said the data call would collect 2018 data later this year or early next year and then 2019 data in 2020.

Birny Birnbaum (Center for Economic Justice—CEJ) said the data call should collect 2018 data after the end of 2019. He said the first six data categories track the State Page but not precisely. He recommended using State Page definitions for those data elements. He recommended the number of policies in force be collected at the beginning and end of the year. He said claims information is included in the Market Conduct Annual Statement (MCAS), although this reporting does not start with 2018 data. He said knowing the number of policies in an SFHA is important, but it may not be readily available as companies may not routinely collect it.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said she agrees with Mr. Birnbaum. She noted that some of the data is collected on the MCAS and that data collection might start in 2020 for 2019 data. It was later determined that private flood data would begin to be collected through the MCAS in 2021 for 2020 data.

Superintendent Dwyer asked if companies would have the SFHA data, and Ms. Brown said she would check with members. Mr. Birnbaum said the claims data in the data call should use definitions equivalent to what MCAS uses.
Commissioner White made a motion, seconded by Commissioner Mulready, to adopt the private flood data call template with revisions made during the conference call (Attachment One-A1). The motion passed unanimously.

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

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PRIVATE FLOOD INSURANCE DATA CALL
2018 Data

NAIC Group Code ......................................... NAIC Company Code ......................................

Company Name ..........................................................................................................................
................................................................................................................................................

Part 1 - Interrogatories

Private Flood Insurance Coverage:

1. Does the reporting entity write any stand-alone first-dollar residential private flood
   insurance? Yes [  ] No [  ]
   If yes, complete Part 2

2. Does the reporting entity write any stand-alone excess residential private flood?
   Yes [  ] No [  ]
   If yes, complete Part 3

3. Does the reporting entity write any first-dollar residential private flood provided as an
   endorsement? Yes [  ] No [  ]
   If yes, complete Part 4

4. Does the reporting entity write any excess residential private flood insurance
   provided as an endorsement? Yes [  ] No [  ]
   If yes, complete Part 5

5. Does the reporting entity write any commercial private flood insurance provided as
   either a stand-alone or package policy? (include both first-dollar and excess)
   Yes [  ] No [  ]
   If yes, complete Part 6
### Part 2 – Standalone Residential Private Flood Policies

#### Policy and Claims Data

**First Dollar**

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<th>Direct Losses Paid</th>
<th>Defense and Cost Containment Expenses Paid</th>
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<th>Defense and Cost Containment Case Reserves Expenses Incurred</th>
<th>Number of Policies In Force (as of 1/1/2018)</th>
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<th>Number of Claims Reported Open on 1/1/2018</th>
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## Part 4 - Residential Private Flood Policy Endorsements

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Part 5 - Residential Private Flood Policy Endorsements
Policy and Claims Data
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<th>States, RIs</th>
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<th>Direct Losses Paid</th>
<th>Defense and Cost Containment Expense Paid</th>
<th>Defense and Cost Containment Expense Incurred</th>
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<th>Number of Policies In Force (as of 12/31/2018)</th>
<th>Number of Claims Opened during the Reporting Year</th>
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PRIVATE FLOOD INSURANCE DATA CALL

DATA DEFINITIONS

This data call is intended to provide state regulators with information regarding the size of the private market for flood insurance, particularly as it relates to residential coverage. The size of the private market is of interest due to constraints in federal coverage such as pricing and limits of coverage offered through the National Flood Insurance Program (NFIP), and in order for state regulators, FEMA and the public to understand the growth of the private flood insurance market.

The data call will be split into two parts, in order to collect private flood insurance data for the data years 2018 and 2019. Subsequently, private flood insurance data will be collected through the NAIC Financial Annual Statement beginning in 2021 with 2020 data. The data obtained through the data call will be made available to the public in the same manner that data received through the Annual Statement is available to the public.

Data submitted for the data call should be separated into five exhibits. Exhibits are described in detail below. Report experience for Private Flood regardless of the line of business in the statutory annual statement in which the experience is reported.

PART 1 | Company Information

NAIC Group Code - The NAIC Group code if the carrier is part of a holding company. If not part of a holding company, leave the field blank.

NAIC Company Code - The NAIC Cocode for the reporting company.

Company Name - Legal name of the insurance company.

Contact Name - The company contact person for the purposes of this report. First name, Last name.

Contact E-mail Address - The email address for the company contact included above.

Private Flood Insurance is coverage that insures commercial and residential property against the peril of flood, not offered through the National Flood Insurance Program.

For Residential Policies, Standalone and Endorsements, First Dollar and Excess, please include flood policies covering the following property types:

- Mobile/manufactured homes intended for use as a dwelling
- Individual unit condo coverage
- Single family homes
- Residential structures including four or fewer family units
Exclude:

- NFIP policies
- Private flood written on a surplus lines basis (subject to the separate flood data collection conducted through the IID).
- Lender-placed or creditor-placed policies.

Part 2 | Standalone Residential Private Flood Policies. First Dollar

This Exhibit should include data relative to residential policies sold on a standalone basis for the sole purpose of insuring against losses due to flood. Coverage should be included for first dollar losses, not contingent to NFIP coverage or amounts over and above NFIP policy limits.

Part 3 | Standalone Residential Private Flood Policies. Excess

This Exhibit should include data relative to residential policies sold on a standalone basis for the sole purpose of insuring against losses due to flood. Coverage should be included for amounts over and above NFIP policy limits.

Part 4 | Residential Private Flood Policy Endorsements. First Dollar

This Exhibit should include data relative to residential policies sold as an endorsement for the purpose of insuring against losses due to flood attached to another policy, including but not limited to, homeowners, dwelling or umbrella. This differs from data collected through the Market Conduct Annual Statement as it includes all endorsements in one place. MCAS collects separately on homeowner’s policy endorsements and all other policy endorsements. Coverage should be included for first dollar losses, not contingent to NFIP coverage or amounts over and above NFIP policy limits.

Part 5 | Residential Private Flood Policy Endorsements. Excess

This Exhibit should include data relative to residential policies sold as an endorsement for the purpose of insuring against losses due to flood attached to another policy, including but not limited to, homeowners, dwelling or umbrella. This differs from data collected through the Market Conduct Annual Statement as it includes all endorsements in one place. MCAS collects separately on homeowner’s policy endorsements and all other policy endorsements. Coverage should be included for amounts over and above NFIP policy limits.
For Commercial Policies, Standalone and Endorsements, First Dollar and Excess, please include flood policies covering the following property types:

- Non-residential coverage
- Commercial coverage including, but not limited to:
  - Allied lines
  - Businessowners policies
  - Commercial general liability
  - Condo master policies

Exclude:

- NFIP policies
- Private flood written on a surplus lines basis (subject to the separate flood data collection conducted through the IID).

Part 6 | Commercial Private Flood Policy Endorsement. First Dollar and Excess

This Exhibit should include data relative to commercial policies sold both as stand-alone coverage and as an endorsement to any underlying policy for the purpose of insuring against losses due to flood. This differs from data collected through the Market Conduct Annual Statement as it includes coverage offered under commercial policies. These amounts should include policies offered as first dollar coverage as well as excess to NFIP policy limits.

**EACH EXHIBIT INCLUDES THE FOLLOWING DATA ELEMENTS:**

**Direct Written Premium**

Written premium is defined as the contractually determined amount charged by the reporting entity to the policyholder for the effective period of the contract based on the expectation of risk, policy benefits, and expenses associated with the coverage provided by the terms of the insurance contract.\(^1\) Amounts should be consistent with the amount reported on the NAIC Annual Financial Statement Exhibit of Premiums and Losses. This includes direct premium written during the calendar year specified (2018 for the first reporting year). Premiums reported should be gross, including policy and membership fees, less return premiums and premiums on policies not taken. Premiums may include new and renewal policies. If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date) the net effect should be reported. Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

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\(^1\) Statement of Statutory Accounting Principles No. 53. Property Casualty Contracts—Premiums.
Direct Premium Earned

Earned premium may be pro-rated daily or monthly, accounting for the portion of expired premiums under the contract. Additional premiums charged to policyholders for endorsements or changes in coverage under the contract shall be recorded on the effective date and accounted for in a manner consistent with the expiration of the initial premium charged pursuant to the policy contract.\(^2\) Amounts should be consistent with the amount reported on the NAIC Annual Financial Statement Exhibit of Premiums and Losses. This includes direct premium earned during the calendar year specified (2018 for the first reporting year). Premiums reported should be gross, including policy and membership fees, less return premiums and premiums on policies not taken. Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

Direct Losses Paid

Direct losses paid should include losses paid less salvage, not including reserves or unpaid claim amounts. Amounts should be consistent with the amount reported on the NAIC Annual Financial Statement Exhibit of Premiums and Losses. Policies may include per-occurrence or claims-made.

Direct Losses Incurred

Direct losses incurred should include losses incurred during the reporting year, including amounts held in reserve. Amounts should be consistent with the amount reported on the NAIC Annual Financial Statement Exhibit of Premiums and Losses.

Defense and Cost Containment Expense Paid

Defense and cost containment expense paid should include only those amounts actually paid during the reporting year. Amounts should be consistent with the amount reported on the NAIC Annual Financial Statement Exhibit of Premiums and Losses. DCC include defense, litigation, and cost containment expenses, whether internal or external. DCC include, but are not limited to, the following items:

- Surveillance expenses
- Litigation management expenses
- Fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in defense of a claim;
- Attorney fees incurred owing to a duty to defend, even when other coverage does not exist; and
- The cost of engaging experts\(^3\)

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\(^3\) Statement of Statutory Accounting Principles No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses

© 2019 National Association of Insurance Commissioners
Defense and Cost Containment Expense Incurred

Defense and cost containment expense incurred should include expenses incurred during the reporting year, including amounts held in reserve. Amounts should be consistent with the amount reported on the NAIC Annual Financial Statement Exhibit of Premiums and Losses. DCC include defense, litigation, and cost containment expenses, whether internal or external. DCC include, but are not limited to, the following items:

- Surveillance expenses
- Litigation management expenses
- Fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in defense of a claim;
- Attorney fees incurred owing to a duty to defend, even when other coverage does not exist; and
- The cost of engaging experts

Number of Policies In Force (as of 1/1/2018)

Amounts should include a count of policies in effect as of Jan. 1, 2018.

Number of Policies In Force (as of 12/31/2018)

Amounts should include a count of policies in effect as of Dec. 31, 2018.

Number of Claims Open on 1/1/2018

Number of Claims Opened during the Reporting Year

Number of Claims Open on 12/31/2018

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4 Statement of Statutory Accounting Principles No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses

© 2019 National Association of Insurance Commissioners
Number of Claims Closed with Payment

Amounts should include claims closed with payment where the claim was closed during the reporting period (calendar year 2018) regardless of the date of loss or when the claim was received. For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims. Please EXCLUDE:

- If a claim is reopened for the sole purpose of refunding the insured’s deductible, do not count it as a paid claim.
- If claims were paid for company loss adjustment expenses and no payment is made to the insured/claimant, do not count it as a paid claim.
- If claims are closed because the amount claimed is below the insured’s deductible, do not count it as a paid claim.
PRIVATE FLOOD INSURANCE DATA CALL

FILING INSTRUCTIONS

Each company that wrote premium for private flood insurance in 2018 should submit THEIR OWN XLSX file through ----.

Files should contain all SIX parts as shown on the data template provided here.

Data elements will be checked upon uploading them to the system. If the file contains errors as described below, the file will be rejected, and errors must be corrected prior to submission.

DATA FORM AND FORMAT AND REASONABILITY CHECKS

The template provided must include six tabs in the following order: Introduction, Part 2, Part 3, Part 4, Part 5, Part 6.

Part 1 should include the following elements.

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Input Requirements</th>
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<tr>
<td>NAIC Company Code</td>
<td>Numeric (max length = 5 characters)</td>
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<tr>
<td>Contact E-Mail Address</td>
<td>E-mail Address (max length = 75 characters)</td>
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</table>

Column A of the template should be unaltered and include the full state & District of Columbia in alphabetical order, followed by the territories in alphabetical order and a total on the final row, (row 58).

The 12 data elements listed in row 1 along the top of the spreadsheet should consist of the following data elements.

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Input Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Written Premium</td>
<td>Numeric (comma delimited, max length including commas = 15 characters)</td>
</tr>
<tr>
<td>Direct Premium Earned</td>
<td>Numeric (comma delimited, max length including commas = 15 characters)</td>
</tr>
<tr>
<td>Direct Losses Paid</td>
<td>Numeric (comma delimited, max length including commas = 15 characters)</td>
</tr>
<tr>
<td>Direct Losses Incurred</td>
<td>Numeric (comma delimited, max length including commas = 15 characters)</td>
</tr>
<tr>
<td>Defense and Cost Containment Expense Paid</td>
<td>Numeric (comma delimited, max length including commas = 15 characters)</td>
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<tr>
<td>Defense and Cost Containment Expense Incurred</td>
<td>Numeric (comma delimited, max length including commas = 15 characters)</td>
</tr>
<tr>
<td>Number of Policies In Force (as of 1/1/2018)</td>
<td>Numeric (comma delimited, max length including commas = 15 characters)</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------</td>
</tr>
<tr>
<td>Number of Claims Open on 1/1/2018</td>
<td>Numeric (comma delimited, max length including commas = 15 characters)</td>
</tr>
<tr>
<td>Number of Claims Opened during the Reporting Year</td>
<td>Numeric (comma delimited, max length including commas = 15 characters)</td>
</tr>
<tr>
<td>Number of Claims Open on 12/31/2018</td>
<td>Numeric (comma delimited, max length including commas = 15 characters)</td>
</tr>
<tr>
<td>Number of Claims Closed with Payment</td>
<td>Numeric (comma delimited, max length including commas = 15 characters)</td>
</tr>
</tbody>
</table>

**ANTICIPATED ANALYSIS OF DATA RECEIVED**

1. **Count of insurers offering by state for each covered loss type** (residential, commercial), policy type (standalone, endorsement), and coverage type (first dollar, excess, both).

2. **Total premiums by state and covered loss type/policy type/coverage type = Direct Premium Written and Earned.**

3. **Average Premium** = Direct Premium Written/Number of policies In Force as of 12/31/2018

4. **Loss Ratio by State and Coverage Type** = (Direct Losses Incurred + Defense and Cost Containment Incurred)/Direct Premium Written

5. **Loss Ratio by State and Coverage Type** = (Direct Losses Paid + Defense and Cost Containment Paid)/Direct Premium Earned

6. **Policy growth** = Count of policies in force beginning and end of year by State and Coverage Type.

7. **Loss Severity** = (Losses Paid + DCC Paid)/Number of Policies in Force as of 12/31/2018

8. **Frequency of Losses** = Number of Claims Closed with Payment/Number of Policies in Force as of 12/31/2018

9. **Claim Frequency** = (Number of Claims Open on 12/31/2018 + Number of Claims Opened during the Reporting Year – Number of Claims Open on 1/1/2018)/Number of Policies In Force as of 12/31/2018
Cannabis Insurance (C) Working Group
Conference Call
October 10, 2019

The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call Oct. 10, 2019. The following Working Group members participated: Ricardo Lara, Chair, represented by Bryant Henley, Camille Dixon and Camilo Pizarro (CA); Michael Conway, Vice Chair, represented by Peg Brown (CO); Joanne Bennett and Austin Childs (AK); Steve Kinion (DE); John Melvin (KY); Robert Baron (MD); Nicole A. Brown and Carl Sornson (NJ); Kelsey Barlow (NV); Cuc Nguyen (OK); Alex Cheng and TK Keen (OR); John Lacek (PA); Matt Gendron (RI); Pat Murray and Christina Rouleau (VT); and Michael Bryant (WA). Also participating were: Vincent Gosz (AZ); Derek Silver (FL); Linda Grant (IN); Jeana Thomas (MO); Anna Krylova (NM); Gerald Scattaglia (NY); and Paige Hansen (TX).

1. Adopted Revisions to its 2020 Proposed Charges

Mr. Henley said revisions were made to the Working Group’s 2020 proposed charges based on feedback from its last conference call and additional changes from Commissioner Lara. The revised 2020 proposed charges are as follows: 1) assess and periodically report on the status of federal legislation that would protect financial institutions from liability associated with providing services to cannabis businesses operating legally under state law; 2) encourage admitted insurers to improve coverage adequacy in the states where cannabis, including hemp, is legal; 3) provide insurance resources to stakeholders and keep up with new products and innovative ideas that may shape insurance in this space; and 4) collect aggregated insurance availability and coverage gap information, as well as other cannabis and hemp insurance-related data to then publicly share the cannabis and hemp insurance-related data in a released report by the end of 2021.

Ms. Brown said she liked the revisions. Mr. Gendron asked if the second charge should include the Working Group capturing information on coverage adequacy, such as the number of insurers writing in a state and what coverages they offer. Ms. Dixon said the Working Group was unsuccessful in its attempts to do this previously when it asked the states to verify similar information collected from the National Cannabis Industry Association (NCIA).

Ms. Brown said Colorado’s recent survey of crop insurers found that there was a significant difference in coverage available for marijuana and hemp. She said large managing general agents (MGAs) are in a better position to negotiate contracts for large vertically integrated operations with large national insurance carriers.

Mr. Keen expressed concern that the second charge presupposed a coverage adequacy problem. Mr. Gendron said this paralleled his earlier concern. Mr. Henley proposed that the word “improve” in the second charge be modified to “ensure.”

Ms. Brown made a motion, seconded by Ms. Bennett, to adopt the charges with the revision to the second charge. The motion passed unanimously.

2. Discussed Memorandum to the Property and Casualty Insurance (C) Committee

Mr. Henley said the memorandum (Attachment Two-A) summarizes the activity of the Working Group and explains the intent of its 2020 proposed charges and future deliverables. There were no comments on the memorandum.

3. Discussed its Next Steps

Anne Obersteadt (NAIC) said the Understanding the Market for Cannabis Insurance white paper will be considered for full adoption by the Executive (EX) Committee and Plenary at the Fall National Meeting.

Aaron Brandenburg (NAIC) said the Property and Casualty Insurance (C) Committee will likely consider the charges of the groups reporting to it for adoption at the Fall National Meeting, with associated materials being posted electronically two weeks prior to the meeting.
4. **Discussed Other Matters**

Mr. Melvin said Kentucky is a hemp-only state and has been receiving blanket exclusions from insurers, particularly in commercial filings. He asked if other states have had similar experiences. Ms. Dixon said California had not.

Mr. Keen asked how many states are hemp-only. Mr. Melvin said there were 14 states according to the National Council on Compensation Insurance (NCCI), most of which were in the southeast portion of the country. Mr. Keen suggested that the best experience comparison would be with other states that are also hemp-only.

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

TO: Superintendent Elizabeth Dwyer (RI)
    Chair of the Property and Casualty Insurance (C) Committee

FROM: Commissioner Ricardo Lara (CA)
    Chair of the Cannabis Insurance (C) Working Group

DATE: 

RE: Update and Proposed 2020 Charges

The Executive (EX) Committee appointed the Cannabis Insurance (C) Working Group during its Aug. 5, 2018, meeting to study insurance issues related to legal cannabis business. Specifically, the Working Group is charged to: “…consider the insurance regulatory issues surrounding the legalized cannabis business, including availability and scope of coverage, workers’ compensation issues, and consumer information and protection. The Working Group will develop a white paper outlining the issues and containing recommendations for the development of regulatory guidance as appropriate. The Working Group will complete its work by first quarter 2020.” This memorandum summarizes the activity of the Working Group and sets forth proposed 2020 charges intended to specify its future deliverables.

Submission of the White Paper to the Committee for Potential Adoption

The primary deliverable of the Cannabis Insurance (C) Working Group is to prepare a White Paper outlining the issues and containing recommendations for the development of regulatory guidance. The Working Group exposed the white paper Understanding the Market for Cannabis Insurance for a 30-day period, ending June 24, on its May 23 conference call. After accounting for all submitted comments, the Working Group unanimously adopted the White Paper on its July 9th conference call. As such, the Working Group submitted the White Paper to the C Committee for approval at the Summer National Meeting. The C Committee unanimously adopted the White Paper on August 5, 2019 at the National meeting in New York. The White Paper will be considered for potential adoption by the Executive (EX) Committee and Plenary during the Fall National Meeting in Texas.

Proposed Working Group Charges for 2020

Given the completion of its charge to develop the Understanding the Market for Cannabis Insurance white paper, the Working Group would like to propose updated charges for 2020.

As such, the following represents proposed changes to the 2020 Charges for the Working Group:

1) Assess and periodically report on the status of federal legislation that would protect financial institutions from liability associated with providing services to cannabis businesses operating legally under state law.

2) Encourage admitted insurers to improve coverage adequacy in states where cannabis, including hemp, is legal.
3) Provide insurance resources to stakeholders, and keep up with new products and innovative ideas that may shape insurance in this space.

4) Collect aggregated insurance availability and coverage gap information, as well as other cannabis and hemp insurance-related data to then publicly share the cannabis and hemp insurance-related data in a released report by the end of 2021.

The Working Group has specified the charges include the evaluation of commercial insurance issues related to hemp. Both hemp and marijuana come from the same cannabis species. Many states are tracking hemp issues in parallel with marijuana issues, as businesses operating in both these spaces face many of the same issues (banking, insurance availability, etc.). Additionally, the Working Group’s proposed charges reflect its intent to examine commercial insurance issues, including commercial auto and workers compensation issues. The Working Group feels issues related to impairment and safety extend beyond just cannabis-related issues and should be undertaken as part of a comprehensive effort under other Working Groups.
Catastrophe Insurance (C) Working Group
Austin, Texas
December 7, 2019

The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met in Austin, TX, Dec. 7, 2019. The following Working Group members participated: Mike Chaney, Chair (MS); David Altmaier, Vice Chair, represented by Virginia Christy and Susanne Murphy (FL); Jerry Workman (AL); Michael Ricker (AK); George Bradner (CT); Colin M. Hayashida (HI); Judy Mottar (IL); Heather Droge (KS); Warren Byrd (LA); Kevin Beagan (MA); Paula Keen (MD); Fred Fuller (NC); Tom Botsko (OH); Cuc Nguyen (OK); Brian Fordham (OR); Mike McKenney (PA); Beth Vollucci (RI); Joe Cregan (SC); Patrick Merkel (TN); J’ne Byckovski and Mark Worman (TX); John Haworth (WA); and James A. Dodrill (WV). Also participating were: Peg Brown (CO); Travis Grassel (IA); and Scott A. White (VA).

1. **Adopted its Summer National Meeting Minutes**

Commissioner Dodrill made a motion, seconded by Mr. Haworth, to adopt the Working Group’s Aug. 3 minutes (see NAIC Proceedings – Summer 2019, Property and Casualty Insurance (C) Committee, Attachment Two). The motion passed unanimously.

2. **Adopted its Drafting Group Reports**

Mr. Bradner said a drafting group consisting of himself, Mr. Workman, Ms. Nelson and Mr. Byrd has been working on updating the NAIC State Disaster Response Plan. The purpose of the document is to provide a template for a state department of insurance (DOI) to use when assisting consumers following a disaster. The document details how a DOI can work with other agencies, including federal, state or local agencies; the NAIC; and other state DOIs. The NAIC State Disaster Response Plan template provides states needing NAIC assistance following a disaster with high-level action items for a state DOI to do prior to contacting the NAIC, as well as the types of assistance the NAIC can provide to the states.

Mr. Bradner said the document is broken up into several topics, including: 1) preparation steps, as well as important planning considerations following a disaster; 2) important contacts that a DOI should collect on a regular basis; 3) resources required for emergency response; 4) major incident management functions; 5) disaster response teams and their purpose; 6) roles and responsibilities of various staff members following a disaster; 7) example response levels and definitions; and 8) contact templates.

Mr. Bradner said the drafting group would like to send the document to Working Group members and interested state insurance regulators for input. Once the input is received and incorporated, the document can be exposed.

Mr. Bradner made a motion, seconded by Mr. Byrd, to adopt the Working Group’s report and expose the document for a 30-day public comment period.

3. **Heard an Update Regarding Federal Legislation and the NFIP**

Brooke Stringer (NAIC) provided an update regarding federal legislation and the National Flood Insurance Program (NFIP). The NFIP continues to operate on a series of short-term extensions since its reauthorization expired two years ago. Last month, the 14th short-term extension was signed into law as part of a federal government spending bill. This extension continues through Dec. 20. There were 17 extensions over a four year period leading up to the last NFIP reauthorization. Currently, there is not much optimism for a deal on a long-term extension within the next few weeks, and additional short-term extensions are likely.

The last substantive Congressional action was in June when the U.S. House of Representatives (House) Committee on Financial Services approved a five year reauthorization bill (H.R. 3167). This bill included some provisions from the NAIC guiding principles for reauthorization, including ensuring that consumers can leave and return to the NFIP without penalty and receive pro-rata refunds when they cancel an NFIP policy midterm to switch to a private flood insurance policy. However, following the committee markup, lawmakers from coastal states introduced an alternative bill, (H.R. 3872/S. 2187) as they did not believe...
Chairwoman Maxine Waters’ bill went far enough to protect policyholders from rate hikes. Neither bill has proceeded further at this time, and there has been no focus on the NFIP reauthorization in the U.S. Senate (Senate). Ms. Stringer will continue to keep the Working Group updated on any Congressional action.

Last month, the Federal Emergency Management Agency (FEMA) announced that it will delay implementation of its Risk Rating 2.0 initiative until Oct. 1, 2021. Risk Rating 2.0 is FEMA’s new flood risk rating system.

4. Heard a Presentation from Milliman and FEMA Regarding Risk Rating 2.0

Nancy Watkins (Milliman) said FEMA’s current rating system, Risk Rating 1.0, is based on first generation technology, which is insufficient for current purposes. The technology needs to be updated due to changes in technology. Some of the limitations of the current rating system include: 1) an inconsistent match of risk to rate; 2) current rates are based on outdated methods; and 3) current rates are confusing and opaque.

Ms. Watkins said the current rating system inconsistently matches risk to rate. Inconsistent matches of risk to rate include scenarios such as: 1) neighbors having very different premiums; 2) mispriced policies for homes under water following a flood event; 3) repetitive loss properties; 4) interstate subsidization; 5) insurance to value effects; and 6) large premiums.

Ms. Watkins said insurance to value effects include the fact that dwelling replacement cost is not considered in premium calculation. Two houses with the same amount of coverage can pay the same premium, even with very different home values; therefore, high value homes are subsidized by low value homes.

Ms. Watkins said current rates are based on outdated methods, as flood zones ignore pluvial (flash) flood risk. For example, Hurricane Harvey damaged more than 204,000 homes and apartments in Harris County, and almost three-quarters of these properties were outside of the federally regulated 100-year flood plain. This flood event left thousands of homeowners uninsured and unprepared. Ms. Watkins said most urban flooding is pluvial and not considered in Risk Rating 1.0.

Ms. Watkins said historical experience regarding flooding is volatile and reflects only what has happened and not what could happen. There are other flood zone limitations including: 1) flood zones based on greater depth of a 100-year flood from either storm surge or riverine flooding at a given point; 2) combined effects of storm surge and riverine flooding not considered; 3) current mapping only produces 100-year flood elevations, but floods come in all sizes; 4) flood depths at other return periods are not considered; 5) correlation between flooding at nearby locations is not considered; and 6) concentration risk that contributes to volatility and reinsurance cost are not considered.

Ms. Watkins said elevation certification requirements are confusing to consumers. Elevation certificates are required for some homes, but not all homes, and they depend on several factors, including: 1) flood zone; 2) the year of construction; and 3) the year of the initial flood map. An elevation certificate may result in a lower premium, even when it is not mandatorily required. The elevation certificate process, decision and cost are something that most homeowners do not fully understand.

Ms. Watkins said grandfathering and remapping effects are confusing to consumers. A home built in a flood zone that is later remapped may change the elevation needs. Additionally, grandfathered rates may not be applicable to a person buying a home that has been remapped, which may substantially increase the premium for the new owner.

Ms. Watkins said there is an issue with take-up rates, as mandatory purchase of flood insurance does not apply in X zones. The lack of rate differentiation in X zones means that higher risk insureds tend to purchase coverage, while lower risk insureds tend not to purchase coverage; this lowers the take-up rate.

David Maurstad (FEMA) said FEMA’s mission is to help consumers before, during and after a disaster. He said FEMA’s intention is to build a culture of preparedness that leads to community resilience and results in less suffering due to a disaster.

Mr. Maurstad said Congress passed the 14th NFIP short-term extension in September; this extension expires on Dec. 20. Throughout the reauthorization process, FEMA believes that there is an opportunity for the U.S. Congress (Congress) to take steps to support the NFIP transformation to provide greater flexibility and make customer-centric changes.
Mr. Maurstad said FEMA continues to emphasize the importance of a timely and multi-year reauthorization that creates a sound financial framework, making the program sustainable for years to come, to increase the number of consumers covered under the NFIP program, improve the customer experience, implement essential program reforms, and move mitigation forward across the nation. He said FEMA will continue to work with Congress and the administration to be sure everyone is fully informed regarding the opportunities and the challenges faced by the NFIP. He said even with the uncertainty of a long-term reauthorization, FEMA will continue to work to transform the NFIP.

Mr. Maurstad said in 2019 there were 45 major disaster declarations across 25 states, five tribal regions, and one territory. Disaster costs also continue to increase. Disaster events in 2018 totaled $91 billion. Through October 2019, there have been a total of 10 disasters costing $1 billion each.

Mr. Maurstad said FEMA is attempting to change the national discussion focusing on the impact of disasters and their response and recovery. He said while this is necessary, FEMA needs to move to more actively engage in thinking about what can be done to reduce disaster suffering and contribute to individual and community resilience prior to a disaster.

Mr. Maurstad said 98% of the counties in the U.S. have experienced flooding events. He said flood insurance allows consumers to get back on the road to recovery more quickly and adds to individual and community resilience. The average flood insurance premium is $700 per year, and the average claim payment is $43,000. It is important to note that one inch of water can cause $25,000 of damage.

Mr. Maurstad said the National Flood Insurance Act instructs FEMA to periodically review the NFIP rating structure to be sure that there are actuarially sound principles. He said a few years ago, FEMA started to prioritize the customer experience and focus on what could be done to increase the take-up rate of flood insurance. FEMA assessed the rating product and pricing and began to build the Risk Rating 2.0 product.

The understanding of flood risk has evolved for the NFIP, insurers and reinsurers. FEMA’s current rates and methodology simply do not show the full flood risk, and incorrect pricing signals are being sent to property owners. Since the 1970s the NFIP rates have been based on property elevation and location within a zone. Relying on that static view resulted in misidentified risk and an inequitable flood insurance program.

The NFIP has inadvertently over the years resulted in the disparity of lower value homes paying relatively more for flood insurance than policyholders with higher value homes. FEMA is working to incorporate innovative technology data and modeling methodologies, as well as include private sector data sets. Risk Rating 2.0 will help policyholders to better understand their individual property risk by incorporating broader geographic and structural variables, such as distance to a close river, with the objective to strive to deliver rates that are fair, easier to understand, and better reflect a property’s unique flood risk.

Risk Rating 2.0 will fundamentally change the way FEMA rates a property’s flood risk and prices flood insurance. Risk Rating 2.0 will provide premium factors that are easier for both agents and policyholders to understand. Risk Rating 2.0 will provide the basis for more informed decision making for property owners, and it will contribute necessary information so property owners can consider mitigation actions that can also better protect the property owner and help to reduce their flood insurance premium.

FEMA now has the tools to address inequity between lower-valued and higher-valued homes. This will also provide a basis for the necessary revenues to cover prospective losses, establish a sound financial framework, and contribute to moving the NFIP to more solid fiscal ground. Risk Rating 2.0 will also ultimately result in better land use, flood plain management decisions, a more informed consumer base, more building structure mitigated to withstand flood events, more people insured, and a more financially prepared nation.

FEMA will provide more information regarding Risk Rating 2.0 when it is certain that the information is ready to release. FEMA has made a lot of progress and has worked with industry, individuals and partners to create a completely new risk rating methodology that will be able to perform and reveal a better flood risk. Risk Rating 2.0 will be rolled out for residential, multi-family and commercial structures at the same time.
Commissioner Dodrill said one of the first meetings he had as an insurance commissioner was with FEMA. He said FEMA came to tell him about existing three-year policies that were about to expire following the June 16 flooding. He said there would be consequences to the individuals if they did not convert the policies to privately paid policies; the consequence was that the next time there is a flood, FEMA is not coming. He said his DOI embarked on a campaign of public outreach over several months to encourage consumers in the state to convert those policies in August to privately paid policies. He said they did not have much success in West Virginia, as the take-up rate on flood policies was low.

Commissioner Dodrill said many of the homes in West Virginia also do not have mortgages, as they have been passed down through the generations. Mandating flood insurance for homes that have federally backed mortgages for flood is not a solution in West Virginia. Subsidization is also a huge issue in West Virginia. Commissioner Dodrill said individuals in his state simply cannot afford to convert the individual assistance policies. He asked Mr. Maurstad how Risk Rating 2.0 is going to be phased in and how it will affect lower income individuals. He also asked about the possibility of insureds paying monthly or quarterly payments instead of payment in full to make flood insurance more affordable by issuing periodic payments.

Mr. Maurstad said FEMA needs to do a better job making sure individuals understand that they have the flood policy and coverage provided by the FEMA individual assistance program. He said it is important for individuals to understand what steps can be taken to prepare for maintaining and obtaining requirements of the individual assistance grant program to be eligible for individual assistance if another flood event occurs.

Mr. Maurstad said FEMA is able to provide resources and information to help the states. He said there is technical assistance that FEMA can provide to help individuals understand that the reason that they lose that coverage is to provide an incentive for them to obtain flood insurance.

Mr. Maurstad said an affordability study has been done for Congress, and there have been proposals suggested during the reauthorization discussions to start some type of affordability program. One specific suggestion by the administration was to slow down the increases for those policyholders that earn 8% or less of the average median income in an area. Affordability is an issue that needs to be addressed.

Mr. Maurstad said monthly installments were actually part of the last reauthorization, and FEMA is in the process of developing a monthly installment program that is going through ruling right now.

Having no further business, the Catastrophe Insurance (C) Working Group adjourned.
The Climate Risk and Resilience Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met in Austin, TX, Dec. 7, 2019. The following Working Group members participated: Mike Kreidler, Chair, Jay Bruns, Annalisa Gellermann and Patrick McNaughton (WA); Michael Ricker (AK); William Arfanis and George Bradner (CT); Colin Hayashida (HI); Judy Mottar (IL); Robert Baron (MD); Steve Kelley and Peter Brickwedde (MN); Anna Krylova (NM); Marshal Bozzo (NY); Tom Botsko (OH); Andrew Stolfi (OR); Shannen Logue and Michael McKenney (PA); and Rosemary Raszka (VT). Also participating were: Travis Grassel (IA); Beth Vollucci (RI); and Scott A. White (VA).

1. **Adopted its Oct. 2 and Summer National Meeting Minutes**

   Mr. Bradner made a motion, seconded by Mr. Baron, to adopt the Working Group’s Oct. 2 (Attachment Four-A) and Aug. 3 (see NAIC Proceedings – Summer 2019, Property and Casualty Insurance (C) Committee, Attachment Three) minutes. The motion passed unanimously.

2. **Heard Updates on Working Group Members’ Climate Resilience-Related Activities**

   Commissioner Kreidler said the work of this Working Group is part of an ongoing global effort for climate action and resilience. Today, the 2019 United Nations (UN) Climate Change Conference (COP25) is meeting in Madrid, Spain. In the run-up to that meeting, the UN released a report warning that even if countries meet commitments made under the Paris Agreement, the world is heading for a 3.2 degrees Celsius global temperature rise over pre-industrial levels, leading to even wider-ranging and more destructive climate impacts. Regional, state and local efforts continue to be fundamental in combating climate risk and improving resilience in the U.S. As such, Commissioner Kreidler said it is prudent to provide an opportunity at each Working Group meeting for members to share what climate resilience activities they, or their departments, have been engaged in. Doing so provides everyone with an opportunity to learn from the other.

   a. **New York**

   Mr. Bozzo said Superintendent Linda A. Lacewell (NY) provided a keynote address during the Insurance and Climate Risk Americas conference, which was held Sept. 16 in New York City. The keynote focused on how the state of New York is approaching climate risk and resilience.

   During the keynote, Superintendent Lacewell shared that New York took the following recent actions:

   - New York Gov. Andrew M. Cuomo recently signed the Climate Leadership and Community Protection Act, committing the state to an 85% reduction in emissions and economy-wide carbon neutrality by 2050.
   - The New York State Department of Financial Services (DFS) recently became the first state banking regulator to join the Network for Greening the Financial System (NGFS). NGFS is an international coalition of bank supervisors with a goal of driving the financial industry to address climate change.
   - DFS became the third state (behind California and Washington) to join the Sustainable Insurance Forum (SIF). SIF is an international network of insurance supervisors seeking to strengthen their understanding of and responses to sustainability issues for the business of insurance.
   - DFS requires its regulated insurers to submit a National Disaster Plan annually and provides guidance on how to do so.

   Superintendent Lacewell also highlighted the following key points:

   - Insurers need to balance the climate vulnerability of their assets and liabilities.
   - Flood risk is a top concern, with the number of National Flood Insurance Program (NFIP) policies having decreased in the state.
   - Transparency is an issue. Consumers overlook the flood exclusion disclaimer on homeowners insurance policies because of the policies’ length.
Insurers need to take an accurate assessment of their climate risk and should consider participation in the Financial Stability Board (FSB) Task Force on Climate-Related Financial Disclosures (TCFD) survey.

Insurers’ use of policyholder incentives to invest in resilience is a positive market trend.

The public-private partnership is more critical than ever.

b. Connecticut

Mr. Bradner stated the Connecticut Insurance Department participated in:

- Former Connecticut Gov. Dannel Malloy’s Council on Climate Change (G3C). On Sept. 3, 2019, current Connecticut Gov. Ned Lamont issued Executive Order No. 3, reestablishing and expanding the membership and responsibilities of G3C. G3C is tasked with monitoring the implementation of Connecticut’s commitment to reduce greenhouse gases 45% by 2030.

- The Connecticut Institute for Resilience and Climate Adaptation (CIRCA) Resilient Connecticut Climate Adaptation Summit, which was held Nov. 12 in Fairfield, CT. Key points included:
  - It is helpful to use an urban development strategy that invests in resilience corridors to avoid investing in flood-prone areas. Resilience corridors are strategic investment areas linking uplands to the coast through transportation hubs and providing egress and access routes across municipalities.
  - The development of a spatial index-based approach by the Resilient Connecticut project to model vulnerabilities for Connecticut coastal towns in multi-scale with multi-criteria. The tool will help regional, municipal and site scale planners assess future sea-level rise and associated flooding.

Mr. Bradner said he presented on Connecticut’s long-term recovery efforts at the Federal Emergency Management Agency’s (FEMA) Regional Resilience Roundtable, which was held July 10 in Boston, MA. Additionally, he attended the Environmental Business Council (EBC) New England Climate Change Resilience and Adaptation Summit, which was held July 26 in Smithfield, RI. During the summit, leaders from New England states provided updates on their specific climate change strategies. He also participated on the “Ensuring Sustainability and Insuring Resilience” panel during the Insurance and Climate Risk Americas conference. During the panel:

- Mr. Bradner discussed resiliency efforts by the NAIC and this Working Group, as well as the Insurance Institute for Business and Home Safety (IIHS) and the Connecticut Recovery Working Group.
- Eric Wilson (New York City Mayor’s Office of Resiliency) spoke to efforts by New York City to address resilience in public and private buildings and discussed sustainable mandates.
- Michael Cohen (RenaissanceRe) discussed creative financial products (such as resilience bonds and parametric insurance) that communities can incorporate into their resiliency initiatives.
- David Levy (University of Massachusetts Boston) discussed efforts to examine how to finance climate adaptation. This includes moving toward rating buildings and cities for resilience to influence insurance rates and bond ratings; bringing in banks, so risk can be reflected in mortgage underwriting and rates; and addressing the tensions between market pricing of risk and affordability.

Commissioner Kreidler said he is glad to have New York join Washington and California in discussions at the SIF. He said having a robust flood insurance market is a better solution than policymakers responding to their constituents with coverage mandates that may not be advantageous to the insurance industry.

Mr. Bozzo said insurers can alter the behavior of policyholders by offering them a discount.

3. Discussed the Climate Survey, Including Resilience Measures Reported by Insurers and the Incorporation of the TCFD Guidelines

Commissioner Kreidler said the NAIC Climate Risk Disclosure Survey (Climate Survey) was developed by this Working Group and adopted by the NAIC membership in 2010. Now that there is almost a decade of responses, it is important to look at how insurers are responding to the survey’s eight questions on how they are accounting for climate risk.

Mr. Bruns said there is a lot of overlap in the TCFD survey and the Climate Survey questions. The Climate Survey is administered to about 1,000 insurers annually and is publicly available on the California Department of Insurance website. The responses are qualitative and were originally developed to better understand how insurers are considering climate risk in their underwriting, operations and reserves. Six states (California, Connecticut, Minnesota, New Mexico, New York and
Washington) administer the Climate Survey to insurers writing more than $100 million in premium. This year, 1,257 insurers responded, representing about 70% of the U.S. market.

The Climate Survey questions are:

1. Does the company have a plan to assess, reduce or mitigate its emissions in its operations or organizations? If yes, please summarize. If no, please describe why not.

2. Does the company have a climate change policy with respect to risk management and investment management? If yes, please summarize. If no, how does the company account for climate change in your risk management?

3. Describe your company's process for identifying climate change-related risks and assessing the degree that they could affect your business, including financial implications. If your company has a process, please summarize. Otherwise, please describe why not.

4. Summarize the current or anticipated risks that climate change poses to your company. Explain the ways that these risks could affect your business. Include identification of the geographical areas affected by these risks. If your company has identified risks, explain the ways that these risks could affect your business. Include identification of the geographical areas affected by these risks. Otherwise, please describe why not.

5. Has the company considered the impact of climate change on its investment portfolio? Has it altered its investment strategy in response to these considerations? If so, please summarize steps you have taken. If the company has considered the impact, please summarize. Otherwise, please describe why not.

6. Summarize steps the company has taken to encourage policyholders to reduce the losses caused by climate change-influenced events. If the company has taken steps, please summarize. Otherwise, please describe why not.

7. Discuss steps, if any, the company has taken to engage key constituencies on the topic of climate change. If the company has taken steps, please summarize. Otherwise, please describe why not.

8. Describe actions the company is taking to manage the risks climate change poses to your business including, in general terms, the use of computer modeling. If the company is taking actions, please summarize what actions the company is taking and in general terms the use of any of computer modeling. Otherwise, please describe why not.

Responses included one respondent stating it is currently on its third greenhouse gas emissions reduction strategy, having met the first two. The most current strategy includes emissions on previously unconsidered sources, such as travel. The Hartford stated that it does have a climate change statement and has updated it. This includes an environmental, social and governance (ESG) statement on its investments. Allstate stated that its process includes managing climate risk through an enterprise risk framework that includes risk return principles, modeling and analytics. Pennsylvania Lumbermens stated that it has increased its surplus in anticipation of larger losses, shifted into more conservative investments and reached out to policyholders ahead of disasters to warn them. USAA said it reaches out to key constituencies through a newsletter and sponsored conferences.

Beginning with the 2019 Climate Survey administration, respondents were asked to refer to the TCFD survey guidelines and were permitted to submit their TCFD survey in lieu of the Climate Survey. The TCFD was established by the FSB in December 2015 to develop a set of voluntary, consistent disclosure recommendations for use by companies in providing information to investors, lenders and insurance underwriters about their climate-related financial risks.

The FSB was established and endorsed by the heads of state and government of the G20 in 2009. The FSB has assumed a key role in promoting the reform of international financial regulation and supervision. The TCFD survey, launched in 2017, was developed by industry participants, including BlackRock, Ernst & Young, Swiss Re, Moody’s and Bloomberg. Support for the TCFD survey has grown to 867 organizations, including the SIF and the International Association of Insurance Supervisors (IAIS).


Jennifer Waldner (American International Group—AIG) said AIG was the first U.S. insurer in 2006 to formally recognize the risks of anthropogenic climate change. The company currently manages more than $2.9 billion in private placement investments in renewable energy projects worldwide. This includes being a leading investor in geothermal, hydroelectric, wind and solar projects. It is also a founding member of the Blue Marble Microinsurance, which is a consortium that provides commercially viable insurance protection to the underserved.
Ms. Waldner said last year, AIG had a 34% reduction in utility usage and related carbon emissions across its New York City and United Kingdom (UK) office operations. An employee-led Sustainability Working Group was formed in 2015 to better organize its sustainability efforts across the company. It also formed a CEO-endorsed Sustainability Task Force to build out a strategic sustainability plan globally in 2018. With the help of a Boston-based consultant, AIG conducted an internal audit and formed five work streams: products and services; operations; investments; external partners; and resilience. At the end of three months, the internal audit showed AIG had 75 initiatives that were sustainable in some way.

Ms. Waldner said AIG approved its sustainability strategy in 2019, which included hiring a chief sustainability officer and launching its TCFD inaugural report in July. The strategy aligns AIG’s sustainability efforts with its core business of “future proofing” communities. Its four pillars are: city/community resilience; financial security; sustainable investments; and sustainable operations. AIG recently formed a risk management engineering and analytics center in partnership with a global engineering firm to help its clients become more resilient. The company also provides financial education to customers and the community through such things as its partnership with Foundation for Financial Planning, which focuses on the underserved. AIG also focuses on reducing its utility usage.

Ms. Waldner said AIG’s sustainability governance structure includes the chief sustainability officer reporting to Thomas Leonardi, executive vice president and vice chair of AIG Life Holdings Inc. The Sustainability Integration Team reports to the chief sustainability officer and was formed to formally embed sustainability throughout the company. An Employee Sustainability Network will be launched in 2020 to allow all employees to be involved in sustainability efforts.

Ms. Waldner said AIG decided to participate in the TCFD survey because: 1) it provides an opportunity to be more responsive and transparent with stakeholders; 2) reflects the company’s increased attention to and awareness of climate-related risks; 3) offers a more consistent approach that aligns with other reporting efforts; 4) provides a structure to guide internal discussions and thinking around climate-related risks; and 5) allows for proactive reporting, with indications that mandatory reporting will likely be instituted in some jurisdictions.

Ms. Waldner said participating in the TCFD survey allows for robust disclosure, while also adhering to the participation in the Climate Survey, thereby reducing survey fatigue. AIG is hopeful other jurisdictions will also allow for the submission of the TCFD survey in lieu of their jurisdiction-specific reports. Through participation in the TCFD survey, the company learned: 1) identifying and engaging with cross-functional colleagues across the company to develop responses is imperative; 2) responding is a commitment of time and resources; and 3) the report is a living disclosure that will undergo continuous iterative updates. The company is also contemplating performing a climate change scenario analysis.

Ms. Waldner said AIG’s next steps include: 1) evaluating how to best build on the foundational disclosure provided in the first TCFD; 2) partnering with the Sustainability Integration Team to help identify and drive current and future initiatives, build business and social impact cases, and develop flagship projects; 3) supporting the work of its newly formed Climate Working Group, ESG Working Group and Enterprise Risk Management (ERM) Sustainability Working Group; and 4) continuing to work with the NAIC and other key stakeholders to report on and discuss climate-related risks.

Commissioner Kreidler said AIG is providing important leadership on sustainability in the insurance industry. The presentation illustrates how sustainability is an important initiative in the U.S. and globally. He said there are likely to be several actions taken in this area soon, as world leaders and stakeholders try to “get ahead of the curve” on climate risk.

5. Discussed Other Matters

Commissioner Kreidler said the Working Group will begin drafting the Insurance Regulatory Frequently Asked Questions (FAQ) through an informal drafting group after the first of the year.

Having no further business, the Climate Risk and Resilience (C) Working Group adjourned.
Climate Risk and Resilience (C) Working Group  
( f.k.a. Climate Change and Global Warming (C) Working Group) 
Conference Call  
October 2, 2019 

The Climate Risk and Resilience Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call Oct. 2, 2019. The following Working Group members participated: Mike Kreidler, Chair, David Forte, Jay Bruns and Patrick McNaughton (WA); Ricardo Lara, Vice Chair, Lisbeth Landsman-Smith and Michael Peterson (CA); Austin Childs (AK); Peg Brown (CO); George Bradner (CT); Colin M. Hayashida (HI); Judy Mottar (IL); Caleb Huntington (MA); Derek Oestreicher (MT); Marshal Bozzo (NY); and Andrew Stolfi, TK Keen and Ying Liu (OR). Also participating were: William Lacy (AR); Leslie Ledogar (DE); Shaw P. Stiller (FL); Kate Kixmiller (IN); and Holly Campbell (RI). 

1. Discussed the Proposed Development of an FAQ

Commissioner Kreidler stated that severe weather events have been escalating in recent years. Using National Oceanic and Atmospheric Administration (NOAA) estimates, this decade has seen an annual average of 10.5 disasters so far. The scale of this increase amounts to one additional billion-dollar disaster every four years. Given the rise in costly disasters, many state policymakers and lawmakers are considering measures that incentivize and strengthen their jurisdictions’ resilience. As they do so, they naturally reach out to their insurance departments for information on catastrophe risk, resilience and insurance. 

Commissioner Kreidler said the purpose of today’s conference call is to get the Working Group’s thoughts on developing a product that can assist insurance departments in fielding these types of questions. This potential product, currently being referred to as the Insurance Regulatory Frequently Asked Questions (FAQ) is meant to be a compilation of questions state insurance regulators find they are frequently being asked (Attachment Four-A1). 

Commissioner Kreidler said the intent is that the Working Group product would consist only of the questions. This would allow each insurance department to voluntarily answer the questions as they relate to their specific state. The responses can then be disseminated by each insurance department to inform state and local efforts related to resilience and insurance. The FAQ is not proposed to address specific legislation, policies or regulations, but rather to be used as a guideline when such actions are being considered. 

California has passed and continues to deliberate on legislation to support resilience, recovery and rebuilding efforts after two destructive years of wildfire losses. Given all this activity, California has provided potential questions for the FAQ by compiling requests it frequently receives from its lawmakers and policymakers. The questions naturally reflect wildfire risk, but many are also applicable to other weather-related perils. Thus, the discussion will focus on getting feedback on the following questions: 

1) Does the Working Group think it would be advantageous for it to develop an FAQ product to assist state insurance departments in fielding frequently asked questions? This FAQ would consist only of questions. Responses would be left to the discretion of each insurance department. 

2) What structure should the FAQ take? Options include: 
   a. Peril-specific. In this approach, the questions would focus on just wildfire. Additional FAQs could potentially be later developed for other single perils, such as flood. 
   b. All weather-related perils, with general questions followed by peril-specific questions being broken out into subsections. 
   c. All weather-related perils, with only general questions and instructions to denote when the response varies for a peril. 

3) Should development of the FAQ be done in an informal drafting group? 

Mr. Peterson said California has been through several major wildfires, even before those in 2017. As a result, they have met with many consumers, first responders, state legislators and other stakeholders to discuss wildfire-related issues. This includes the Risk and Resilience Summit, sponsored by the NAIC in May, where state insurance regulators met for two days of discussions on insurance issues and shared responses to growing wildfire insurance risk. The Summit included a visit to Paradise, CA, and meetings with local officials, homeowners and first responders. The questions currently listed in the FAQ
are an outgrowth of this Summit, a recent data call and other related discussions. They are by no means exhaustive, but rather a start.

The first section of the FAQ is on mitigation. Mitigation represents an important tool to improving affordability and availability of insurance. However, policy structures can be elusive in how mitigation is best promoted. For instance, the government in the Netherlands invests substantially in flood prevention, which, in part enables people to live where they do. The questions represent different incentive tactics that legislators and policymakers can look to when crafting laws and policies. This includes incorporating incentives into pricing, tax incentives, mitigation grants and resilience standards. For instance, those in the Wildland-Urban Interface (WUI) often believe that meeting a certain level of home mitigation should secure them guaranteed coverage in the admitted market.

The second section of the FAQ is on the supervision of claims themselves. The speed of claims and additional living expenses (ALE) have been common themes for California. It can be advantageous for consumers to receive a portion of their payout without having to go through an exhaustive inventory list. Additionally, issues often surface around time constraints for using ALE and whether ALE should apply in cases of partial loss, when local infrastructure, such as the water system, is unusable.

The third section of the FAQ is on nonrenewal. In August, California released the results of its data call that showed an increase in non-renewals in the WUI communities. One common theme was the amount of notice a consumer gets prior to a nonrenewal. The California legislature responded by increasing the required notice of nonrenewal from 45 days to 75 days to allow consumers adequate time to take mitigation steps to prevent a non-renewal.

The fourth section of the FAQ is on underinsurance, which is a common concern with legislators, state insurance regulators and consumers. There may be a divergence between how much coverage a home has and how much it takes to replace it.

The fifth section of the FAQ is focused on safeguards to abrupt increases in insurance premiums and the impact of using new data sources to more granularly segment risk.

The sixth section of the FAQ is focused on rebuilding restrictions, which needs more focus. In California, some or all of a consumer’s insurance payout can be used to rebuild in a less risky area. This could benefit consumers and insurers as it results in a quicker claim resolution and less insured risk. However, there are different interpretations of state statutes in whether consumers can use their full coverage limit to rebuild elsewhere or if a deduction in land value should apply. These are common questions that we have heard in California in the aftermath of catastrophic wildfires and we wanted to see if they are applicable to other states and could be beneficial to consider pre-disaster.

Commissioner Kreidler stated that states may differ in which perils are emphasized in the FAQ, but most of the questions reflect at some level the dilemmas all states face after a catastrophe. Most states have Fair Access to Insurance Requirements (FAIR) Plans dating back to their implementation in the 1960s. Washington almost discontinued its FAIR plan due to low use but ultimately decided to keep it.

Commissioner Stolfi stated the FAQ is a good idea. He asked if the FAQ should focus on personal lines issues, commercial lines issues or both. He stated Oregon receives many questions on whether carriers are trying to exclude wildfire coverages. He suggested adding questions relating to building codes, exclusions and withdrawals. He stated it would be extremely useful to Oregon, and likely other states, to see how other states respond to these questions. As such, he is in support of compiling each state’s answers to the FAQ for sharing purposes.

Mr. Bozzo stated the FAQ represents a good set of discussion points. He added that being able to compare what is being done in each state would be of great benefit. He also stated it would be more beneficial to all states to include all perils.

Commissioner Kreidler stated he agrees that a more all-perils approach is best in the FAQ. He stated that an all weather-related perils, with general questions followed by peril-specific questions being broken out into subsections, makes the most sense.

Mr. Bradner suggested questions relating to the type of products each state offers in its FAIR plan be added to the FAQ. The residual market can vary drastically by state. FAIR plan products can offer consumers an option when there is not one in the admitted market.
Commissioner Kreidler stated he agrees. States can benefit from seeing other states’ FAIR plan structures and how they provide needed coverage without diminishing the admitted market.

Ms. Brown stated the FAQ is interesting. Colorado does not have a FAIR plan and is currently developing a data call to find out what areas do not have admitted insurance coverage options due to carriers withdrawing from higher risk communities. She said she also supports compiling state responses to the FAQ. Additionally, the Working Group may get industry directed suggestions on what changes are necessary to improve the affordability and availability of insurance.

Commissioner Kreidler stated he agrees, and he said Washington is also in the process of doing a data call to develop a baseline. He asked if there were any objections to developing an FAQ.

Mr. Bozzo stated the questions were an effective starting point but should be fine-tuned to reflect questions relevant to all and those that are more region-specific.

Commissioner Kreidler stated he would be interested in seeing how other states, such as New York, view and deal with flood issues, even if Washington does not face flood risk in the same way. The Working Group should begin with more general questions that apply to all states but may decide in the future to develop a more peril-specific FAQ. Additionally, responding to the FAQ would, of course, be voluntary for states and they could modify the questions as they fit.

Commissioner Stolfi said Oregon supports the FAQ and the collection of states’ responses to it.

Anne Obersteadt (NAIC) said the NAIC state government relations policy advisor recommended tweaking the FAQ toward each peril and packaging it accordingly. State lawmakers are more likely to see an FAQ packaged specifically for the peril under consideration as relevant. For instance, the FAQ could be packaged with a flood coverage page and added discussion related specifically to flood. The FAQ could then be repackaged for wildfire risk in the same way. The Working Group could consider developing general questions relevant to all states and perils first and then add subsections to the FAQ for peril-specific questions in the future. The FAQ with a flood subsection could then be packaged as a flood-specific FAQ for those lawmakers and policymakers only interested in flood. Likewise, the FAQ with a wildfire subsection could be packaged as a wildfire-specific FAQ for those only interested in wildfire.

Commissioner Kreidler stated the approach to start general and then narrow the scope by adding subsections with peril-specific questions later makes sense. He asked NAIC staff to implement the revisions thus far suggested by Working Group members on the call, with further drafting of the FAQ to be done through an informal drafting group.

Having no further business, the Climate Risk and Resilience (C) Working Group adjourned.
Insurance Regulatory FAQ on Catastrophe Events

PURPOSE

The purpose of the Insurance Regulatory Frequently Asked Questions on Catastrophe Events ("CAT FAQ") is to inform state and local efforts related to catastrophe risk, resilience, and insurance. While it doesn't address specific legislation, policies, or regulations, it can be used as a guideline when such actions are being considered.

The CAT FAQ was developed by compiling the questions insurance departments receive most frequently from legislators and policymakers. The questions are intended to be answered by each state insurance department. Thus, the responses will reflect the nuances of each state.

COMMONLY ASKED QUESTIONS

Tentative list of questions to be added/revised by Working Group.
(If responses are different by peril, please note.)

I. Mitigation
   A. Mitigation generally reduces risks and promotes more availability of insurance. What incentives do consumers have to mitigate their home?
   B. Are there incentives built in to the pricing of insurance policies?
   C. If a state funds mitigation incentives, such as grants, loans, and/or public-private partnerships, is there an overall strategy to improve availability of insurance in the state?
   D. How do statewide mitigation efforts, such as Utah’s Catastrophic Wildfire Plan, prioritize projects, monitor progress, and fund maintenance to reduce the risk of future losses?
   E. If mitigation is a potential pathway to a more resilient insurance market, are states with similar risks making similar pre-disaster investments?
   F. Do states have specific statewide standards for home or community mitigation in the wildland-urban interface?
   G. Are states offering any tax incentives for home mitigation actions?
   H. Are there any restrictions on local governments in regard to land development?
   I. Is there any scenario under which a consumer is "guaranteed" offer/renewal of insurance?
Insurance Regulatory FAQ on Catastrophe Events

COMMONLY ASKED QUESTIONS CONTINUED

II. Supervision of claims
   A. Speed
      i. What are the state laws regarding the timing of the payment of claims?
      ii. Are insurers required to distribute a certain percentage of an insured’s contents coverage
           before an inventory is submitted?
      iii. How have states approached getting money to consumers as quickly as possible so that
           they can start recovering?
   B. Additional Living Expenses (ALE)
      i. What are the time constraints for using ALE?
      ii. Does ALE apply to partial losses, or when local infrastructure is not accessible or useable
          (e.g., inaccessible roads or unusable water system) or only to total losses?

III. Nonrenewal
   A. What are the options if a consumer is non-renewed?
   B. Are there any circumstances under which a consumer must be renewed by an insurer?
   C. How much advance warning are insurers required to give insureds and is this enough time to
      take any mitigation actions to prevent a non-renewal?
   D. What prevents an insurer from asking for mitigation actions from a homeowner (replacing a
      wood shake roof with a metal roof) and then making a decision to non-renew that consumer?
   E. Are there mechanisms to determine what percentage of non-renewed consumers decide to go
      without property insurance?
   F. How are non-renewals impacting ranches and farms?
   G. What authority do regulators have over the use of wildfire models by insurers for underwrit-
      ing?

IV. Underinsurance
   A. Are insurers required to provide any regularly updated estimate of replacement cost to con-
      sumers?
   B. Are there other safeguards for consumers to reduce the likelihood of being unintentionally
      underinsured?
Insurance Regulatory FAQ on Catastrophe Events

COMMONLY ASKED QUESTIONS CONTINUED

Tentative list of questions to be added/revised by Working Group.

(If responses are different by peril, please note.)

V. Insurance Premiums
   A. Are there safeguards against abrupt insurance premium increases related to a specific risk?
   B. Are there any state laws or regulations governing “grace periods” for the payment of premiums after disasters?
   C. Do insurers commonly use predictive modeling to price insurance and how has that affected premiums for consumers?
   D. Increases in data allow insurers to segment their rates into more and more granular segments. This may increase the connection between insurance premium and risk, but also may decrease the effects of pooling. How are states addressing this issue?

VI. Rebuilding Restrictions
   A. Are consumers who suffer a total loss required to build on the same property or can they use their insurance coverage to purchase a home in a different, potentially less risky area?
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee conducted an e-vote that concluded Dec. 5, 2019. The following Working Group members participated: Don Beatty, Chair (VA); Kendra Zoller, Vice Chair (CA); George Bradner (CT); Warren Byrd (LA); Shirley Corbin (MD); LeAnn Cox (MO); Michael McKenney (PA); Matt Gendron (RI); and David Forte (WA).

1. **Adopted its Nov. 7 and Oct. 1 Minutes**

The Working Group conducted an e-vote to consider adoption of its interim minutes. The motion passed, with a majority of the Working Group members voting in favor of adopting its Nov. 7 (Attachment Five-A) and Oct. 1 (Attachment Five-B) minutes.

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

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The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call Nov. 7, 2019. The following Working Group members participated: Don Beatty, Chair (VA); Kendra Zoller, Vice Chair, and Risa Salat-Kolm (CA); Kristin Fabian and George Bradner (CT); Tom Travis (LA); Shirley Corbin (MD); LeAnn Cox (MO); Michael McKenney (PA); Matt Gendron and Beth Vollucci (RI); Anna Van Fleet and Jamie Gile (VT); and David Forte and Eric Slavich (WA). Also participating were: Ken Williamson (AL); Vincent Gosz and Tom Zuppan (AZ); Heather Droge and Tate Flott (KS); Chris Aufenthie (ND); Carl Sornson (NJ); Anna Krylova (NM); Rodney Beetch (OH); Cuc Nguyen (OK); Lee Hill (SC); Dan Nelson (SD); Kathy Stajduhar (UT); Jody Ullman (WI); and Donna Stewart (WY).

1. Discussed Sections 1, Section 2 and Section 3 of the Draft Pet Insurance Model Act

   a. Section 1—Short Title

      Ms. Zoller said the term “health” should not be used in the title, as pet insurance is a property/casualty (P/C) line of business.

      Ms. Cox agreed that the term “health” could be confusing, and she suggested the use of the term “care.”

      Mr. Forte said he agreed with not using the term “health” and would be agreeable to using the term “care” or not changing the title at all.

      Mr. Beatty asked if any Working Group members wanted to use the term “health” in the title. No Working Group members stated that they want to use the term “health.”

      Ms. Zoller said the term “care” could sound like the care plans offered by pet stores, which are not pet insurance.

      Ms. Salat-Kolm suggested keeping the title as “Pet Insurance Model Act.” All Working Group members agreed on keeping the title as “Pet Insurance Model Act.”

   b. Section 2—Scope and Purpose

      Ms. Salat-Kolm said there was discussion about the term “resident” and if it referred to the pet or the pet owner. She said there is agreement that the term “resident” means pet owner.

      Mr. Forte said changing the term “covers” to “issued to” would help clarify that the term “resident” indicates the pet owner.

      Mr. Gendron said there could be policies issued in a state to a pet owner that is not a resident of that state.

      Ms. Salat-Kolm said the language could be revised to “policies issued in this state.”

      Mr. Gendron agreed with this language.

      John P. Fielding (Steptoe & Johnson), representing the North American Pet Health Insurance Association (NAPHIA), suggested removing the term “covers” and using language similar to other model laws, such as the Travel Insurance Model Act (#632).

      Lisa Brown (American Property Casualty Insurance Association—ACPIA) suggested changing the word “is” to “are” in Section 2 Part B to have correct subject and verb agreement. She also suggested changing the word “and” to “or” between the words “policies” and “certificates” in Section 2 Part B to clarify that companies can write either individual coverage, group policies or both.

      Mr. Travis and Ms. Van Fleet agreed.
c. **Section 3—Definitions**

Ms. Zoller said definitions in the policy are helpful, noting that the white paper, *A Regulator’s Guide to Pet Insurance*, found that current definitions are inconsistent and confusing.

Mr. McKenney asked if other lines of business in California have definitions mandated by statutes. He said he does not believe it is common in other lines of business to mandate definitions language.

Ms. Salat-Kolm said the California Fair Claims Settlement Practices Regulations have definitions. She said the better the definition, the clearer it would be to the consumer.

Mr. McKenney wondered if having standard definitions would make it more difficult for companies to compete in the market.

Mr. Zoller said the definitions have been in law in California, and they have received support from companies.

Mr. McKenney said with the exception of the standard fire policy, there is not another line of business that mandates standard definitions.

Ms. Van Fleet said the development of minimum standard definitions is currently happening with supplemental health policies, so there is a framework for developing minimum standard-type definitions so there is a floor of protection for consumers.

Mr. McKenney said the current draft may be creating a model law that, including both Section 3 and Section 4, creates requirements that do not exist on any other P/C coverage, especially on an optional coverage; and it may be overly burdensome and keep small players out of the market.

Ms. Zoller suggested that the Working Group look at current definitions from different companies to see how much they differ.

Ms. Cox said forcing companies to use the exact definitions within the model act would limit more innovative products. She said not all companies would have a website if they are application based. She said companies that want to have more laymen’s term policies would not want to have such wordy definitions that could confuse the policyholder even more. She suggested adding wording to the definitions that would be substantially similar but not less favorable than what is stated in the model law. She said some policies are using more youthful language to appeal to younger policyholders.

Mr. Gendron said he would find it appropriate for a policy to have more generous terms in the definitions than those currently in the model law.

Mr. Beatty said the suggestion of the Working Group is to have minimum standard definitions.

Ms. Brown said there are current policies with definitions that are substantially similar to those in the model law and requiring exact language would require refiling policies with the state insurance departments. She asked what would happen if a company wanted to develop a product that only covered a certain aspect of pet care, such as diagnosis, and if these required definitions would prevent that type of product from coming to market.

Mr. Gendron said policies that want to cover only certain aspects can still use these definitions and then explain in the disclosures section what is and is not covered by the policy.

Ms. Zoller said there is language in the model that states, “nothing in this Act shall in any way prohibit or limit the types of exclusions pet insurers may use in their policies or require pet insurers to have any of the limitations or exclusions defined below.”

Mr. Fielding said there is a distinction between the definitions of things that would always be similar, such as “chronic condition,” and the definition of things that could be different, such as “pet insurance” and “veterinary expenses.” He said despite exclusions and disclosures, the definition could lead the consumer to believe that something is covered even when it is not. He proposed using the term “eligible expenses” and letting the disclosures state what is and is not covered.
Mr. Forte suggested removing the term “pet” when speaking of pet insurers, as not all entities that use the term “pet insurer” are insurance companies selling pet insurance. He said the phrase “main page” may be confusing, as some companies do not exclusively sell pet insurance and it may not appear on their main page.

Mr. Beatty said the Working Group will want to review all sections that reference websites.

Ms. Van Fleet said Vermont does not have a framework for approving group pet insurance products, so she suggested removing the language for group policies.

Mr. Fielding asked if Vermont would consider keeping group policy language in the model.

Mr. Forte said having the group language would make adoption of the model law difficult.

Ms. Zoller said California currently covers those that have a certificate issued in a different state in a group policy. She asked if pet insurance offered as an employee benefit is offered as a group policy or an individual policy.

Mr. Fielding said he has seen both group and individual policies as a part of employee benefits programs.

Ms. Brown agreed that there are both types of policies currently written.

Ms. Salat-Kolm suggested removing the terms “individual” and “group” to make the statement broader.

Mr. Forte said the definition for “chronic condition” should be clearer. He said he would like a further definition of the term than what is currently in the model law.

Mr. Travis said the Working Group should look for a better definition of “chronic condition” from the health line of business.

The Working Group will continue discussion on these sections during future conference calls.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call Oct. 1, 2019. The following Working Group members participated: Don Beatty, Chair, and Jessica Baggarley (VA); Kendra Zoller, Vice Chair, and Risa Salat-Kolm (CA); Kristin Fabian and George Bradner (CT); Angela King (DC); Warren Byrd and Tom Travis (LA); Sheri Cullen (MA); Linas Glemza (MD); LeAnn Cox and Jeana Thomas (MO); Michael McKenney and John Lacek (PA); Matt Gendron and Beth Vollucci (RI); Anna Van Fleet (VT); and Jeff Baughman, Dan Forsman, David Forte and Eric Slavich (WA). Also participating were: Ken Williamson (AL); Carl Sornson (NJ); Anna Krylova (NM); Dan Nelson (SD); and Jody Ullman (WI).

1. Discussed Its Referrals Regarding the Collection of Additional Pet Insurance Data

Mr. Beatty said during its June 27 conference call, the Working Group decided to ask NAIC staff to begin drafting referrals to the Blanks (E) Working Group and the Market Regulation and Consumer Affairs (D) Committee for data collection. He said the first referral had to do with collecting additional pet insurance data on the annual financial statement, noting that there are a couple possibilities for collecting additional data. He said the data could be collected through the state page, likely as a subset of the inland marine line of business, or the premium, loss and other data could be collected through a supplement to the annual financial statement that only pet insurance carriers would be required to complete.

Mr. Gendron said if pet insurance were added as a line on the state page, the companies that do not write pet insurance would leave that line as zero.

Tracey Laws (Chubb) said Chubb would prefer to report on a supplement because adding a line to the annual financial statement would require system changes that would have associated costs.

John Fielding (Steptoe & Johnson), representing the North American Pet Health Insurance Association (NAPHIA), said he would like to talk to NAPHIA’s member insurance companies to get thoughts on the best way to report pet insurance data in the annual financial Statement.

Mr. Beatty said industry representatives should submit comments on how they would prefer to report this data.

Ms. Laws asked what data would be collected through a supplement.

Aaron Brandenburg (NAIC) said the focus would be on the data collected in the columns of the state page, but the supplement could ask for more detail, such as number of exposures or policies.

Mr. Gendron said he would agree with collecting policy count numbers.

Mr. Beatty said NAIC staff are working on collecting feedback on the process of collecting pet insurance data through the Market Conduct Annual Statement (MCAS).

Mr. McKenney said he is looking for standard MCAS data for pet insurance.

Mr. Brandenburg said NAIC staff can work to gather complaints data, as well as work to collecting pet insurance data through the MCAS.

2. Discussed and Exposed Four Sections of the Draft Pet Insurance Model Act

Mr. Beatty said the Request for NAIC Model Law Development asking for permission to begin work on a Pet Insurance Model Act was adopted by the Executive (EX) Committee at the Summer National Meeting, so the Working Group can now begin work on developing it. He said the Working Group chair, vice chair and NAIC staff put together a document to help start the discussion and, after each conference call, there will be a public comment period to obtain opinions on each section of the draft model act.
Mr. Gendron said in reference to Section 1—Short Title, the description should read “Pet Insurance Act.” He also said in reference to Section 2—Scope and Purpose, Part B that “Pet Insurance that covers any resident of this state” should be changed to “Pet Insurance policies that are issued to any resident of this state” to clarify that the policy is issued to the named resident of the state. He also suggested replacing the “and” separators with “or.”

Mr. Fielding (NAPHIA) said the draft appears to be based on a bill that was vetoed in California before the current California law was enacted.

Ms. Zoller said the draft is just a starting point and that the two parts of the law that were vetoed are Section 7—Preexisting Conditions and Section 8—Reimbursement Benefits.

Mr. Fielding also suggested, in reference to Section 1, the description should read “Pet Health Insurance Act.”

Ms. Zoller said the addition of the word “health” could be confusing since this is a property/casualty (P/C) line of business.

Ms. Salat-Kolm agreed that this type of policy does not only cover things that would be considered health insurance.

Mr. Fielding said the term “health” would help differentiate between other types of coverages that cover liabilities of owning a pet.

Mr. Byrd also agreed that the term “health” would help in clarifying the purpose of this line of business.

Ms. Cox suggested using the term “care” in place of “health” so as not to confuse with traditional health insurance.

Lisa Brown (American Property Casualty Insurance Association—ACPIA) said the introductory paragraph of Section 3—Definitions seems to suggest that the definitions in a policy would have to be exactly those that appear in the model. She said it would be helpful if the definitions would be able to be substantially similar.

Mr. Byrd asked if there were issues with any of the terms as currently defined.

Ms. Brown said she has heard concerns that the “veterinary expenses” definition could be too limiting for some companies.

Mr. McKenney said he is not sure if other policy types include terms that must be defined in an exact way.

Ms. Law said mandating language in an insurance policy is limiting to competition in the marketplace.

Ms. Zoller said the definitions as defined in Section 3 are current law in California.

Mr. McKenney said the model law draft, as is, is too restricting compared to other lines of business.

Mr. Forte said he is not sure if the term “group” should be included in Section 3D, as he is unaware of P/C insurance being sold as a group policy.

Ms. Cox said Missouri does not allow for group insurance in the pet insurance market.

Mr. Beatty asked what the regulatory objections would be to allowing group insurance.

Mr. Bradner said the objection would have to do with how cancellations and non-renewals are handled.

Mr. McKenney agreed and said it would change the nature of the business and the rate filing laws in many states.

Mr. Byrd asked if any insurers currently sell group pet insurance policies.

Mr. Fielding said he will check with NAPHIA member insurance companies if policies are currently sold as group or only individual.
Mr. Gendron suggested reducing the language found in Section 3F and inserting bracketed language referencing the appropriate state licensing authority or statute.

Gary Henning (Zurich Insurance) asked if Section 4—Disclosures applies to only the insurer or if it also applies to a program administrator selling the insurer’s policies.

Mr. Byrd asked if those administrators would be the agent for the insurer.

Mr. Henning said these companies work as brokers.

Mr. Beatty said it would be the insurer’s responsibility to get the information to the consumer.

Mr. Gendron said state insurance regulators put restrictions on insurers and agreed it is the insurer’s responsibility. He also said it is important to include disclosures on preexisting conditions and hereditary disorders if they are excluded in the policy.

Mr. Beatty said the disclosures will be important to include because many of the complaints received about pet insurance policies are regarding consumers not knowing what is excluded in a policy.

Mr. McKenney said the disclosure requirements are more restricting than those currently in place in mandatory lines of insurance like automobile and homeowners.

Ms. Salat-Kolm said one of the biggest problems with pet insurance is that people do not know what they are buying.

Mr. Bradner agreed that it is a problem when exclusions are not disclosed.

Mr. McKenney said there is no data to determine if this is a problem. Ms. Zoller said there are complaints in California, noting that the A Regulator’s Guide to Pet Insurance white paper addressed some of these problems.

Mr. Byrd said the Working Group should not wait for problems to occur before implementing a law to address potential issues.

Mr. Gendron said pet insurance has evolved in the past 15 years and that consumer expectations may be too close to human health insurance.

Mr. Gendron said there may be a misconception of what should be included in pet insurance and if a wellness product would fit into an insurance policy.

Ms. Baggarley said Virginia currently sees wellness programs included in insurance policies.

Mr. Beatty said Section 1, Section 2, Section 3 and Section 4 of the draft Pet Insurance Model Act will be exposed for a 30-day public comment period ending Oct. 31.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Terrorism Insurance Implementation (C) Working Group of the Property and Casualty Insurance (C) Committee met in Austin, TX, Dec. 8, 2019. The following Working Group members participated: Marshal Bozzo, Chair (NY); Michael Ricker (AK); George Bradner (CT); Sean O’Donnell (DC); Virginia Christy (FL); Judy Mottar (IL); Heather Droge (KS); Angela Nelson (MO); Fred Fuller (NC); Cuc Nguyen (OK); Beth Vollucci (RI); J’ne Byckovski and Mark Worman (TX); Rebecca Nichols (VA); and Rosemary Raszka (VT).

1. **Adopted its Summer National Meeting Minutes**

Mr. Bradner made a motion, seconded by Ms. Nelson, to adopt the Working Group’s Aug. 4 minutes (see NAIC Proceedings – Summer 2019, Property and Casualty Insurance (C) Committee, Attachment Four). The motion passed unanimously.

2. **Discussed the Reauthorization of TRIA**

Brooke Stringer (NAIC) said the federal Terrorism Risk Insurance Act (TRIA) is set to expire Dec. 31, 2020, and the NAIC has seen significant Congressional action on TRIA reauthorization legislation. She said the U.S. House of Representatives (House) passed a seven year TRIA reauthorization bill (H.R. 4634), which does not make any substantial changes to the program. The bill would require the Government Accountability Office (GAO) to conduct a study on cyber terrorism risks, including an analysis of whether the states’ definition of cyber liability under a property and casualty line of insurance is adequate coverage for an act of cyber terrorism. It would also require biennial U.S. Department of the Treasury (Treasury Department) reporting on affordability and availability of terrorism risk insurance for places of worship. Ms. Stringer said the U.S. Senate (Senate) Committee on Banking, Housing, and Urban Affairs approved by voice vote a seven-year reauthorization bill (S. 2877), which tracks the House version. The bill may add a study on nuclear, biological, chemical and radiological (NBCR) coverage as the bill moves forward.

Ms. Stringer noted that the NAIC supports both the House and Senate bills, and it sent letters of support, which are posted on the NAIC website. She said there is widespread support from the insurance industry and all sectors of the economy that is spurring Congressional action. She said, given the strong support in both Congressional chambers, TRIA reauthorization legislation could be in a good position to be attached to the end-of-year spending package or potentially adopted by the Senate in December 2019 or January 2020.

Ms. Stringer also reported that Director Chlora Lindley-Myers (MO) testified on behalf of the NAIC at an October joint insurance and national security subcommittee hearing at the House Committee on Financial Services. She underscored state insurance regulators’ support for the program and urged prompt Congressional action on a long-term reauthorization. She also highlighted some findings from the state insurance regulator data calls. Cyber coverage was a topic that received much attention at the hearing.

3. **Heard a Report on the 2020 Terrorism Risk Insurance Data Call**

Mr. Bozzo said workers’ compensation data will be requested from the National Council on Compensation Insurance (NCCI) and independent bureaus as it has in the past, likely with a letter being distributed in January 2020 asking for data to be submitted by March 1, 2020.

Mr. Bozzo said information about the joint state insurance regulator/Treasury Department data call will be distributed early next year with a due date of May 15, 2020, the same as past years. He said there may be a change to the modeled loss question within the data call. He reported that state insurance regulators and Federal Insurance Office (FIO) staff may begin holding state insurance regulator meetings or conference calls to discuss potential changes to the data call in future years. Based on possible changes to TRIA, future data calls may ask for data on cyber coverages or religious institutions. Mr. Bozzo said state insurance regulators expect that the State Supplement will continue in 2020 as in past years.
4. **Heard a Report on the 2019 Data Call**

Aaron Brandenburg (NAIC) reported on terrorism risk insurance data received in the State Supplement portion of the data call that was due Sept. 30. He said most files have been received and the vast majority of the files have passed the basic data quality checks. He said the NAIC is following up with companies that did not file or that submitted incorrect data elements. He said the most common error was in terrorism or total exposures where some companies had obvious errors.

In terms of total premiums reported, companies submitted nearly $38 billion in premium in allied lines, fire, commercial multiperil–non liability, and boiler and machinery lines of business. The total terrorism premium submitted was about $920 million, making the terrorism premium approximately 2.4% of the total premium. Mr. Brandenburg said these figures are comparable to what has been reported previously in data calls.

The data call found that most terrorism premium, over 90%, was written as an endorsement instead of a standalone policy. Most premium was categorized as certified, about six times as much as what was reported as both certified and non-certified. Very little of the premium was labeled as non-certified. Because the exposure data is still not credible, conclusions are not able to be drawn, but it appears that commercial multiperil–non liability has the highest portion of exposures covered by terrorism insurance.

Mr. Brandenburg said the NAIC will continue to contact companies and clean the data. The next step will then be to look at statewide and ZIP Code results in looking at premium and exposure amounts and take-up rates.

Having no further business, the Terrorism Insurance Implementation (C) Working Group adjourned.
2020 Proposed Charges

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Property and Casualty Insurance (C) Committee will:
   A. Discuss issues arising and make recommendations with respect to advisory organization and insurer filings for personal and commercial lines, as needed. Report yearly.
   B. Monitor the activities of the Casualty Actuarial and Statistical (C) Task Force.
   C. Monitor the activities of the Surplus Lines (C) Task Force.
   D. Monitor the activities of the Title Insurance (C) Task Force.
   E. Monitor the activities of the Workers’ Compensation (C) Task Force.
   F. Provide an impartial forum for considering appeals of adverse decisions involving alien insurers delisted or rejected for listing to the Quarterly Listing of Alien Insurers. Appeal procedures are described in the International Insurers Department (IID) Plan of Operation.
   G. Monitor and review developments in case law and rehabilitation proceedings related to risk-retention groups (RRGs). If warranted, make appropriate changes to the Risk Retention and Purchasing Group Handbook.
   H. Monitor the activities of the Federal Crop Insurance Corporation (FCIC) that affect state insurance regulators:
      1. Serve as a forum for discussing issues related to the interaction of federal crop insurance programs with state insurance regulation.
      3. Monitor the regulatory information exchanges between the FCIC and state insurance regulators, as well as the FCIC and the NAIC, and make recommendations for improvement or revisions, as needed.
   I. Report on the private flood insurance market using data obtained from the state insurance regulator private flood insurance data call.

2. The Cannabis Insurance (C) Working Group will:
   A. Assess and periodically report on the status of federal legislation that would protect financial institutions from liability associated with providing services to cannabis businesses operating legally under state law.
   B. Encourage admitted insurers to ensure coverage adequacy in states where cannabis, including hemp, is legal.
   C. Provide insurance resources to stakeholders and keep up with new products and innovative ideas that may shape insurance in this space.
   D. Collect aggregated insurance availability and coverage gap information, as well as other cannabis and hemp insurance-related data, to then publicly share in a released report by the end of 2021.

3. The Catastrophe Insurance (C) Working Group will:
   A. Monitor and recommend measures to improve the availability and affordability of insurance and reinsurance related to catastrophe perils for personal and commercial lines.
   B. Evaluate potential state, regional and national programs to increase capacity for insurance and reinsurance related to catastrophe perils.
   C. Monitor and assess proposals that address disaster insurance issues at the federal and state levels. Assess concentration-of-risk issues and whether a regulatory solution is needed.
   D. Provide a forum for discussing issues and recommending solutions related to insuring for catastrophe risk, including terrorism, war and natural disasters.
E. Provide a forum for discussing various issues related to catastrophe modeling, and monitor issues that will result in changes to the Catastrophe Computer Modeling Handbook.
F. Investigate and recommend ways the NAIC can assist states in responding to disasters, and discuss issues surrounding loss mitigation. Update the State Disaster Response Plan, as needed, so that it provides a blueprint for action by the states to respond to catastrophic events.
G. Continue to examine ways to help state insurance regulators facilitate the private flood insurance market.
H. Study, in coordination with other NAIC task forces and working groups, earthquake matters of concern to state insurance regulators. Consider various innovative earthquake insurance coverage options aimed at improving take-up rates.

4. The Climate Risk and Resilience (C) Working Group will:
   A. Engage with industry and stakeholders in the U.S. and abroad on climate related risk and resiliency issues.
   B. Investigate and recommend measures to reduce risks of climate change related to catastrophic events.
   C. Identify insurance and other financial mechanisms to protect infrastructure and reduce exposure to the public.
   D. Identify sustainability, resilience and mitigation issues and solutions related to the insurance industry.
   E. Evaluate private-public partnerships to improve insurance market capacity related to catastrophe perils.
   F. Investigate and receive information regarding the use of modeling by carriers and their reinsurers concerning climate risk.
   G. Review the impact of climate change on insurers through presentations by interested parties.
   H. Review innovative insurer solutions to climate risk, including new insurance products through presentations by interested parties.

5. The Lender-Placed Insurance Model Act (C) Working Group will:
   A. Complete the drafting and adoption of a new model law concerning lender-placed insurance as it relates to mortgages.

6. The Pet Insurance (C) Working Group will:
   A. Complete the development of a model law or guideline to establish appropriate regulatory standards for the pet insurance industry.

7. The Terrorism Insurance Implementation (C) Working Group will:
   A. Coordinate the NAIC’s efforts to address insurance coverage for acts of terrorism. Work with the U.S. Department of the Treasury’s Terrorism Risk Insurance Program (TRIP) Office on matters of mutual concern. Discuss long-term solutions to address the risk of loss from acts of terrorism.
   B. Review and report on data collection related to insurance coverage for acts of terrorism.

8. The Transparency and Readability of Consumer Information (C) Working Group will:
   A. Study and evaluate actions that will improve the capacity of consumers to comparison shop on the basis of differences in coverage provided by different insurance carriers offering personal lines products.
   B. Systematize and improve presale disclosures of coverage.
   C. Facilitate consumers’ capacity to understand the content of insurance policies and assess differences in insurers’ policy forms.
   D. Assist other groups with drafting language included within consumer-facing documents.
   E. Study and discuss whether there is a need for consumer disclosures regarding significant premium increases on property/casualty (P/C) insurance products.
   F. Update and develop webpage and mobile content for A Shopping Tool for Homeowners Insurance and A Shopping Tool for Automobile Insurance.
   G. Discuss and draft a disclosure for state insurance regulators to consider requiring to be added to homeowners’ policies regarding the fact that homeowners policies do not cover losses from flood, earthquake or other specified disasters.
2020 Proposed Charges

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Casualty Actuarial and Statistical (C) Task Force will:
   A. Provide reserving, pricing, ratemaking, statistical and other actuarial support to NAIC committees, task forces and/or working groups. Propose changes to the appropriate work products (with the most common work products noted below) and present comments on proposals submitted by others regarding casualty actuarial and statistical matters. Monitor the activities, including the development of financial services regulations and statistical (including disaster) reporting, regarding casualty actuarial issues.
      1. Property and Casualty Insurance (C) Committee – ratemaking, reserving or data issues.
      2. Blanks (E) Working Group – P/C annual financial statement, including Schedule P; P/C quarterly financial statement; P/C quarterly and annual financial statement instructions, including Statement of Actuarial Opinion (SAO) and Actuarial Opinion Summary Supplement.
   B. Monitor national casualty actuarial developments and consider regulatory implications.
      1. Casualty Actuarial Society (CAS) – Statements of Principles and Syllabus of Basic Education.
      3. Society of Actuaries (SOA) – general insurance track’s basic education.
   C. Facilitate discussion among state insurance regulators regarding rate filing issues of common interest across the states through the scheduling of regulator-only conference calls.
   D. Work with the CAS and SOA to identify: 1) whether the P/C Appointed Actuaries’ logs of continuing education (CE) should contain any particular categorization to assist regulatory review; 2) what types of learning P/C Appointed Actuaries are using to meet CE requirements for “Specific Qualification Standards” today; and 3) whether more specificity should be added to the P/C Appointed Actuaries’ CE requirements to ensure that CE is aligned with the educational needs for a P/C Appointed Actuary.
   E. In coordination with the Big Data (EX) Working Group:
      1. Draft and propose changes to the Product Filing Review Handbook to include best practices for the review of predictive models and analytics filed by insurers to justify rates.
      2. Draft and propose state guidance (e.g., information, data) for rate filings that are based on complex predictive models.
      3. Facilitate training and the sharing of expertise through predictive analytics webinars (Book Club).

2. The Actuarial Opinion (C) Working Group will:
   A. Propose revisions to the following, as needed, especially to improve actuarial opinions, actuarial opinion summaries, and actuarial reports, as well as the regulatory analysis of these actuarial documents and loss and premium reserves:
3. Annual Statement Instructions—Property/Casualty.
4. Regulatory guidance to appointed actuaries and companies.
5. Other financial blanks and instructions, as needed.

3. The **Statistical Data (C) Working Group** will:
   A. Consider updates and changes to the *Statistical Handbook of Data Available to Insurance Regulators*.
   B. Consider updates and developments, provide technical assistance, and oversee the production of the following reports and databases. Periodically evaluate the demand and utility versus the costs of production of each product.
   1. *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance*.
   2. *Auto Insurance Database*.

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

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Draft: 11/18/19
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Property and Casualty Insurance (C) Committee, Dec. 9, 2019
Adopted by the Surplus Lines (C) Task Force, Aug. 3, 2019

2020 Proposed Charges

SURPLUS LINES (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

NAIC Support Staff: Andy Daleo/Bob Schump
2020 Proposed Charges

TITLE INSURANCE (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Title Insurance (C) Task Force will:
   A. Monitor issues and developments occurring in the title insurance industry, and provide support and expertise to other NAIC committees, task forces and/or working groups, or outside entities, as appropriate.
   B. Review and assist various regulatory bodies in combating fraudulent and/or unfair real estate settlement activities. Such efforts could include working with the Antifraud (D) Task Force and other NAIC committees, task forces and/or working groups to combat mortgage fraud and mitigating title agent defalcations through the promotion of closing protection letters and other remedies. Report results at each national meeting.
   C. Consult with the Consumer Financial Protection Bureau (CFPB) and other agencies responsible for information, education and disclosure for mortgage lending, closing and settlement services about the role of title insurance in the real estate transaction process.
   D. Consider the effectiveness of changes in financial reporting by title insurance companies and identify further improvements and clarifications to blanks, instructions, Statement of Statutory Accounting Principles (SSAPs), solvency tools, and other matters, as necessary. Coordinate efforts with the Statutory Accounting Principles (E) Working Group.
   E. Revise the Title Insurance Consumer Shopping Tool Template to include questions and answers about title insurance-related fraud topics, including but not limited to, closing protection letters and wire fraud.
   F. Evaluate the effectiveness of closing protection letters, including but not limited to, intent, state regulation and requirements, consumer protections offered and excluded, and potential alternatives for coverage.

NAIC Support Staff: Anne Obersteadt/Aaron Brandenburg
2020 Proposed Charges

WORKERS’ COMPENSATION (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Workers’ Compensation (C) Task Force will:
   A. Oversee activities of the NAIC/IAIABC Joint (C) Working Group.
   B. Discuss issues with respect to advisory organizations, rating organizations, statistical agents, and insurance companies in the workers’ compensation arena.
   C. Monitor the movement of business from the standard markets to the assigned risk pools. Alert state insurance department representatives if growth of the assigned risk pools changes dramatically.
   D. Follow workers’ compensation issues regarding cannabis in coordination with the Cannabis Insurance (C) Working Group.

2. The NAIC/IAIABC Joint (C) Working Group will:
   A. Study issues of mutual concern to insurance regulators and the International Association of Industrial Accident Boards and Commissions (IAIABC). Review relevant IAIABC model laws and white papers and consider possible charges in light of the Working Group’s recommendations.
   B. Complete the drafting and adoption of the white paper, Changing Employee Relationships – Completion date anticipated in early 2020.

NAIC Support Staff: Sara Robben/Aaron Brandenburg
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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FOR NAIC USE ONLY

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REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

| No Impact [ ] |
| Modifies Required Disclosure [ ] |

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ ] Adopted Date
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify) [ ]

BLANK(S) TO WHICH PROPOSAL APPLIES

[ ] ANNUAL STATEMENT
[ ] INSTRUCTIONS
[ ] CROSSCHECKS
[ ] QUARTERLY STATEMENT
[ ] Life and Accident & Health
[ ] Separate Accounts
[ ] Other Specify
[ ] Property/Casualty
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Anticipated Effective Date: Annual 2021

IDENTIFICATION OF ITEM(S) TO CHANGE

A new Private Flood Insurance Supplement collecting residential and commercial private flood insurance data and revisions to the Credit Insurance Experience Exhibit (CIEE) to collect lender-placed flood coverages.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The State Page currently collects private flood insurance data but does not split residential from commercial coverages. Regulators, as well as industry and consumers, have a desire to better monitor and assess the growth of the residential private flood insurance market as that market begins to grow. A new Supplement will separate residential from commercial as well as capturing stand alone/endorsement and first dollar/excess policy information. The revisions to the CIEE will allow for the collection of lender-placed flood coverages in order to get a more complete picture of the private flood insurance market.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: __________________________

Other Comments: __________________________

** This section must be completed on all forms.

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CCmteFloodBlankRequest_Final
PRIVATE FLOOD INSURANCE SUPPLEMENT
For The Year Ended December 31, 2020
(To Be Filed by March 31)

NAIC Group Code ........................................  NAIC Company Code...................................

Company Name

Part 1 - Interrogatories

Private Flood Insurance Coverage:

1. Does the reporting entity write any stand-alone first-dollar residential private flood
   insurance?  
   Yes [ ]  No [ ]
   If yes, complete Part 2

2. Does the reporting entity write any stand-alone excess residential private flood?
   Yes [ ]  No [ ]
   If yes, complete Part 3

3. Does the reporting entity write any first-dollar residential private flood provided as an
   endorsement?  
   Yes [ ]  No [ ]
   If yes, complete Part 4

4. Does the reporting entity write any excess residential private flood insurance
   provided as an endorsement?  
   Yes [ ]  No [ ]
   If yes, complete Part 5

5. Does the reporting entity write any commercial private flood insurance provided as
   either a stand-alone or package policy? (include both first-dollar and excess)
   Yes [ ]  No [ ]
   If yes, complete Part 6
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© 2019 National Association of Insurance Commissioners
### Part 3 - Standalone Residential Property Flood Policies

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### Part 5 - Residential Private Flood Policy Endorsements

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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1 Defense and cost containment expenses incurred</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2 Adjusting and other expenses incurred</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(a) Provide a description of "other" coverages (including their percent of Line 1.6, Column 7). _______________________________ ____________________________________________________________________

7. Earned Exposure:
December 9, 2019

The following document provides information regarding ways for a department of insurance (DOI) to encourage the growth of private residential flood insurance.

Currently, the Property and Casualty Insurance (C) Committee is considering enhancing the collection of private flood data. These efforts include: 1) collecting information that separates residential private flood insurance premiums from commercial private flood insurance premiums; and 2) breaking the information down by stand-alone policies and endorsements to homeowners insurance policies, by both first dollar and excess. Additionally, the proposed supplement will provide claims and policy data.

Furthermore, it has been proposed that lender-placed flood insurance data be collected on the Credit Insurance Experience Exhibit and private flood insurance data be collected for the surplus lines market through the Surplus Lines (C) Working Group.

The Market Regulation and Consumer Affairs (D) Committee has developed a private flood insurance line for the Market Conduct Annual Statement (MCAS), which will collect 2020 data in 2021. The data is expected to follow the same format as the homeowners MCAS with a focus on private flood insurance.

Other considerations for the Property and Casualty Insurance (C) Committee include:

- Considering ways to incorporate a conforming conditions clause in the form approval process.
- Referring state law conflicts relating to statute of limitations and cancellation/renewal provisions to the Government Relations Leadership Council (GRLC) to resolve at the federal level.
CONSIDERATIONS FOR STATE INSURANCE REGULATORS IN BUILDING THE PRIVATE FLOOD INSURANCE MARKET

DECEMBER 9, 2019
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Continuous Coverage

Non-Compete Clause

NFIP Subsidized Rates

Ability to Assess Flood Risk Accurately
BACKGROUND AND PURPOSE

State insurance regulators have first-hand experience with the devastating effects that floods have on the constituents in their states, and they believe it is critical that flood insurance is both available and affordable in order to encourage purchases that thereby protect homes, businesses and personal property. Although private flood insurance is being written largely in the commercial market, this paper will focus on the residential flood insurance market.

For more than a half-century, the federal government’s National Flood Insurance Program (NFIP) has been the primary player in the residential flood insurance market, underwriting most policies while private insurers have largely focused on a relatively small residential supplemental market. While the NFIP has done a laudable job in making flood insurance available for millions of residential properties, a significant flood insurance gap exists across the U.S.\(^1\) with flood event after flood event revealing a substantial number of damaged properties being uninsured.\(^2\) A Federal Emergency Management Agency (FEMA) analysis from 2018 indicates that 69% of American homes in high-risk flood zones do not have flood insurance. Concurrently, there has been a heightened interest amongst private carriers to expand their residential flood insurance offerings, greatly assisted by the development of more sophisticated flood mapping and risk modeling technologies.

Funding for continuation of the NFIP expired in September 2017, and since then, the U.S. Congress has passed numerous short-term extensions, and more are expected. The federal Biggert-Waters Flood Insurance Reform Act of 2012 (Biggert-Waters) requires lenders to accept private flood insurance policies meeting certain requirements just as they would an NFIP policy to satisfy the federal mandatory purchase mortgage requirement. The NAIC has been engaged legislatively and with the federal banking regulators on their rulemaking.\(^3\) In February 2019, after six years of deliberation, the federal banking regulators finalized their rule. The final rule provides the requirements\(^4\) for lenders to accept provide flood insurance policies. The rule also provides lenders the option to accept private flood insurance policies that do not meet the mandatory acceptance requirements set forth in Biggert-Waters subject to certain conditions.

State insurance regulators and the NAIC support a long-term NFIP reauthorization, as well as the facilitation of increased private sector involvement in the sale of flood insurance, which can help ensure that consumers have access to multiple options. In 2016, the NAIC developed the “NAIC Principles for National Flood Insurance Program (NFIP) Reauthorization”\(^5\) and has testified in Congress on the importance of ensuring a viable private flood insurance market as an alternative to the NFIP.\(^6\)

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\(^2\) www.pciaa.net/docs/default-source/industry-issues/4_lessonslearned.pdf.

\(^3\) https://www.naic.org/documents/government_relations_comment_letter_federal_banking_private_flood_insurance.pdf.

\(^4\) The key conditions in the final rule are: 1) a requirement that the policy provide sufficient protection for a designated loan, consistent with general safety and soundness principles; and 2) a requirement that the regulated lending institution document its conclusion regarding the sufficiency of protection in writing. The final rule also allows regulated lending institutions to exercise their discretion to accept certain plans providing coverage issued by “mutual aid societies.”


Following from this NAIC action, the purpose of this document is to provide state insurance regulators with concrete actions that can be and/or have been taken to assist with the development of the burgeoning private insurance market for residential flood insurance.
OVERALL STATE OF THE FLOOD INSURANCE MARKET

According to the most recent data collected by the NAIC (Table 1), approximately $644 million of direct premium was written in the private flood insurance market in 2018 throughout the U.S. In 2018, the private flood insurance market represented 15% of the total flood insurance market ($4.2 billion). The private flood insurance market has been growing over the past few years, with the $644 million in direct premium written in 2018 being an increase of 9% from 2017 direct written premiums, and an increase of 71% since 2016. In 2018, California, Florida, Louisiana, New Jersey, New York, Pennsylvania, Puerto Rico and Texas each had $20 million or more of private flood insurance direct written premium (Table 1), with these eight states/jurisdictions representing nearly 60% of the total private flood insurance market.

It is important to note that the NAIC Annual Statement data used in Table 1 and Table 2 does not differentiate between residential private flood insurance premium and commercial private flood insurance premium. The NAIC is exploring data collection via a supplement and/or data call to collect data for residential private flood insurance and commercial private flood insurance separately.

Beyond this aggregate view of premium being written by state, for a relative sense of market penetration and growth of the private flood market, two other views of the NAIC data are presented: 1) private flood as a percentage of total flood written per state in 2018 (Table 1); and 2) private flood growth by state from 2016 to 2018 (Table 2).

| Table 1: Private Flood as a Percentage of Total Flood Written per State in 2018 |
|-----------------|-----------------|-----------------|----------------|-----------------|
| State | Direct Premium Written – Private | Direct Written Premium – NFIP | Total | Private Flood Percentage |
| AK | $726,128 | $2,173,734 | $2,899,862 | 25% |
| AL | $4,717,310 | $37,369,849 | $42,087,159 | 11% |
| AR | $2,918,840 | $13,387,226 | $16,306,066 | 18% |
| AS | $17 | $38,356 | $38,373 | 0% |
| AZ | $13,616,250 | $20,785,412 | $34,401,662 | 40% |
| CA | $83,598,726 | $184,728,154 | $268,326,880 | 31% |
| CO | $6,815,467 | $17,996,733 | $24,812,200 | 27% |
| CT | $8,554,006 | $52,057,947 | $60,611,953 | 14% |
| DC | $2,023,055 | $1,481,959 | $3,505,014 | 58% |
| DE | $1,870,439 | $19,394,560 | $21,264,999 | 9% |
| FL | $79,664,174 | $974,338,089 | $1,054,002,263 | 8% |
| GA | $13,822,654 | $59,793,148 | $73,615,802 | 19% |
| GU | $23,475 | $348,208 | $371,683 | 6% |
| HI | $3,511,428 | $40,778,877 | $44,290,305 | 8% |
| IA | $9,261,662 | $12,894,876 | $22,156,538 | 42% |
| ID | $1,685,637 | $4,443,509 | $6,129,146 | 28% |
| IL | $15,571,396 | $41,782,653 | $57,354,049 | 27% |
| IN | $9,754,263 | $22,122,449 | $31,876,712 | 31% |
| KS | $5,619,810 | $8,096,167 | $13,715,977 | 41% |
Table 1: Private Flood as a Percentage of Total Flood Written Per State in 2018 (cont’d)

<table>
<thead>
<tr>
<th>State</th>
<th>Direct Premium Written – Private</th>
<th>Direct Written Premium – NFIP</th>
<th>Total</th>
<th>Private Flood Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>KY</td>
<td>$ 5,562,791</td>
<td>$ 19,859,236</td>
<td>$ 25,422,027</td>
<td>22%</td>
</tr>
<tr>
<td>LA</td>
<td>$ 20,518,942</td>
<td>$ 332,451,130</td>
<td>$ 352,970,072</td>
<td>6%</td>
</tr>
<tr>
<td>MA</td>
<td>$ 17,035,775</td>
<td>$ 77,215,928</td>
<td>$ 94,251,703</td>
<td>18%</td>
</tr>
<tr>
<td>MD</td>
<td>$ 6,161,138</td>
<td>$ 38,179,561</td>
<td>$ 44,340,699</td>
<td>14%</td>
</tr>
<tr>
<td>ME</td>
<td>$ 1,826,143</td>
<td>$ 8,778,305</td>
<td>$ 10,604,448</td>
<td>17%</td>
</tr>
<tr>
<td>MI</td>
<td>$ 7,287,062</td>
<td>$ 20,395,079</td>
<td>$ 27,682,141</td>
<td>26%</td>
</tr>
<tr>
<td>MN</td>
<td>$ 6,072,364</td>
<td>$ 7,828,757</td>
<td>$ 13,901,121</td>
<td>44%</td>
</tr>
<tr>
<td>MO</td>
<td>$ 10,054,439</td>
<td>$ 21,828,499</td>
<td>$ 31,882,938</td>
<td>32%</td>
</tr>
<tr>
<td>MP</td>
<td>$ 1,406</td>
<td>$ -</td>
<td>$ 1,406</td>
<td>100%</td>
</tr>
<tr>
<td>MS</td>
<td>$ 5,401,764</td>
<td>$ 43,786,173</td>
<td>$ 49,187,937</td>
<td>11%</td>
</tr>
<tr>
<td>MT</td>
<td>$ 1,107,818</td>
<td>$ 3,679,000</td>
<td>$ 4,786,818</td>
<td>23%</td>
</tr>
<tr>
<td>NC</td>
<td>$ 10,477,327</td>
<td>$ 109,932,602</td>
<td>$ 120,409,929</td>
<td>9%</td>
</tr>
<tr>
<td>ND</td>
<td>$ 1,808,961</td>
<td>$ 6,508,148</td>
<td>$ 8,317,109</td>
<td>22%</td>
</tr>
<tr>
<td>NE</td>
<td>$ 3,426,045</td>
<td>$ 8,737,796</td>
<td>$ 12,163,841</td>
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</tr>
<tr>
<td>NH</td>
<td>$ 1,579,406</td>
<td>$ 8,531,507</td>
<td>$ 10,110,913</td>
<td>16%</td>
</tr>
<tr>
<td>NJ</td>
<td>$ 33,570,528</td>
<td>$ 215,735,820</td>
<td>$ 249,306,348</td>
<td>13%</td>
</tr>
<tr>
<td>NM</td>
<td>$ 2,025,523</td>
<td>$ 10,462,171</td>
<td>$ 12,487,694</td>
<td>16%</td>
</tr>
<tr>
<td>NV</td>
<td>$ 4,598,626</td>
<td>$ 8,083,596</td>
<td>$ 12,682,222</td>
<td>36%</td>
</tr>
<tr>
<td>NY</td>
<td>$ 47,243,273</td>
<td>$ 205,299,097</td>
<td>$ 252,542,370</td>
<td>19%</td>
</tr>
<tr>
<td>OH</td>
<td>$ 15,400,298</td>
<td>$ 33,185,859</td>
<td>$ 48,586,157</td>
<td>32%</td>
</tr>
<tr>
<td>OK</td>
<td>$ 3,076,462</td>
<td>$ 11,092,205</td>
<td>$ 14,168,667</td>
<td>22%</td>
</tr>
<tr>
<td>OR</td>
<td>$ 6,248,012</td>
<td>$ 23,928,017</td>
<td>$ 30,176,029</td>
<td>21%</td>
</tr>
<tr>
<td>PA</td>
<td>$ 22,141,354</td>
<td>$ 65,301,183</td>
<td>$ 87,442,537</td>
<td>25%</td>
</tr>
<tr>
<td>PR</td>
<td>$ 21,658,142</td>
<td>$ 7,645,531</td>
<td>$ 29,303,673</td>
<td>74%</td>
</tr>
<tr>
<td>RI</td>
<td>$ 2,317,465</td>
<td>$ 18,409,898</td>
<td>$ 20,727,363</td>
<td>11%</td>
</tr>
<tr>
<td>SC</td>
<td>$ 13,703,417</td>
<td>$ 137,792,886</td>
<td>$ 151,496,303</td>
<td>9%</td>
</tr>
<tr>
<td>SD</td>
<td>$ 834,247</td>
<td>$ 3,115,261</td>
<td>$ 3,949,508</td>
<td>21%</td>
</tr>
<tr>
<td>TN</td>
<td>$ 12,179,549</td>
<td>$ 24,574,361</td>
<td>$ 36,753,910</td>
<td>33%</td>
</tr>
<tr>
<td>TX</td>
<td>$ 63,221,041</td>
<td>$ 435,173,125</td>
<td>$ 498,394,166</td>
<td>13%</td>
</tr>
<tr>
<td>UT</td>
<td>$ 2,712,200</td>
<td>$ 2,509,861</td>
<td>$ 5,222,061</td>
<td>52%</td>
</tr>
<tr>
<td>VA</td>
<td>$ 9,475,832</td>
<td>$ 78,057,383</td>
<td>$ 87,533,215</td>
<td>11%</td>
</tr>
<tr>
<td>VI</td>
<td>$ 37,329</td>
<td>$ 2,185,181</td>
<td>$ 2,222,510</td>
<td>2%</td>
</tr>
<tr>
<td>VT</td>
<td>$ 698,550</td>
<td>$ 4,937,502</td>
<td>$ 5,636,052</td>
<td>12%</td>
</tr>
<tr>
<td>WA</td>
<td>$ 12,061,004</td>
<td>$ 31,765,783</td>
<td>$ 43,826,787</td>
<td>28%</td>
</tr>
<tr>
<td>WI</td>
<td>$ 5,896,222</td>
<td>$ 11,790,299</td>
<td>$ 17,686,521</td>
<td>33%</td>
</tr>
<tr>
<td>WV</td>
<td>$ 1,804,872</td>
<td>$ 16,683,897</td>
<td>$ 18,488,769</td>
<td>10%</td>
</tr>
<tr>
<td>WY</td>
<td>$ 899,933</td>
<td>$ 1,580,170</td>
<td>$ 2,480,103</td>
<td>36%</td>
</tr>
<tr>
<td>Total</td>
<td>$ 643,879,997</td>
<td>$ 3,571,032,713</td>
<td>$ 4,214,912,710</td>
<td>15%</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>AK</td>
<td>$726,128</td>
<td>$957,063</td>
<td>$555,129</td>
<td>-24%</td>
</tr>
<tr>
<td>AL</td>
<td>$4,717,310</td>
<td>$4,799,724</td>
<td>$3,005,135</td>
<td>-2%</td>
</tr>
<tr>
<td>AR</td>
<td>$2,918,840</td>
<td>$2,826,120</td>
<td>$1,607,656</td>
<td>3%</td>
</tr>
<tr>
<td>AS</td>
<td>$17</td>
<td>-</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>AZ</td>
<td>$13,616,250</td>
<td>$11,068,965</td>
<td>$6,260,448</td>
<td>23%</td>
</tr>
<tr>
<td>CA</td>
<td>$83,598,726</td>
<td>$71,951,648</td>
<td>$48,786,070</td>
<td>16%</td>
</tr>
<tr>
<td>CO</td>
<td>$6,815,467</td>
<td>$6,097,813</td>
<td>$4,735,996</td>
<td>12%</td>
</tr>
<tr>
<td>CT</td>
<td>$8,554,006</td>
<td>$9,810,824</td>
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<td>-13%</td>
</tr>
<tr>
<td>DC</td>
<td>$2,023,055</td>
<td>$2,838,882</td>
<td>$1,829,183</td>
<td>-29%</td>
</tr>
<tr>
<td>DE</td>
<td>$1,870,439</td>
<td>$1,669,426</td>
<td>$740,005</td>
<td>12%</td>
</tr>
<tr>
<td>FL</td>
<td>$79,664,174</td>
<td>$84,491,040</td>
<td>$47,796,186</td>
<td>-6%</td>
</tr>
<tr>
<td>GA</td>
<td>$13,822,654</td>
<td>$12,154,732</td>
<td>$6,953,126</td>
<td>14%</td>
</tr>
<tr>
<td>GU</td>
<td>$23,475</td>
<td>$61,491</td>
<td>$9,396</td>
<td>-62%</td>
</tr>
<tr>
<td>HI</td>
<td>$3,511,428</td>
<td>$4,707,292</td>
<td>$3,149,891</td>
<td>-25%</td>
</tr>
<tr>
<td>IA</td>
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</tr>
<tr>
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<td>$1,246,073</td>
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<td>35%</td>
</tr>
<tr>
<td>IL</td>
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<td>$14,022,683</td>
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<td>11%</td>
</tr>
<tr>
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<tr>
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<td>$5,184,777</td>
<td>$3,636,333</td>
<td>7%</td>
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<td>LA</td>
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<td>$17,883,168</td>
<td>$11,495,497</td>
<td>15%</td>
</tr>
<tr>
<td>MA</td>
<td>$17,035,775</td>
<td>$15,255,682</td>
<td>$8,980,394</td>
<td>12%</td>
</tr>
<tr>
<td>MD</td>
<td>$6,161,138</td>
<td>$4,881,020</td>
<td>$3,004,956</td>
<td>26%</td>
</tr>
<tr>
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<td>$1,393,303</td>
<td>$1,449,308</td>
<td>31%</td>
</tr>
<tr>
<td>MI</td>
<td>$7,287,062</td>
<td>$5,784,426</td>
<td>$3,112,100</td>
<td>26%</td>
</tr>
<tr>
<td>MN</td>
<td>$6,072,364</td>
<td>$6,034,414</td>
<td>$4,382,496</td>
<td>1%</td>
</tr>
<tr>
<td>MO</td>
<td>$10,054,439</td>
<td>$8,579,964</td>
<td>$5,611,173</td>
<td>17%</td>
</tr>
<tr>
<td>MP</td>
<td>$1,406</td>
<td>$673</td>
<td>-</td>
<td>109%</td>
</tr>
<tr>
<td>MS</td>
<td>$5,401,764</td>
<td>$4,954,089</td>
<td>$3,545,564</td>
<td>9%</td>
</tr>
<tr>
<td>MT</td>
<td>$1,107,818</td>
<td>$965,222</td>
<td>$546,157</td>
<td>15%</td>
</tr>
<tr>
<td>NC</td>
<td>$10,477,327</td>
<td>$9,385,350</td>
<td>$5,916,463</td>
<td>12%</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>ND</td>
<td>$1,808,961</td>
<td>$1,518,138</td>
<td>$1,033,168</td>
<td>19%</td>
</tr>
<tr>
<td>NE</td>
<td>$3,426,045</td>
<td>$2,733,969</td>
<td>$1,819,577</td>
<td>25%</td>
</tr>
<tr>
<td>NH</td>
<td>$1,579,406</td>
<td>$1,773,337</td>
<td>$1,516,804</td>
<td>-11%</td>
</tr>
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<td>NJ</td>
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<td>$28,862,467</td>
<td>$17,035,409</td>
<td>16%</td>
</tr>
<tr>
<td>NM</td>
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<td>$1,735,136</td>
<td>$662,921</td>
<td>17%</td>
</tr>
<tr>
<td>NV</td>
<td>$4,598,626</td>
<td>$4,574,608</td>
<td>$2,440,079</td>
<td>1%</td>
</tr>
<tr>
<td>NY</td>
<td>$47,243,273</td>
<td>$47,674,483</td>
<td>$27,419,308</td>
<td>-1%</td>
</tr>
<tr>
<td>OH</td>
<td>$15,400,298</td>
<td>$14,202,904</td>
<td>$5,628,305</td>
<td>8%</td>
</tr>
<tr>
<td>OK</td>
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<td>$3,507,498</td>
<td>$1,746,619</td>
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</tr>
<tr>
<td>OR</td>
<td>$6,248,012</td>
<td>$4,730,473</td>
<td>$2,910,035</td>
<td>32%</td>
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<tr>
<td>PA</td>
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<td>$18,832,760</td>
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<tr>
<td>PR</td>
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<td>$19,554,982</td>
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<td>11%</td>
</tr>
<tr>
<td>RI</td>
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<td>$2,623,963</td>
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<td>$10,633,358</td>
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<tr>
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<td>$8,584,856</td>
<td>$5,939,417</td>
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<tr>
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<td>$53,512,832</td>
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</tr>
<tr>
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<td>$1,958,666</td>
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</tr>
<tr>
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</tr>
<tr>
<td>VT</td>
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</tr>
<tr>
<td>WA</td>
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<td>$11,566,163</td>
<td>$9,609,189</td>
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<tr>
<td>WI</td>
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<td>$4,140,377</td>
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</tr>
<tr>
<td>WV</td>
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<tr>
<td>WY</td>
<td>$899,933</td>
<td>$959,541</td>
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<td>-6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$643,879,997</td>
<td>$589,147,189</td>
<td>$376,130,254</td>
<td>9%</td>
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</table>

Clearly, this data suggests that there are considerable opportunities for private flood insurance placement and market development. However, it is important to note that in 2018, the majority of growth occurred in the private commercial flood insurance market. The residential private flood insurance market showed a slight decline from 2017.7

As insurers’ familiarity with flood catastrophe models grows, as underwriting experience develops and as state regulatory structures evolve, the number of private flood insurance policies in force could continue to grow, including among admitted carriers. Therefore, it is important to understand what the states have done (or not done) to enhance this growth.

STATE ACTION

During the six years of uncertainty regarding the federal banking rules for private flood insurance, a number of states began undertaking efforts to encourage the growth of a private flood insurance market in their state. Florida’s efforts to establish a private flood insurance market have been applauded as a potential model to be used in other states looking to expand their residential private flood insurance offerings. Florida has the largest flood insurance market in the country; approximately 35% of NFIP policies are written there. Florida has enacted legislation to create a statutory framework, allowing private insurers to offer multiple types of flood coverage ranging from standard coverage, which mirrors the NFIP, to other enhanced coverages. This legislation includes: 1) streamlining the rate filing process for private flood insurers; 2) eliminating the diligent search requirement for flood policies issued by surplus lines carriers until July 2019; and 3) providing a process by which the Office of Insurance Regulation (OIR) will certify that a private insurer’s policy equals or exceeds coverage provided by the NFIP. Florida’s OIR issued an informational memorandum providing guidance on how private insurers will need to demonstrate the financial capacity to assume this risk, as well as options for developing private flood rates and policy forms.

In addition to Florida, we can draw upon the existing experiences from other states in developing a robust flood insurance market along the key aspects of insurance regulation.

The NAIC reached out to the states on the drafting group to provide information that was not readily available on the states’ websites, as well as to gather information from other resources, including: 1) the Wharton School of the University of Pennsylvania study *The Emerging Private Residential Flood Insurance Market in the United States*; 2) Government Accountability Office (GAO) reports; and 3) a recently updated Congressional Research Service (CRS) report regarding private flood insurance and the NFIP. In the future, the NAIC might want to consider sending a more detailed questionnaire to the states to gather more information regarding the developing private flood insurance market.

State efforts to grow a viable private flood insurance market include:

**Legislative and Regulatory Changes**
- Supporting private flood insurance legislation.
- Approving private flood insurance products.
- Tailoring rate and form requirements for private flood insurance coverage.
- Allowing private flood insurers to submit rates on an informational basis.
- Removing diligent search requirements.

**Consumer Information**
- Conducting consumer outreach.
- Listing private flood insurance products on a department of insurance’s (DOI) website.
- Collecting residential private flood insurance data.

**Agent and Lender Actions**
- Implementing specific continuing education (CE) requirements for producers.
- Increasing the weighting of flood insurance questions on producer licensing exams.
- Conducting agent education.
- Conducting lender education.

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LEGISLATIVE AND REGULATORY CHANGES

Supporting Private Flood Insurance Legislation
In addition to Florida’s legislation, West Virginia has passed legislation requiring insurers to file their private flood insurance plan of operation with the insurance commissioner and authorizing expedited processing of surplus lines policies for flood insurance.

Approving Private Flood Insurance Products
Personal lines private flood insurance products are being approved by a number of states. Currently, Alabama, California, Mississippi and Pennsylvania are among states approving new personal lines private flood insurance products for entry into the market.

In January 2018, the Insurance Services Office (ISO) developed a new private flood insurance form, for both personal and commercial flood insurance. The ISO forms are similar to a homeowner’s policy form. However, the damage to the property must be caused by flooding. As of March 2018, ISO personal flood insurance forms have been filed in 43 jurisdictions, and commercial flood insurance forms have been filed in 45 jurisdictions. The states with independent rating bureaus are not reflected in these numbers.

TAILORING RATE AND FORM REQUIREMENTS FOR PRIVATE FLOOD INSURANCE COVERAGE

The states might want to consider permitting insurers to file private flood insurance products without a prior approval requirement. For example, Florida law permits private flood insurance rates to be implemented without prior approval at the time of filing. However, insurers are required to keep supporting actuarial data for two years. Furthermore, Florida law allows insurers to request the state to certify that a private policy provides flood coverage that equals or exceeds that offered by NFIP. (See Appendix I for information on Florida’s process.)

Maryland, South Carolina and Pennsylvania have not relaxed the rate and form filing requirements. However, they are committed to an efficient and swift overview of private flood insurance filings, and they will work with insurers to make the filing and approval process as smooth as possible.

EXPORT LIST / WAIVING DILIGENT SEARCH REQUIREMENTS

Insurance generally must be sold in the admitted market. Only after a “diligent search” of the admitted market is performed and coverage is denied can insurance be placed in the surplus lines market. However, states make exceptions for those types of insurance that are known to not be available in the admitted market. These insurance products are listed on what is known as an “Export list.” When a type of insurance is listed on an Export list, the applicant can go straight to the surplus lines market without the need for the diligent search, thereby obtaining coverage more easily and quickly. At least 14 states have placed flood insurance on their “Export list,” including: Alaska, Arizona, Connecticut, Idaho, Louisiana, New Jersey, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Virginia, West Virginia and Wisconsin.
Allowing Private Flood Insurers to Submit Rates on an Informational Basis
Allowing insurers to submit rates on an informational basis in states with prior approval rate filing laws is another way to encourage the growth of the private flood insurance market. Two states that have taken this approach include Florida and New Jersey.\(^9\) (See Appendix I for information on Florida’s process.)

**CONSUMER INFORMATION**

Consumer Outreach

It is important to understand that everyone lives in a flood zone. Some people live in higher-risk flood zones than others, but we all live in a flood zone.

When people say they live or do not live in a flood zone, they typically mean what is known as a “special flood hazard area”. A “special flood hazard area” is an area within FEMA’s 100-year flood plain. This is where flood insurance is typically mandatory as a condition of obtaining a property loan. But there are flood zones outside of the 100-year flood plain as well. For example, there is also what FEMA classifies as moderate risk flood zones. These are the properties in the 500-year flood plain. By definition, and according to FEMA, these properties have between a 0.2% and a 1% chance of flooding in any given year. That might sound small, but over the course of a 30-year mortgage, these properties, according to FEMA, have between a 6% and 26% chance of being inundated by a flood. And flood insurance is not mandatory as a condition of obtaining a property loan in these moderate-risk flood zones.

Consumers need to understand that their property may still be at risk for flooding even if they do not live in a special flood hazard area and are not required to purchase it. They also need to understand that flood insurance can be relatively inexpensive, especially when the property is not in the highest-risk flood zones. There are options available to them, from both the NFIP and the private flood insurance market. And they can purchase lower limits of coverage; they do not need to insure the full replacement cost of their home if they do not wish to do so. Purchasing just $20,000 of coverage, for example, might go a long way in the event of a flood and may be cheaper to purchase than believed. Further, renters can buy policies that cover only their personal property and not the dwelling that they rent.

There are also many consumers under the misconception that flood damage will be covered by their homeowners insurance policy or rental insurance policy. Therefore, they are unaware of their actual flood risk, and they learn that they are uninsured for this catastrophic peril only after a flood event for which they have no coverage.

State DOIs, as well as the NAIC, are launching consumer outreach programs to help address this coverage gap.

Some states now require a flood disclosure with homeowners policies. For example, Texas recently passed a law requiring a conspicuous disclosure when homeowners policies do not include flood coverage.

The NAIC Communications Department has also launched a flood campaign this year to inform consumers of the importance of purchasing flood insurance, either private flood insurance or flood insurance provided by the NFIP. Additionally, the NAIC recently released a special section of its website.

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dedicated to educating consumers about the risks of flooding and what kinds of coverage options are available to protect against those risks.

Finally, the NAIC’s Transparency and Readability of Consumer Information (C) Working Group has created both a basic flood insurance document and several graphic materials containing flood facts, to be used by DOIs for consumer outreach via social media.

**Listing Private Flood Insurance Writers on a DOI Website**

While many DOIs include information regarding NFIP policies on their websites, some states, including Florida, Louisiana, New Jersey and Pennsylvania, provide a list of private flood insurance writers and their contact information on their websites.

It is worthwhile to note that surplus lines writers are generally not listed by the line of business they write. However, it has been suggested that there would be value for the states to provide information regarding which surplus lines writers are writing residential private flood insurance. Pennsylvania lists the surplus lines producers placing residential flood insurance on its website.

**Collecting Residential Private Flood Insurance Data**

Florida and Texas both collect comprehensive data regarding residential private flood insurance. As described previously, the NAIC has been collecting private flood insurance data since the data year 2016. Before that, the private flood insurance line was not a separate entry in the annual statement. While residential and commercial private flood insurance are not separated in the property/casualty (P/C) annual statement blank, the NAIC, through its Property and Casualty Insurance (C) Committee, is considering enhancements to the annual statement that would require insurers to report the residential private flood insurance premiums and commercial private flood insurance premiums independently. The Surplus Lines (C) Task Force is considering similar changes to alien surplus lines private flood insurance data that is reported to the International Insurers Department (IID).

The Wholesale & Specialty Insurance Association (WSIA) is also providing the Reinsurance Association of America (RAA) with data regarding surplus lines insurance. The RAA is working on an open source database that provides information regarding private flood insurance.

These changes would allow state insurance regulators and FEMA to better measure the growth of the private residential flood insurance market.

**AGENT AND LENDER ACTIONS**

**Continuing Education and Producer Licensing Requirements**

FEMA requires all insurance producers licensed in property, casualty or personal lines of authority who sell flood insurance through the NFIP to complete a one-time course, as required by the federal Flood Insurance Reform Act of 2004. This is also the only educational requirement in many states.

At least one state has increased the weighting of the flood insurance questions on their producer licensing exam.

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Agent Education


When purchasing insurance, many times the insurance agent is the consumer’s first point of contact. Therefore, it would be valuable if an agent could explain the risks of flooding, even if a consumer does not own or rent property in a high-risk flood zone. Recent flood events remind us that where it can rain, it can flood, and many floods occur outside of a high-risk flood zone. If agents help to educate the consumer, it will help eliminate the cost of inaction, as the occurrence of a flood event could be financially unbearable for homeowners or renters if they are not insured or are underinsured. It is critical for agents to make a special effort to educate homeowners regarding the need for flood insurance, even if a business or home is not located in a high-risk flood zone.

DOIs can provide agents with information that they have learned as a result of a flood event, and they can foster agent education by requiring CE requirements to improve an agent’s knowledge of flood insurance.

Other states’ adoption of such practices would likely improve agents’ knowledge of flood insurance, therefore helping their clients to obtain more effective flood coverage, whether through the NFIP or the private market.

Lender Education

A large percentage of Americans have a mortgage on their home. Therefore, lender education is another opportunity for consumer flood insurance education. Recent catastrophic flooding events have illustrated that floods can happen anywhere. Therefore, it may be in the best interest of homeowners to purchase flood insurance even if they do not live in a high-risk flood zone.

While state insurance regulators do not have the authority to regulate lenders, lenders should still be educated regarding the importance of flood insurance. When navigating the loan process, lenders do not always discuss purchasing flood insurance unless the borrower’s home is in a high-risk flood zone. A discussion about purchasing flood insurance even if the homeowner does not live in a high-risk flood zone should ideally be addressed with the borrower.

DOIs can raise awareness regarding flood insurance by bringing agents, consumers, lenders, FEMA, private flood insurance writers, etc. together in communities to discuss the importance of a homeowner purchasing flood insurance.

MARKET UNCERTAINTY AND THE DEVELOPMENT OF A PRIVATE FLOOD INSURANCE MARKET

The May 2019 CRS report, “Private Flood Insurance and the National Flood Insurance Program,” identified some of the barriers to the development of a private flood insurance market. Some of the barriers identified in the report include: 1) regulatory uncertainty; and 2) continuous coverage.

Most directly relevant for the NAIC members is the notion of regulatory uncertainty, which is covered below. The remaining topics will be addressed in Appendix II.
In 2016, the U.S. experienced several major flood catastrophes, causing billions of dollars in property losses. Following these storms, it was found that somewhere between 50% and 80% of these losses were not insured, which implies that communities are unable to bounce back quickly following large catastrophic events.

Floods are expected to cost U.S. households $20 billion each year. An Insurance Information Institute (I.I.I.) survey indicated that 15% of American homeowners had a flood insurance policy in 2018 and that there were approximately 5.18 million flood insurance policies held by the NFIP. Milliman estimates the potential private residential flood insurance market to represent between $34 billion and $48 billion in direct written premium. This data clearly indicates an opportunity for growth in the residential private flood insurance market in the U.S.

Recently, comments have surfaced regarding the possibility of the residential private flood insurance market cherry-picking their risks. It is important to remember the NFIP was meant to be a temporary solution that was put into place 50 years ago due to private insurers not insuring flood. While the NFIP is important, every state has some type of residual market that aids in insuring and providing insurance coverage for those who are unable to obtain insurance coverage available in the market. While not directly related to flood insurance, two good examples of successful residual markets are Florida Citizens and Louisiana Citizens. As the market has grown and shrunk in both Florida and Louisiana, both Florida Citizens and Louisiana Citizens needed to and provided a safe and reliable source of insurance for consumers. The NFIP can continue to evolve and do the same thing. Milliman believes Risk Rating 2.0 will help the NFIP and provide helpful information regarding the actual risk of a flood insurance policy; however, it was recently announced that the implementation of Risk Rating 2.0 will be delayed until Oct. 1, 2021 to allow for more analysis of its impact.

Milliman is of the opinion that a private market can coexist alongside the NFIP. Private flood insurance can be written in the admitted and non-admitted market. However, it needs to be determined if the guaranty funds will cover flood insurance in the admitted market, as flood may be excluded in many states.

Many private insurers have not serviced or written flood insurance policies. Additionally, private insurers do not have access to historical data; this poses a problem. It will be important to balance the need to protect consumers against the need to promote the private flood insurance market.

New entrants to the private flood insurance market are likely to purchase significant amounts of reinsurance. Flood insurance is inherently high-risk and volatile, so insurers may require higher amounts of profit and contingencies built into rates than for a typical homeowner's insurance product. States allowing these options might make it easier for an insurer to offer private flood insurance. For example, Wisconsin has no limitations or requirements for reinsurance cost and profit provision assumptions.

The issue of continuous coverage is problematic. In order for an NFIP policyholder to preserve any subsidies provided by the NFIP, a policyholder is required to have continuous flood insurance coverage. Currently, a policyholder loses subsidies or cross-subsidies when private flood insurance is purchased, if the policyholder chooses to return to the NFIP.

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13 Milliman
14 https://www.iii.org/fact-statistic/facts-statistics-flood-insurance
15 https://www.fema.gov/total-policies-force-calendar-year
16 Milliman
Unless there is legislation in place allowing private flood insurance to be deemed as continuous coverage, homeowners may be averse to purchasing private flood insurance. Homeowners do not want to find themselves in a situation causing them to lose their subsidy should they elect to return to the NFIP for flood insurance coverage. While legislation has been introduced in the U.S. House of Representatives allowing private flood insurance to count towards continuous coverage, legislation has yet to be passed.

The availability of private flood insurance provides the added benefit of increasing consumer choice. As private insurers are entering the flood insurance market, some of the policies offered are providing broader coverage than that provided by the NFIP. Additionally, some policyholders are finding private flood insurance policies to be less expensive than those offered by the NFIP.17

**SUMMARY**

In the past few years, many states have experienced catastrophic flooding. Following the flood events, it has become even more apparent that a significant number of consumers are either uninsured or underinsured for the flood peril.

While the NFIP still writes a majority of the residential flood insurance policies, there are considerable opportunities for the development of the residential private flood insurance market.

This document provides details about how a few states have put procedures in place to enhance the private flood insurance market in a state. These procedures include: 1) supporting private flood insurance legislation and initiatives; 2) tailoring rate and form requirements for residential private flood insurance products; and 3) consumer, agent and lender education.

It is noteworthy to say that the states experiencing large flooding events have seen growth in the private flood insurance market regardless of any other actions. For example, following Hurricane Harvey, Texas saw growth in its residential private flood insurance market. Catastrophic events are a reminder to consumers of the devastation caused by flooding.

While there are several barriers for the residential private flood insurance market, the most significant barrier for private insurers may be uncertainty about the state regulatory environment.

To avoid unintended consequences policymakers interested in facilitating a private flood insurance market should familiarize themselves with the requirements for residential customers with a federally backed mortgage to purchase flood insurance coverage and with the existing private insurance markets that provide coverage for flood damage, including coverage provided under: (a) commercial policies, (b) residential policies providing coverage in excess of required flood insurance coverage limits, (c) residential policies for those not mandated to purchase flood insurance, and (d) comprehensive auto coverages. With such knowledge, legislative and regulatory changes can be tailored to accomplish the policy objectives without adversely impacting existing flood insurance markets.

The attached appendices discuss steps that Florida has taken in its approach to cultivate the private residential flood insurance market and discussion of other barriers to the entrance of residential private flood insurers.

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Appendix I — Actions Florida Has Taken

**FLORIDA’S FORM FILING PROCESS EXAMPLE**

Florida reviews form filings, providing flood coverage differently based on the type of flood coverage being provided.

**Subject to the Requirements of Florida’s Flood Statute**

The coverage provided under the policy must meet one of the definitions of type of flood coverage, as defined by S. 627.715, F.S. Of the five defined types, "standard," "preferred" and "customized" are defined to meet or exceed the coverage provided by the standard NFIP policy. "Flexible" flood insurance must cover losses from the peril of "flood" as defined by the statute, but it does not have to provide coverage comparable to the entire NFIP policy. "Supplemental" flood coverage is meant to supplement an NFIP or private flood policy. Policies that fall under these definitions may have certain provisions that differ from that which would otherwise be required if not written under the flood statute.

**Items Not Subject to the Requirements of Florida’s Flood Statute**

The coverage does not have to meet or exceed the coverage provided by the standard NFIP policy. However, the provisions of the flood statute that allow changes to the form and rate requirements, as well as allowing for a certification provided by the Florida OIR, do not apply. This means that forms and rates would be subject to all the requirements of Florida law, and the coverage does not have to meet the definition of "flood" under the statute.

*Florida’s private flood insurance statute, S. 627.715 F.S., does not apply to the commercial lines market. Forms providing commercial flood coverage must comply with all applicable Florida laws.*

**REVIEW OF FLORIDA’S FORM FILING PROCESS**

How the Florida OIR Reviews Form Filings Subject to its Flood Statute

The Florida OIR coordinates with FEMA about training to educate forms analysts about the details and nuances of a federal NFIP policy. Forms analysts:

- Review the policy or endorsement and compare it to the NFIP policy.
- Review the provisions of the underlying policy that are not superseded by changes made in the endorsement.
- Make sure that the flood coverage in total (including definitions, deductibles, limits, conditions, property not covered, exclusions, etc.) are as broad as that provided under the NFIP policy.
- Exclude provisions, specific to the NFIP, that would not make sense to be in a private company’s policy.

**State Law Conflict**

There are certain provisions in the federal private flood definition that may conflict with a state’s law.

For example, the statute of limitations under the standard NFIP policy is one year after the date of denial. In Florida, the statute of limitations for most claims is five years from the date of loss. The insurer could use the standard NFIP provision, or the insurer could use a provision such as one year after the date of denial of a claim or five years from the date of the loss, whichever is greater. The modified provision would be considered as providing better coverage.
Another potential area in which there could be conflict between the standard NFIP policy and state law is the requirement for notice of cancellation. The NFIP requires 45 days, which may be more or less than state provisions.

In Florida, to comply with the flood statute or other than Flexible or Supplement flood insurance, the insurer would have to give at least 45 days notice.

The general filing requirement for forms is found in S. 627.410, F.S., which requires the Florida OIR to approve forms before use.

For commercial flood coverage, the insurer has the option to file the forms as informational pursuant to S. 627.4102, F.S.

FLORIDA RATE PROCESS EXAMPLE

Florida allows insurers to offer personal residential flood insurance coverage that meets the requirements of the flood statute. Insurers may decide to either submit the rate filings subject to the normal filing requirements of review and approval or (until Oct. 1, 2025) submit the filing for informational purposes.

Personal residential flood insurance rates submitted for informational purposes are subject to examination by the Florida OIR for a period of two years from the effective date to determine if the rates are excessive, inadequate or unfairly discriminatory.

If the coverage does not meet the requirements of the “flood statute,” the rate filing is subject to the normal filing requirements of review and approval. Commercial non-residential property rates (including that for flood coverage) are informational due to a separate provision of Florida laws, and they are an exception to these filing requirements.

FLORIDA FLOOD STATUTE – FLOOD POLICY TYPES

Florida’s flood statute (S. 627.715, F.S.) sets up five types of flood coverage that may be written using the special deviations allowed for flood insurance.

- Standard flood insurance (equivalent to coverage provided under the standard flood policy under the NFIP).
- Preferred flood insurance.
- Customized flood insurance.
- Flexible flood insurance.
- Supplemental flood insurance.

Flexible and supplemental coverage are the only flood coverage types under the statute that do not require flood insurance coverage to meet or exceed what is provided under the standard NFIP policy. Flexible coverage must provide coverage for the peril of flood as defined by the statute (which mirrors that of the NFIP). However, there are ancillary coverages that are not required to be provided.
APPENDIX II — BARRIERS TO THE RESIDENTIAL PRIVATE FLOOD INSURANCE MARKET

Flood Coverage Being “At Least as Broad as” the NFIP

Biggert-Waters specifies that private flood insurance satisfies the mandatory purchase mortgage requirement when a private flood insurance policy affords coverage that is “at least as broad as” the coverage offered by an NFIP flood insurance policy.¹⁸

Since there was not a federal banking rule in place regarding private flood insurance following the passage of Biggert-Waters, it was challenging to implement the use of private flood insurance for the mandatory purchase mortgage requirement. Some lending institutions thought that they did not have the knowledge necessary to assess whether a flood insurance policy met the definition of private flood insurance set forth in Biggert-Waters.

The federal banking rule became effective July 1, 2019. The rule fulfills the condition in Biggert-Waters that regulated lending institutions accept private flood insurance policies satisfying the conditions specified in the Act. Furthermore, the federal banking rule allows lending institutions to accept an insurer’s written assurances stated in a private flood insurance policy that the appropriate criteria is met. The rule also permits lending institutions to accept some flood insurance coverage plans provided by mutual aid societies.

Theoretically, the federal banking rule removes the acceptance of private flood insurance as a barrier to the private flood insurance market. However, educating the banking industry is clearly still needed as state insurance regulators are still hearing that lenders are telling borrowers that the only flood insurance policy that is acceptable is an NFIP flood policy. Thus, further education regarding the federal banking rule needs to be done. States may want to consider drafting a bulletin that can be used for these purposes.

Lenders may accept private flood insurance that meets the “discretionary acceptance” definition, which states that lending institutions may accept private flood insurance policies that do not meet the “mandatory acceptance” requirements, provided that certain conditions are met, such as that the policy provides sufficient protection of the loan, consistent with general safety and soundness principles.¹⁹

This distinction may be important for insurers with a product designed with higher-deductible options and/or a shorter cancellation notice for nonpayment of premiums.

Finally, many property owners are not required to purchase flood insurance because their home is outside of a Special Flood Hazard Area (SFHA) or because they do not have a federally backed mortgage. As a result, any flood insurance policy covering such properties is not required to be as broad as the NFIP policy.

Continuous Coverage

If an NFIP policy holder lets an NFIP policy lapse, by either not paying premium or going to a private flood insurer, any subsidy the NFIP policy holder would have received is immediately eliminated.²⁰ Legislation currently being considered by Congress to reauthorize the NFIP includes the ability of policyholders to leave the NFIP in order to purchase a private flood insurance policy and then return to the NFIP without penalty.

¹⁸ 42 U.S.C §4012a(b).
¹⁹ Ibid
²⁰ As required by §100205(a)(1)(B) of Biggert-Waters (P.L. 112-141, 126 Stat. 917), only for NFIP policies that lapsed in coverage as a result of the deliberate choice of the policyholder.
Non-Compete Clause

FEMA dropped its non-compete clause in 2018. FEMA now allows Write Your Own (WYO) companies to sell NFIP policies. Therefore, this is no longer a barrier.

NFIP Subsidized Rates

One of the hurdles facing private flood insurance growth involves the NFIP’s subsidized rates, as NFIP premiums do not always reflect the full risk of flooding. NFIP rates allow certain policyholders to have more affordable premiums. Additionally, NFIP rates do not incorporate profit, which is an important element for private flood insurers. Private flood insurers need to charge rates that represent the full risk of the peril.\(^{21}\)

If the NFIP were to reform its rate structure to collect full-risk rates, it might result in the encouragement of more private insurers to write policies in the private flood insurance market. Full-risk NFIP rates would fall closer to what a private insurer would charge. It is important to note that full-risk rates would likely lead to higher rates than those that currently exist.\(^{22}\)

Presently, FEMA is in the process of redesigning its rating system. The new NFIP rating system will be known as Risk Rating 2.0. This new rating structure will add replacement cost value and consider the distance between a property and a source of water. Additionally, Risk Rating 2.0 takes into consideration things that are not reflected in the current rating structure, such as intense rainfall.\(^{24}\) As stated previously it was recently announced that Risk Rating 2.0 will be delayed until Oct. 1, 2021 to allow for more analysis on its impact.

Ability to Assess Flood Risk Accurately

On June 11, 2019, the NFIP released data on flood losses and claims. Prior to the release of this data, insurers viewed the lack of access to NFIP data on flood losses and claims as a barrier for private companies offering flood insurance.

For private flood insurers to manage and diversify their risk exposure, consumer participation to manage and diversify their risk exposure is required. Many private insurers have expressed the view that broader participation in the flood insurance market would be necessary to address adverse selection and maintain a sufficiently large risk pool.\(^{25}\)

An established goal of the NFIP is to increase the number of flood insurance policies in force. Even though there is a mandatory purchase requirement for homeowners to purchase flood insurance in certain flood zones, this does not always occur.

As more insurers begin to write private flood insurance, it is likely that consumers will be offered more choices. Private flood insurers may also offer coverages not available through the NFIP. These coverages might include coverage such as basement coverage, business interruption, additional living expenses, etc. Private insurers might also be able to offer higher coverage limits than those offered by the NFIP.

\(^{22}\) Ibid.
\(^{23}\) Ibid.
\(^{24}\) Ibid.
Private flood insurance offered as an endorsement to a standard homeowners insurance policy could possibly eliminate instances where it is necessary to differentiate between flood and wind damage.26

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

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The Casualty Actuarial and Statistical (C) Task Force met in Austin, TX, Dec. 7, 2019. The following Task Force members participated: Steve Kelley, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Rich Piazza (LA); Lori K. Wing-Heier represented by Michael Ricker (AK); Keith Schraad represented by Tom Zuppan (AZ); Andrew N. Mais represented by Wanchin Chou (CT); Stephen C. Taylor represented by David Christhilf (DC); David Altmaier represented by Sandra Starnes (FL); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Travis Grassel (IA); Robert H. Muriel represented by Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Sandra Darby (ME); Anata G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by Cynthia Amann (MO); Mike Causey represented by Kevin Conley (NC); John G. Franchini represented by Anna Krylova (NM); Barbara D. Richardson represented by Stephanie McGee (NV); Jillian Froment represented by Tom Botsko (OH); Mike Mulready represented by Cuc Nguyen and Andrew Schallhorn (OK); Andrew Stolfi represented by Brian Fordham (OR); Jessica Altmann represented by Shennan Logue and Michael McKenney (PA); Raymond G. Farmer represented by Joe Cregan (SC); Kent Sullivan represented by J’ne Byckovski and Miriam Fisk (TX); Mike Kreidler represented by Eric Slavich (WA); and James A. Dodrill represented by Tonya Gillespie (WV).

1. **Adopted its Nov. 12, Oct. 15 and Summer National Meeting Minutes**

Mr. Vigliaturo said the Task Force met Nov. 12 and Oct. 15. During these meetings, the Task Force took the following action: 1) adopted its 2020 proposed charges; 2) adopted a revised implementation plan for the Casualty Actuarial Society (CAS)/Society of Actuaries (SOA) Task Force’s Appointed Actuary Continuing Education Verification Process to delay implementation for one year; and 3) exposed the *Regulatory Review of Predictive Models* white paper for a public comment period ending Nov. 22.

The Task Force also met Nov. 19, Sept. 17 and Aug. 20 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss rate filing issues.

The Task Force held its Predictive Analytics Book Club conference calls Nov. 26, Oct. 22, Oct. 8 and Aug. 27. During its Nov. 26 meeting, David Snell (Actuaries and Technology) presented on neural networks. During its Oct. 22 meeting, Pradnya Nimkar (Clara Analytics) presented, “Natural Language Processing.” During its Oct. 8 meeting, Louise Francis (Francis Analytics and Actuarial Data Mining) presented on numerous models used and associated issues and pitfalls in modeling. During its Aug. 27 meeting, Ms. Darby presented on data, the open source model “R” and predictive analytics.

Mr. Piazza made a motion, seconded by Mr. Botsko, to adopt the Task Force’s Nov. 12 (Attachment One), Oct. 15 (Attachment Two) and Aug. 3 (see *NAIC Proceedings – Summer 2019, Casualty Actuarial and Statistical (C) Task Force*) minutes. The motion passed unanimously.

2. **Adopted the Report of the Actuarial Opinion (C) Working Group**


During the Working Group’s Nov. 20 conference call, Ms. Fisk described Texas’ efforts to collect data on Actuarial Opinion Summaries and encouraged the states to consider submitting their data. Ms. Krylova asked the chair to include this as an agenda item for a future Task Force call.

Ms. Krylova said the hardcopy of the 2019 P/C *Annual Statement Instructions* contains some minor errors. The electronic version of the instructions, found in various places on the NAIC’s website, is (and has always been) correct. As has been the case in previous years, any corrections to the hardcopy are housed on the Blanks (E) Working Group’s web page. While the errors in the hardcopy are not considered material, the chair of the Working Group is going to send an email to P/C appointed actuaries to alert them to the errors.

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Mr. Dyke made a motion, seconded by Mr. Botsko, to adopt the report of the Actuarial Opinion (C) Working Group, including its Nov. 20 minutes (Attachment Three); its combined Oct. 4, Oct. 1, Sept. 20, Sept. 12, Sept. 10 and Sept. 6 minutes (Attachment Four); and the 2019 Regulatory Guidance (Attachment Four-B). The motion passed unanimously.

3. **Adopted the Report of the Statistical Data (C) Working Group**

Kris DeFrain (NAIC) provided the report of the Statistical Data (C) Working Group. The *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance* report has been publicly released. The *Report on Profitability by Line by State* and the *Competition Database Report* are adopted, and they should be released in December. The *Auto Insurance Database* will be considered for adoption after the Fall National Meeting.

Mr. Chou made a motion, seconded by Mr. Piazza, to adopt the report of the Statistical Data (C) Working Group. The motion passed unanimously.

4. **Discussed the CAS/SOA Task Force’s Appointed Actuary CE Verification Project and Inclusion in the 2020 Actuarial Opinion Instructions**

Mr. Vigliaturo said any proposed changes to the instructions are due to the Blanks (E) Working Group by Feb. 22, 2020.

Mr. Dyke summarized the proposal for revised 2020 Actuarial Opinion instructions to implement the CAS and SOA Appointed Actuary Continuing Education Verification Process. He said each appointed actuary will attest to the CAS or SOA that specific qualification standards in the Actuarial Standards Board’s (ASB) *U.S. Qualification Standards* are met. The appointed actuaries would also log continuing education (CE), categorize CE according to the Task Force’s adopted categorization, and submit the log to the CAS or SOA if audited. Non-members of the CAS or SOA can choose to report to either organization.

Mr. Dyke said the CE log format and instructions are being developed and should be released in January 2020. He said there is no new requirement for CE, except the logging format would be required for appointed actuaries. He said the common log would facilitate the consolidation of CE categorization.


5. **Heard a Presentation about Current Pricing Practices in the UK**

Peter Kochenburger (University of Connecticut School of Law) presented on motor insurance pricing practices in the United Kingdom (UK). The longer a policyholder stays with one insurer in the UK, the higher the insurance price. He said there is no evidence that these practices increase insurance access for lower income consumers or improve the market. The UK’s Financial Conduct Authority (FCA) has not yet decided what actions to take. He said the U.S. addressed price optimization.

Ralph Blanchard (Travelers) said the U.S. consumer protections are significantly higher compared to other countries.

Mr. Kochenburger said he is envious of the ability of the FCA to gather a significant amount of market data.

6. **Discussed the Regulatory Review of Predictive Models White Paper and Comments Received**

Mr. Piazza said the third draft of the *Regulatory Review of Predictive Models* white paper was exposed during the Task Force’s Oct. 15 conference call for a 38-day public comment period ending Nov. 22. The Task Force received 11 comment letters (Attachment Five). He said the ad hoc group is getting close to a final paper for the Task Force’s consideration.

Mr. Chou said confidentiality is important, and he believes a field test should be conducted, similar to how the life actuaries had a field test when they introduced something new.

Mr. Piazza said there is merit in discussing a field test. He said the white paper would be best practice and guidance. He said implementation would vary from state to state regarding whether a state would require any specific information elements.

Birny Birnbaum (Center for Economic Justice—CEJ) said regulatory best practices and the review of complex models are different from actuarial standards of practice (ASOPs) that guide actuaries. He said numerous non-actuaries develop models, and state insurance regulators review models; they are not limited by ASOPs.
Mr. Birnbaum delineated two types of unfair discrimination. One is where consumers of similar risk are treated differently without expected differences in claims or expenses. The other is discrimination against certain protected classes, such as race, religion, national origin and, in some states, gender. He that the paper should develop more guidance on the second type of unfair discrimination. He said the potential to introduce proxy discrimination or unintentional discrimination where the data sources include bias against protected classes, or the algorithm incorporates or reflects that bias, has increased with models.

David Kodama (American Property Casualty Insurance Association—APCIA) said the ASOPs are critical guidance because they provide a standard of expectation for rate filings. He said he also supports field testing prior to adoption of the white paper. He said a data dump might not be useful. He suggested mapping the information items back to the best practices. He suggested that the paper should identify the essential core elements needed in a filing so the state insurance regulators can do their jobs of evaluating that rates are not inadequate, excessive nor unfairly discriminatory.

Andrew Pauley (National Association of Mutual Insurance Companies—NAMIC) said NAMIC still has concerns about confidentiality, the degree of what state insurance regulators might ask for as opposed to what they need, and prescriptive elements that seem to be moving toward a model regulation. He said there should not be unnecessary disclosures. He said he has substantive concerns about not mentioning the positive aspects of large databases. He said the Task Force should be conscious about regulatory bias, and it should not approach rate models like a market conduct examination. He suggested adding some of the detail drafting notes to the paper.

7. Discussed the ASB’s Request for Input on a Potential P/C Rate Filing ASOP

Mr. Vigliaturo said during the Nov. 12 conference call, the Task Force discussed the ASB’s request for input on a potential property/casualty (P/C) rate filing ASOP. He said there were quite a few different opinions amongst the members. He said he answered the questions asked by the ASB and, as a state insurance regulator, he thought most questions were specific to the individual state. He said that seems to argue against writing a Task Force letter. However, he said there might be common themes that could result from discussion. Volunteers are asked to submit potential answers to the ASB’s questions and any overall comments by Jan. 7, 2020, to NAIC staff.

Mr. Birnbaum said he believes the development of an ASOP on rates violates antitrust laws.

Mr. Vigliaturo said Robert Hunter (Consumer Federation of America) had a similar concern expressed in his letter to the ASB. He said he would like to seek advice from NAIC Legal Division staff about whether the Task Force should submit comments.

Shawna Ackerman (American Academy of Actuaries—Academy) said there are attorneys in the ASB meetings. She said the Academy does not believe that there is any possibility that asking for information is an antitrust violation.

8. Heard Reports from Actuarial Organizations

Richard Gibson (Academy) said the Casualty Practice Council focused on catastrophe issues. In 2019, Academy groups published a monograph on the National Flood Insurance Program (NFIP), letters to the U.S. Congress (Congress) encouraging early re-authorization of the Terrorism Risk Insurance Act (TRIA), and a monograph on wildfires. In 2020, the Academy groups plan to publish a monograph on cyber risk, a paper on insurance-linked securities, P/C risk-based capital (RBC) research, and an updated actuaries’ climate index.

Stephen J. Koca (Academy) said the Committee on Property and Liability Financial Reporting (COPLFR) assisted with the Regulatory Guidance, held its limited attendance opinion writing seminar, and held a webinar on changes to the Actuarial Opinion instructions and Regulatory Guidance. The COPLFR will compile a frequently asked questions (FAQ) document.

David Ogden (Actuarial Board for Counseling and Discipline—ABCD) discussed P/C-related issues submitted to the ABCD, including inadequate rates and assessments, inclusion of cost-free insurance capital in rates, and who should sign a rate filing. Kathleen A. Riley (ASB) discussed exposure and adoption actions taken or expected on various ASOPs.

Providing information on P/C actuarial research, R. Dale Hall (SOA) presented the SOA’s general insurance actuarial research and education (Attachment Six), and Mr. Blanchard presented the CAS’s P/C actuarial research (Attachment Seven).

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
The Casualty Actuarial and Statistical (C) Task Force met via conference call Nov. 12, 2019. The following Task Force members participated: Steve Kelley, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Rich Piazza and Larry Steiner (LA); Lori K. Wing-Heier represented by Michael Ricker (AK); Jim L. Ridling represented by Daniel Davis and Jerry Workman (AL); Keith Schraad represented by Vanessa Darrah (AZ); Ricardo Lara represented by Lynne Wehmuller (CA); Michael Conway represented by Rolf Kaumann and Sydney Sloan (CO); Andrew N. Mais represented by Wanchin Chou and Susan Andrews (CT); David Altmaier represented by Jie Cheng, Howard Eagelfeld, Robert Lee and Sandra Starnes (FL); Doug Ommen represented by Travis Grassel and Andria Seip (IA); Robert H. Muriel represented by Judy Mottar (IL); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by Julie Lederer (MO); Mike Causey represented by Richard Kohan (NC); Marlene Caride represented by Mark McGill and Carl Sormson (NJ); John G. Franchini represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Jillian Froment represented by Tom Botsko (NE); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by Julie Lederer (MO); Mike Causey represented by Richard Kohan (NC); Marlene Caride represented by Mark McGill and Carl Sormson (NJ); John G. Franchini represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Jillian Froment represented by Tom Botsko (NE); Glen Mulready represented by Kate Yang (OK); Andrew Stolfi represented by David Dahl and Ying Liu (OR); Jessica Altman represented by Kevin Clark, Michael McKenney and James DiSanto (PA); Raymond G. Farmer represented by Michael Wise (SC); Kent Sullivan represented by J'ne Byckovski, Nicole Elliott, Miriam Fisk, Andy Liao and Bethany Sims (TX); Mike Kreidler represented by Eric Slavich (WA); and James A. Dodrill represented by Joylynn Fix and Juanita Wimmer (WV).

Also participating was: Gordon Hay (NE).

1. Received a Report from the Actuarial Opinion (C) Working Group


2. Received a Report from the Statistical Data (C) Working Group

Mr. Sornson said the Task Force is currently conducting an e-vote to consider adoption of the Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance report. The Task Force should expect to consider adoption of the Report on Profitability by Line by State and the Competition Database Report soon.

The Working Group is also working on the Auto Insurance Database report.

3. Discussed CAS/ SOA CE Task Force’s Appointed Actuary Continuing Education Verification Process

Mr. Vigliaturo said as a response to the Task Force’s 2018 charge to ensure continued competence of appointed actuaries, the CAS and SOA formed the CAS/ SOA Appointed Actuary Continuing Education (CE) Task Force (CAS/ SOA CE Task Force) in 2018. Mr. Dyke presented three documents: 1) a background document prepared by NAIC staff to explain chronology of the project; 2) the project plan; and 3) an updated implementation plan containing CE categorization as revised on the Casualty Actuarial and Statistical (C) Task Force’s Oct. 15 conference call.

Mr. Dyke said the attestation process will be on the CAS and SOA websites to attest they have met the specific qualification standards for CE. He said that will be in place soon.

Mr. Dyke said it was decided on the Casualty Actuarial and Statistical (C) Task Force’s Oct. 15 conference call that the revised logging process for 2019 would be announced a little too late and it would be burdensome to go back to document categories. He said it is also an issue that the requirements are not yet in the actuarial opinion instructions. He said that on the Oct. 15 conference call, the Task Force agreed to postpone the CE logging process until 2020. Once the log is created and produced, the appointed actuaries will have plenty of time to complete that log. He said the two-year transition process is removed and, for the year 2020, appointed actuaries will log their CE using the identified categories.

Mr. Dyke said the CAS/SOA CE Task Force reviewed the comment letters sent to the Casualty Actuarial and Statistical (C) Task Force in response to public exposure of the implementation plan. Most of the comments will be accounted for when
instructions for log categorization are documented. For example, the instructions will explain that as many categories as applies can be checked for an individual CE event.

Ralph Blanchard (Travelers) said regulators should be prepared to receive a long list of categories for any one presentation. No changes were made to the implementation plan from the submitted comments.

Mr. Dyke said one outstanding issue is what do with appointed actuaries who are not members of CAS or SOA.

Mr. Davis asked if it is a long-term goal to make sure appointed actuaries’ CE is balanced in some way. In accordance with the Casualty Actuarial and Statistical (C) Task Force’s charges, Mr. Dyke said the short-term goal is to review the categorization and determine if there are different categories that should be in the U.S. qualification standards and/or whether to modify categories in the annual financial statement instructions. The qualification standards would be expected to be modified to reflect the NAIC’s new categorization. He said the longer-term goal is to understand the types of CE and how appointed actuaries obtaining CE and whether the CE is organized or self-study. He said the Casualty Actuarial and Statistical (C) Task Force will need to decide if it has other long-term goals.

Given the deadline is late February 2020 for proposed changes to annual financial statement instructions, Mr. Dyke will draft some language to document the agreed process for 2020 CE logging by appointed actuaries in support of the attestation for year-end 2020. He said the plan is to codify what has been agreed by the Casualty Actuarial and Statistical (C) Task Force.

4. Discussed the ASB’s Request for Input on Potential P/C Rate Filing ASOP

Mr. Vigliaturo said the Actuarial Standards Board (ASB) has requested input on a potential property/casualty (P/C) rate filing Actuarial Standard of Practice (ASOP). He asked whether to respond as a Task Force or as individuals. He recommended regulators respond individually. Mr. Piazza agreed, saying the questions posed seemed to anticipate individual responses.

Mr. Stolyarov said he is opposed to the ASOP being created. He said an ASOP is sometimes included in a filing as an attempt to defend against a regulator’s objection. He said the individuals developing the ASOP would predominately be written by the industry and consulting actuaries who would make such filings.

Mr. Davis said an ASOP promotes fruitful discussion and debate.

Mr. Chou said regulators’ voices would be heard in the process of development. He said the ASOP on reviewing capital adequacy provides flexibility for each state’s requirements.

Mr. Dyke said it is beneficial for organizations like the Task Force to provide comments on exposure drafts and requests for input. All comments are considered. If there are any consensus items, then the comments have meaning to them. The ASOPs are useful and not prescriptive, but they do promote good actuarial practice. They should not supersede any state or federal requirements. He said it is understood one must follow the law.

Mr. Stolyarov said the current ASOPs on loss and expense reserves regard fairly uniform state regulatory requirements. He said rate filing requirements are not subject to accreditation and are significantly different between states.

Mr. Hay said he has not yet seen reasons actuaries are advocating for the ASOP. He said the ASOPs are not binding on the people who usually submit the filings.

5. Received a Report on the Predictive Analytics Technical Advanced Statistics Training

Kris DeFrain (NAIC) said the technical advanced statistics training on predictive analytics starts Nov. 13. She said regulators should register with the NAIC’s Education and Training Department.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
The Casualty Actuarial and Statistical (C) Task Force met via conference call Oct. 15, 2019. The following Task Force members participated: Steve Kelley, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Rich Piazza and Larry Steinert (LA); Lori K. Wing-Heier represented by Michael Ricker (AK); Jim L. Ridling represented by Daniel Davis and Jerry Workman (AL); Keith Schraad represented by Vanessa Darrah and Tom Zuppan (AZ); Ricardo Lara represented by Mitra Sanandajifar and Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson and Sydney Sloan (CO); Andrew N. Mais represented by Wanchin Chou and Susan Andrews (CT); Stephen C. Taylor represented by David Christhilf (DC); David Altmaier represented by Robert Lee (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Robert H. Muriel represented by Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd and Heather Droe (KS); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by LeAnn Cox, Julie Lederer and Anthony Senevey (MO); Marlene Caride represented by Mark McGill (NJ); Barbara D. Richardson represented by Gennady Stolyarov (NV); Jillian Froment represented by Tom Botsko (OH); Glen Multready represented by Nicolas Lopez and Cuc Nguyen (OK); Jessica Altman represented by Kevin Clark, Michael McKenney and James DiSanto (PA); Raymond G. Farmer represented by Will Davis, Darien Porter and Michael Wise (SC); Kent Sullivan represented by Brock Childs, Miriam Fisk, Eric Hintikka, Elizabeth Howland, Walt Richards, Brian Ryder and Bethany Sims (TX); Mike Kreidler represented by Eric Slavich (WA); and James A. Dodrill represented by Juanita Wimmer (WV).

1. Received a Report from the Actuarial Opinion (C) Working Group

Ms. Lederer said the Actuarial Opinion (C) Working Group met six times via conference call to discuss a draft *Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion* (Regulatory Guidance) document for 2019. She said a 2019 charge for the Working Group is that “based on language for the *Annual Statement Instructions—Property/Casualty* requiring completion of the appointed actuary’s attestation of qualification, provide additional guidance in the 2019 regulatory guidance document.” She said an initial draft was exposed in May, and one comment was received. During recent conference calls, verbal comments have been made. During its Oct. 4 conference call, the Working Group adopted the Regulatory Guidance document pending one section, which is the Casualty Actuarial Society (CAS)/Society of Actuaries (SOA) Task Force’s Appointed Actuary Continuing Education Verification Process.

2. Received a Report from the Statistical Data (C) Working Group

Mr. McGill said the Statistical Data (C) Working Group will soon consider adoption of the *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance* report. The Working Group is also reviewing data for the *Auto Insurance Database* report.

3. Adopted its 2020 Proposed Charges

Mr. Vigliaturo presented the Task Force’s 2020 proposed charges. He said most changes are nonsubstantive. He said the charges regarding the financial handbooks are moved to the Actuarial Opinion (C) Working Group. He said some charges are revised to reflect completion of charges in 2019.

Mr. Stolyarov made a motion, seconded by Mr. Piazza, to adopt the Task Force’s 2020 proposed charges and refer them to its parent committee (see NAIC Proceedings – Fall 2019, Property and Casualty Insurance (C) Committee, Attachment Seven). The motion passed unanimously.

4. Adopted a Revised Implementation Plan for the CAS/SOA Task Force’s Appointed Actuary Continuing Education Verification Process

Mr. Vigliaturo said, as a response to the Task Force’s 2018 charge to ensure continued competence of appointed actuaries, the CAS and SOA formed the CAS/SOA Appointed Actuary Continuing Education (CE) Task Force (CAS/SOA CE Task Force) in 2018. He said Mr. Dyke has been a member of the CAS/SOA CE Task Force and has been a liaison with the Casualty Actuarial and Statistical (C) Task Force. The Casualty Actuarial and Statistical (C) Task Force has thus far agreed with the
initial plan proposed by the CAS/SOA CE Task Force in late 2018. Mr. Vigliaturo said the plan has two main components: 1) attestation requirements; and 2) CE categorization requirements.

The attestation requirements would be implemented annually with the same timing as a CAS actuary attests to having met the U.S. qualification standard’s CE requirements on his or her CAS profile. The project would result in an attestation option for both CAS and SOA members: to attest to meeting the specific standard’s CE of the U.S. qualification standard required to be a U.S. appointed actuary. The attestation would be made public, and the CAS and SOA would audit CE requirements for a percentage of attesting membership.

The other component of the plan are the categorization requirements. Mr. Dyke said in May 2019, the Task Force exposed the process developed by a joint CAS/SOA CE Task Force to accept and review CE logs for appointed actuaries. The letters were reviewed and discussed at the Summer National Meeting. At that meeting, the Academy said it had a couple of additional letters that were unable to be submitted due to extenuating circumstances. At that meeting, the Task Force adopted a motion to ask the CAS and SOA to formally implement the process as described in the implementation report, with consideration given to the comment letters, including the new Academy letters, with periodic reports to Casualty Actuarial and Statistical (C) Task Force.

Pursuant to the motion, the CAS/SOA CE Task Force has been proceeding with implementation, meeting bi-weekly, with a new attestation and log to be introduced for appointed actuaries for year-end 2019. In early September, the Actuarial Opinion (C) Working Group began finalizing the changes to the Regulatory Guidance document for 2019. At that time, the document included a reference to the new CE logging procedure. As the procedure had not been announced by the CAS or SOA to its members, there was some concern that the Regulatory Guidance would be the first notice of the new requirement. There were additional concerns raised by interested parties, including the Academy’s Committee on Property and Liability Financial Reporting (COPLFR). One concern was that the Annual Statement Instructions did not include a reference to the new process or indicate that a new CE log would be required, so it did not seem appropriate for the Regulatory Guidance document to include any reference to the procedure. There was also concern about the timing of the announcement of the changes close to year-end and growing confusion whether this would usurp the current CE requirements for issuing 2019 property/casualty (P/C) Statements of Actuarial Opinion. He said the changes do not usurp the current CE requirements.

He proposed the 2019 implementation of the CE categorization process be eliminated from the project plan. He said that would allow the requirement to be added to the 2020 Annual Statement Instructions and grant the CAS and SOA additional time to develop and test a new CE log to determine if the CE categories are appropriate. He said it is important to ensure the log is an effective and efficient collection of CE for appointed actuaries. He said another benefit is that appointed actuaries can focus on the new qualification documentation requirements for year-end 2019, which he said may be more time-consuming than initially expected. Mr. Dyke said the attestation part of the project is expected to move forward, but there should be discussion of the CE categorization. Mr. Dyke said the appointed actuaries’ 2020 CE would be required to be categorized. The log would only be submitted to the CAS or SOA if requested.

Ms. Lederer said her understanding about the 2019 year-end attestation is that when CAS actuaries attest that they “meet U.S. qualification standards,” actuaries would also be able to attest that they “meet U.S. specific qualification standards.” She asked if 2019 logs would be required to be submitted to the CAS or SOA automatically. Mr. Dyke said there is no automatic submission of a CE log, but a larger percentage of appointed actuaries will be audited.

Ms. Darby made a motion, seconded by Mr. Chou, to remove the requirement to categorize 2019 CE from the implementation plan. The motion passed unanimously.

5. Exposed the Regulatory Review of the Predictive Analytics White Paper

Mr. Piazza said the white paper was exposed on May 14 for a public comment period ending June 28. Comments were submitted (see NAIC Proceedings – Summer 2019, Casualty Actuarial and Statistical (C) Task Force, Attachment One-A). Newly drafted Section VIII and Section IX were exposed Aug. 3 for a public comment period ending Sept. 16. Comments were submitted (Attachment Two-A). An Excel file was distributed detailing reasons for any changes, reasons why wording was not
changed and any revised wording (Attachment Two-B). He said drafters from Arizona, Louisiana, Maine, Minnesota, Nevada, New Jersey and Texas met numerous times via conference call.

Mr. Piazza said there are many changes to the white paper. Some changes include: 1) modification to best practices; 2) consolidation and modification of some information elements; 3) revision of some of the importance levels of information items; 4) addition of a glossary of terms; 5) expansion of “Other Considerations” in Section X to add context; and 6) deletion and movement of some information in the eliminated section “Recommendations Going Forward” to the “Other Considerations” section. He said the white paper is nearing completion, with some minor sections remaining to be completed and the mapping of best practices to each information element and vice versa. He said Section XVI is the reference section and will be completed towards the end of the project.

Mr. Chou suggested the Task Force should plan to seek industry and regulatory feedback after adoption of the white paper and then review and enhance it in a year or so. Mr. Piazza said the white paper might need to be reviewed and revised after receiving practical feedback on how well it serves the states. Ms. Darby questioned what would objectively be used as a measure of how well the guidance is working. She said a review might be more subjective than objective. Mr. Vigliaturo said evaluation of usefulness is always a good idea; he said he would be concerned about reopening the paper based on the amount of time it has taken to write the paper initially.

Mr. Chou asked for guidance on what a good split of the data into training, test and validation datasets would be. Mr. Piazza said some minimum standards could be provided as guidance. Mr. Vigliaturo said he does not want to impose standards that are rulemaking, but it would be a good discussion.

David Kodama (American Property Casualty Insurance Association—APCIA) asked about the difference between best practices and information elements. Mr. Piazza said a best practice is a goal; it is not a detailed objective or criteria to be met. An information element represents information that will help assist state insurance regulators in meeting the goal. If the goal is to understand the inputs that go into a model, the information elements will help the state insurance regulator understand the inputs.

Mr. Piazza made a motion, seconded by Mr. Stolyarov, to expose the white paper for a 38-day public comment period ending Nov. 22. The motion passed unanimously.


Kris DeFrain (NAIC) said the 2019 Statement of Actuarial Opinion instructions were adopted by the NAIC members in September. The instructions are now final and ready for implementation.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
Dear Casualty Actuarial and Statistical Task Force (CASTF),

Thank you for the opportunity to comment on the exposure of sections 7 & 8 of the “Regulatory Review of Predictive Models”. Below are our comments.

On pages 25-26, the white paper says “Univariate methods were considered rational... But, GLM results are not always rational...” In this section, it is not clear what is meant by the term “rational”. For example, univariate methods could be considered irrational because their factors do not form a rating plan that accurately rates individual policies (because univariate methods double-count losses). From this view, GLM methods are rational and univariate methods are not. We would suggest removing the term “rational” and being more specific in explaining what was meant by this term.

On page 26, in the section “B. Credibility of Model Output”, there should be acknowledgement that if a GLM method lacks credibility, then other methods will also lack credibility. A lack of credibility is not an issue that is unique to GLMs. In these instances, a company may need to seek alternative methods of determining rating factors.

On page 27, sections 2.a and 2.c are similar and could be combined.

Once again, thank you for the opportunity to comment.

Sincerely,

Allstate Property & Casualty Actuarial Leadership

For any questions, please contact:
Mike Woods, FCAS, CSPA, MAAA
Allstate Insurance Company
2775 Sanders Rd
Northbrook, IL 60062
mike.woods@allstate.com
From: Kodama, David <david.kodama@apci.org>
Sent: Monday, September 16, 2019 9:38 PM
To: DeFrain, Kris <kdefrain@naic.org>
(Resend)

Kris,

Thank you for the opportunity to comment on the exposed newly-drafted Sections VIII and IX of the Best Practices for Regulatory Review of Predictive Analytics White Paper. The following provides our comments and recommended edits for consideration by the Task Force.

From page 24, delete what appears to be more commentary than guidance: But, with computing power growing exponentially, insurers are finding many ways to improve their operations and competitiveness through use of often very complex predictive models in all areas of their insurance business.

Finding rating or underwriting characteristics that may violate public policy is becoming more difficult for regulators with the increasing and innovative ways insurers use predictive models.

From page 26, delete what appears to be more commentary than guidance: But, GLM results are not always rational and the relationship to costs may be difficult to explain. Comment misinforms the regulator that the standard should always be a rational relationship that is linear and intuitive. The value of modeling and the advanced computing power and analytics that drive it is the enabling of actuaries to refine risk-based pricing in a way that reflects the dynamic environment and complexities in multivariate relationships that impact risk of loss. While the filing company should strive to provide rational explanation and validation, the critical measure should be in how rating outcomes relate to the experience of loss cost and expense.

From page 26, B. Credibility of Model Output, delete sentence: GLM output is typically assumed to be 100% credible no matter the size of the underlying data set. Credibility is always an issue that the actuary – and the data modeler - must contend with. Validation evidence is therefore the goal. Or, consider replacing text under B. Credibility of Model Output with: GLM models produce point estimates as well as confidence intervals. Modelers may apply judgment to make selections that consider the parameter estimates from the GLM model, the confidence intervals around the parameter estimates, the business problem at hand, and credibility. The performance of the final rating factors, which may include parameter estimates directly from the GLM model as well as selections, should be demonstrated through a reasonable validation exercise.

Thank you
dk

David Kodama, Jr., Assistant Vice President, Research & Policy Analysis, 847-553-3611
California Comments

Draft: 4/4/2019
As adopted by the Casualty Actuarial and Statistical (C) Task Force on XX/XX/XX

EXPOSURE NOTE: The drafting group are still considering comments on the 5/14/19 draft; no changes are yet made to the previously exposed sections of this paper. Two new sections are drafted in this paper and will be exposed for public comment at the Summer National Meeting: Part VIII Proposed Changes to the Product Filing Review Handbook and Part IX Proposed State Guidance. Please note that we expect changes from the comments on the 5/14 draft and any changes made will also be reflected in these two new sections.

Casualty Actuarial and Statistical (C) Task Force
Regulatory Review of Predictive Models

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I. INTRODUCTION

Insurers’ use of predictive analytics along with big data has significant potential benefits to both consumers and insurers. Predictive analytics can reveal insights into the relationship between consumer behavior and the cost of insurance, lower the cost of insurance for many, and provide incentives for consumers to better control and mitigate loss. However, predictive analytic techniques are evolving rapidly and leaving many regulators without the necessary tools to effectively review insurers’ use of predictive models in insurance applications.

When a rate plan is truly innovative, the insurer must anticipate or imagine the reviewers’ interests because reviewers will respond with unanticipated questions and have unique educational needs. Insurers can learn from the questions, teach the reviewers, and so forth. When that back-and-forth learning is memorialized and retained, filing requirements and insurer presentations can be routinely organized to meet or exceed reviewers’ needs and expectations. Hopefully, this paper helps bring more consistency and to the art of reviewing predictive models within a rate filing.

The Casualty Actuarial and Statistical (C) Task Force (CASTF) has been charged with identifying best practices to serve as a guide to state insurance departments in their review of predictive models and underlying rating plans. There were two charges given to CASTF by the Property and Casualty Insurance (C) Committee at the request of the Big Data (EX) Working Group:

A. Draft and propose changes to the Product Filing Review Handbook to include best practices for review of predictive models and analytics filed by insurers to justify rates.

B. Draft and propose state guidance (e.g., information, data) for rate filings that are based on complex predictive models.

This paper will identify best practices when reviewing predictive models and analytics filed by insurers with regulators to justify rates and provide state guidance for review of rate filings based on predictive models. Upon adoption of this paper by the Executive (EX) Committee and Plenary, the Task Force will evaluate how to incorporate these best practices into the Product Filing Review Handbook and will recommend such changes to the Speed to Market (EX) Working Group.

II. WHAT IS A “BEST PRACTICE?”

A best practice is a form of program evaluation in public policy. At its most basic level, a practice is a “tangible and visible behavior… [based on] an idea about how the actions… will solve a problem or achieve a goal.” 2 Best practices are used to maintain quality as an alternative to mandatory legislated standards and can be based on self-assessment or benchmarking. 3 Therefore, a best practice represents an effective method of problem solving. The “problem” regulators want to solve is probably better posed as seeking an answer to this question: How can regulators determine that predictive models, as used in rate filings, are compliant with state laws and regulations?

Key Regulatory Principles

In this paper, best practices are based on the following principles that promote a comprehensive and coordinated review of predictive models across states:

1. State insurance regulators will maintain their current rate regulatory authority.

2. State insurance regulators will be able to share information to aid companies in getting insurance products to market more quickly.

3. State insurance regulators will share expertise and discuss technical issues regarding predictive models.

4. State insurance regulators will maintain confidentiality, where appropriate, regarding predictive models.

In this paper, best practices are presented in the form of guidance to regulators who review predictive models and to insurance companies filing rating plans that incorporate predictive models. Guidance will identify specific information

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1. In this paper, references to “model” or “predictive model” are the same as “complex predictive model” unless qualified.
useful to a regulator in the review of a predictive model, comment on what might be important about that information and, where appropriate, provide insight as to when the information might identify an issue the regulator needs to be aware of or explore further.

III. DO REGULATORS NEED BEST PRACTICES TO REVIEW PREDICTIVE MODELS?

The term “predictive model” refers to a set of models that use statistics to predict outcomes. When applied to insurance, the model is chosen to estimate the probability or expected value of an outcome given a set amount of input data; for example, models can predict the frequency of loss, the severity of loss, or the pure premium. The generalized linear model (GLM) is a commonly used predictive model in insurance applications, particularly in building an insurance product’s rating plan.

Depending on definitional boundaries, predictive modeling can sometimes overlap with the field of machine learning. In this modeling space, predictive modeling is often referred to as predictive analytics.

Before GLMs became vogue, rating plans were built using univariate methods. Univariate methods were considered intuitive and easy to demonstrate the relationship to costs (loss and/or expense). Today, many insurers consider univariate methods too simplistic since they do not take into account the interaction (or dependencies) of the selected input variables.

According to many in the insurance industry, GLMs introduce significant improvements over univariate-based rating plans by automatically adjusting for correlations among input variables. Today, the majority of predictive models used in private passenger automobile and homeowners’ rating plans are GLMs. However, GLM results are not always intuitive, and the relationship to costs may be difficult to explain. This is a primary reason regulators can benefit from best practices.

A GLM consists of three elements:

- Each component of Y is independent and a probability distribution from the exponential family, or more generally, a selected variance function and dispersion parameter.
- A linear predictor $\eta = X \beta$.
- A link function $g$ such that $E(Y) = \mu = g^{-1}(\eta)$.

As can be seen in the description of the three GLM components above, it may take more than a casual introduction to statistics to comprehend the construction of a GLM. As stated earlier, a downside to GLMs is that it is more challenging to interpret the GLMs output than with univariate models.

GLM software provides point estimates and allows the modeler to consider standard errors and confidence intervals. GLM output is typically assumed to be 100% credible no matter the size of the underlying data set. If some segments have little data, the resulting uncertainty would not be reflected in the GLM parameter estimates themselves (although it might be reflected in the standard errors, confidence intervals, etc.). Even though the process of selecting relativities often includes adjusting the raw GLM output, the resultant selections are not then credibility-weighted with any complement of credibility. Nevertheless, selected relativities based on GLM model output may differ from GLM point estimates.

Because of this presumption in credibility, which may or may not be valid in practice, the modeler and the regulator reviewing the model would need to engage in thoughtful consideration when incorporating GLM output into a rating plan to ensure that model predictiveness is not compromised by any lack of actual credibility. Therefore, to mitigate the risk that model credibility or predictiveness is lacking, a complete filing for a rating plan that incorporates GLM output should include validation evidence for the rating plan, not just the statistical model.

To further complicate regulatory review of models in the future, modeling methods are evolving rapidly and not limited just to GLMs. As computing power grows exponentially, it is opening up the modeling world to more sophisticated forms of data acquisition and data analysis. Insurance actuaries and data scientists seek increased predictiveness by using even more complex predictive modeling methods. Examples of these are predictive models utilizing random forests, decision

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4 A more thorough exploration of different predictive models will be found in many statistics’ books, including Geisser, Seymour (September 2016), Predictive Inference: An Introduction. New York: Chapman & Hall.

5 The generalized linear model (GLM) is a flexible family of models that are unified under a single method. Types of GLM include logistic regression, Poisson regression, gamma regression and multinomial regression.

6 More information on model elements can be found in most statistics’ books.
trees, neural networks, or combinations of available modeling methods (often referred to as ensembles). These evolving
techniques will make the regulators’ understanding and oversight of filed rating plans incorporating predictive models
even more challenging.

In addition to the growing complexity of predictive models, many state insurance departments do not have in-house
actuarial support or have limited resources to contract out for support when reviewing rate filings that include use of
predictive models. The Big Data (EX) Working Group identified the need to provide states with guidance and assistance
when reviewing predictive models underlying filed rating plans. The Working Group circulated a proposal addressing aid
to state insurance regulators in the review of predictive models as used in private passenger automobile and homeowners’
insurance rate filings. This proposal was circulated to all of the Working Group members and interested parties on
December 19, 2017, for a public comment period ending January 12, 2018. The Big Data Working Group effort resulted in
the new CASTF charges (see the Introduction section) with identifying best practices that provide guidance to states in
the review of predictive models.

So, to get to the question asked by the title of this section: Do regulators need best practices to review predictive models?
It might be better to ask this question another way: Are best practices in the review of predictive models of value to
regulators and insurance companies? The answer is “yes” to both questions. Best practices will aid regulatory reviewers
by raising their level of model understanding. With regard to scorecard models and the model algorithm, there is often not
sufficient support for relative weight, parameter values, or scores of each variable. Best practices can potentially aid in
fixing this problem.

However, best practices are not intended to create standards for filings that include predictive models. Rather, best practices
will assist the states in identifying the model elements they should be looking for in a filing that will aid the regulator in
understanding why the company believes that the filed predictive model improves the company’s rating plan, making that
rating plan fairer to all consumers in the marketplace. To make this work, both regulators and industry need to recognize that:

- Best practices merely provide guidance to regulators in their essential and authoritative role over the
rating plans in their state.
- All states may have a need to review predictive models whether that occurs with approval of rating plans
or in a market conduct exam. Best practices help the regulator identify elements of a model that may
influence the regulatory review as to whether modeled rates are appropriately justified. Each regulator
needs to decide if the insurer’s proposed rates are compliant with state laws and regulations and whether
to act on that information.
- Best practices will lead to improved quality in predictive model reviews across states, aiding speed to
market and competitiveness of the state marketplace.
- Best practices provide a framework for states to share knowledge and resources to facilitate the technical
review of predictive models.
- Best practices aid training of new regulators and/or regulators new to reviewing predictive models. (This
is especially useful for those regulators who do not actively participate in NAIC discussions related to
the subject of predictive models.)
- Each regulator adopting best practices will be better able to identify the resources needed to assist their
state in the review of predictive models.

Lastly, from this point on in this paper, best practices will be referred to as “guidance.” This reference is in line with the
intent of this paper to support individual state autonomy in the review of predictive models.

IV. SCOPE

The focus of this paper will be on GLMs used to create private passenger automobile and home insurance rating plans.

The knowledge needed to review predictive models, and guidance in this paper regarding GLMs for personal automobile
and home insurance may be transferrable when the review involves GLMs applied to other lines of business. Modeling

2 All comments received by the end of January were posted to the NAIC website March 12 for review.
depends on context, so the GLM reviewer has to be alert for data challenges and business applications that differ from the most familiar personal lines. For example, compared to personal lines, modeling for rates in commercial lines is more likely to encounter low volumes of historical data, dependence on advisory loss costs, unique large accounts with some large deductibles and products that build policies from numerous line-of-business and coverage building blocks. Commercial lines commonly use individual risk modifications following experience, judgment, and/or expense considerations. A regulator may never see commercial excess and surplus lines filings. The legal and regulatory constraints (including state variations) are likely to be more evolved, and challenging, in personal lines. A GLM rate model for personal lines in 2019 is either an update or a late-adopter’s defensive tactic. Adopting GLM for commercial lines has a shorter history.

Guidance offered here might be useful (with deeper adaptations) when starting to review different types of predictive models. If the model is not a GLM, some listed items might not apply. Not all predictive models generate p-values or F tests. Depending on the model type, other considerations might be important. When transferring guidance to other lines of business and other types of model, unique considerations may arise depending on the context in which a predictive model is proposed to be deployed, the uses to which it is proposed to be put, and the potential consequences for the insurer, its customers and its competitors. This paper does not delve into these possible considerations but regulators should be prepared to address them as they arise.

V. CONFIDENTIALITY

Regulatory reviewers are required to protect confidential information in accordance with applicable State law. However, insurers should be aware that a rate filing might become part of the public record. Each state determines the confidentiality of a rate filing, supplemental material to the filing, when filing information might become public, the procedure to request that filing information be held confidentially, and the procedure by which a public records request is made. It is incumbent on an insurer to be familiar with each state’s laws regarding the confidentiality of information submitted with their rate filing.

VI. GUIDANCE FOR REGULATORY REVIEW OF PREDICTIVE MODELS (BEST PRACTICES)

Best practices will help the regulator understand if a predictive model is cost based, if the predictive model is compliant with state law, and how the model improves, the company’s rating plan. Best practices can, also, make the regulator’s review more consistent across states and more efficient, and assist companies in getting their products to market faster.

With this in mind, the regulator’s review of predictive models should:

1. Ensure that the factors developed based on the model produce rates that are not excessive, inadequate, or unfairly discriminatory.
   a. Review the overall rate level impact of the revisions proposed based on the predictive model output in comparison to rate level indications provided by the filer.
   b. Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers.
   c. Review the individual input characteristics to and output factors from the predictive model (and its sub-models), as well as, associated selected relativities to ensure they are not unfairly discriminatory.

2. Thoroughly review all aspects of the model including the source data, assumptions, adjustments, variables, and resulting output.
   a. Determine that individual input characteristics to a predictive model are related to the expected loss or expense differences in risk. Each input characteristic should have an intuitive or demonstrable actual relationship to expected loss or expense.
   b. Determine that the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values and outliers are handled.
   c. Determine that any adjustments to the raw data are handled appropriately, including but not limited to, trending, development, capping, removal of catastrophes.
   d. Determine that rating factors from a predictive model are related to expected loss or expense differences in risk. Each rating factor should have a demonstrable actual relationship to expected loss or expense.
e. Obtain a clear understanding how often each risk characteristic, used as input to the model, is updated and whether the model is periodically rerun, so model output reflects changes to non-static risk characteristics.

3. Evaluate how the model interacts with and improves the rating plan.
   a. Obtain a clear understanding of the characteristics that are input to a predictive model (and its sub-models), their relationship to each other and their relationship to non-modeled characteristics/variables used to calculate a risk’s premium.
   b. Obtain a clear understanding of how the selected predictive model was built and why the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.
   c. Obtain a clear understanding of how model output interacts with non-modeled characteristics/variables used to calculate a risk’s premium.
   d. Obtain a clear understanding of how the predictive model was integrated into the insurer’s state rating plan and how it improves that plan.
   e. For predictive model refreshes, determine whether sufficient validation was performed to ensure the model is still a good fit.

4. Enable competition and innovation to promote the growth, financial stability, and efficiency of the insurance marketplace.
   a. Enable innovation in the pricing of insurance though acceptance of predictive models, provided they are actuarially sound and in compliance with state laws.
   b. Protect the confidentiality of filed predictive models and supporting information in accordance with state law.
   c. Review predictive models in a timely manner to enable reasonable speed to market.

VII. PREDICTIVE MODELS – INFORMATION FOR REGULATORY REVIEW

This section of the paper identifies the information a regulator may need to review a predictive model used by an insurer to support a filed P/C insurance rating plan. The list is lengthy but not exhaustive. It is not intended to limit the authority of a regulator to request additional information in support of the model or filed rating plan. Nor is every item on the list intended to be a requirement for every filing. However, the items listed should help guide a regulator to obtain sufficient information to determine if the rating plan meets state specific filing and legal requirements.

Though the list seems long, the insurer should already have internal documentation on the model for more than half of the information listed. The remaining items on the list require either minimal analysis (approximately 25%) or deeper analysis to generate the information for a regulator (approximately 25%)

The “Importance to Regulator’s Review” ranking of information a regulator may need to review is based on the following level criteria:

Level 1 - This information is necessary to begin the review of a predictive model. These data elements pertain to basic information about the type and structure of the model, the data and variables used, the assumptions made, and the goodness of fit. Ideally, this information would be included in the filing documentation with the initial submission of a filing made based on a predictive model.

Level 2 - This information is necessary to continue the review of all but the most basic models; such as those based only on the filer’s internal data and only including variables that are in the filed rating plan. These data elements provide more detailed information about the model and address questions arising from review of the information in Level 1. Insurers concerned with speed to market may also want to include this information in the filing documentation.

Level 3 - This information is necessary to continue the review of a model where concerns have been raised and not resolved based on review of the information in Levels 1 and 2. These data elements address even more detailed aspects of the model including (to be listed after we assign levels). This information does not necessarily need to be included with the initial submission, unless specifically requested in a particular jurisdiction, as it is typically requested only if the reviewer has concerns that the model may not comply with state laws.
**Level 4** - This information is necessary to continue the review of a model where concerns have been raised and not resolved based on the information in Levels 1, 2, and 3. This most granular level of detail is addressing the basic building blocks of the model and does not necessarily need to be included by the filer with the initial submission, unless specifically requested in a particular jurisdiction. It is typically requested only if the reviewer has serious concerns that the model produces rates or factors that are excessive, inadequate, or unfairly discriminatory.

### A. Selecting Model Input

<table>
<thead>
<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Importance to the Regulation/Review</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.1.a</td>
<td>Review the details of all data sources for input to the model (only need sources for filed input characteristics). For each source, obtain a list all data elements used as input to the model that came from that source.</td>
<td>1</td>
<td>Request details of all data sources. For insurance experience (policy or claim), determine whether calendar, accident, fiscal or policy year data and when it was last evaluated. For each data source, get a list all data elements used as input to the model that came from that source. For insurance data, get a list all companies whose data is included in the datasets. Request details of any non-insurance data used (customer-provided or other), including who owns this data, how consumers can verify their data and correct errors, whether the data was collected by use of a questionnaire/checklist, whether data was voluntarily reported by the applicant, and whether any of the data is subject to the Fair Credit Reporting Act. If the data is from an outside source, find out what steps were taken to verify the data was accurate.</td>
</tr>
<tr>
<td>A.1.b</td>
<td>Reconcile raw insurance data and with available external insurance reports.</td>
<td>3</td>
<td>Accuracy of insurance data should be reviewed as well.</td>
</tr>
<tr>
<td>A.1.c</td>
<td>Review the geographic scope and geographic exposure distribution of the raw data for relevance to the state where the model is filed.</td>
<td>1</td>
<td>Evaluate whether the data is relevant to the loss potential for which it is being used. For example, verify that hurricane data is only used where hurricanes can occur.</td>
</tr>
<tr>
<td>A.1.d</td>
<td>Be aware of any non-insurance data used (customer-provided or other), including who owns this data, how consumers can verify their data and correct errors, whether the data was collected by use of a questionnaire/checklist, whether it was voluntarily reported by the applicant, and whether any of the variables are subject to the Fair Credit Reporting Act. If the data is from an outside source, determine the steps that were taken by the company to verify the data was accurate.</td>
<td>2</td>
<td>If the data is from a third-party source, the company should provide information on the source. Depending on the nature of the data, data should be documented and an overview of who owns it and the topic of consumer verification should be addressed.</td>
</tr>
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</table>
## 2. Sub-Models

<table>
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<tr>
<th></th>
<th>Consider the relevance of (e.g., is there a bias) of overlapping data or variables used in the model and sub-models.</th>
<th></th>
<th>Check if the same variables/datasets were used in both the model, a submodel or as stand-alone rating characteristics. If so, verify there was no double-counting or redundancy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.2.a</td>
<td>Determine if sub-model output was used as input to the GLM; obtain the vendor name, and the name and version of the sub-model.</td>
<td>1</td>
<td>The regulator needs to know name of 3rd party vendor and contact whether model or sub-model. Examples of such sub-models include credit/financial scoring algorithms and household composite score models. Sub-models can be evaluated separately and in the same manner as the primary model under evaluation. A sub-model contact for additional information should be provided. SMEs on sub-model may need to be brought into the conversation with regulators (whether in-house or 3rd-party sub-models are used).</td>
</tr>
<tr>
<td>A.2.b</td>
<td>If using catastrophe model output, identify the vendor and the model settings/assumptions used when the model was run.</td>
<td>1</td>
<td>For example, it is important to know hurricane model settings for storm surge, demand surge, long/short-term views.</td>
</tr>
<tr>
<td>A.2.c</td>
<td>If using catastrophe model output (a sub-model) as input to the GLM under review, verify whether loss associated with the modeled output was removed from the loss experience datasets.</td>
<td>1</td>
<td>If a weather-based sub-model is input to the GLM under review, loss data used to develop the model should not include loss experience associated with the weather-based sub-model. Doing so could cause distortions in the modeled results by double counting such losses when determining relativities or loss loads in the filed rating plan. For example, redundant losses in the data may occur when non-hurricane wind losses are included in the data while also using a severe convective storm model in the actuarial indication. Such redundancy may also occur with the inclusion of fluvial or pluvial flood losses when using a flood model, inclusion of freeze losses when using a winter storm model or including demand surge caused by any catastrophic event.</td>
</tr>
<tr>
<td>A.2.d</td>
<td>If using output of any scoring algorithms, obtain a list of the variables used to determine the score and provide the source of the data used to calculate the score.</td>
<td>1</td>
<td>Any sub-model should be reviewed in the same manner as the primary model that uses the sub-model’s output as input.</td>
</tr>
<tr>
<td>A.2.e</td>
<td>Determine if the sub-model was previously approved (or accepted) by the regulatory agency.</td>
<td>2</td>
<td>If the sub-model was previously approved, that may change the extent of the sub-model’s review. If approved, verify when and that it was the same model currently under review.</td>
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</table>

## 3. Adjustments to Data
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<tbody>
<tr>
<td><strong>A.3.a</strong></td>
<td>Determine if premium, exposure, loss or expense data were adjusted (e.g., developed, trended, adjusted for catastrophe experience or capped) and, if so, how? Do the adjustments vary for different segments of the data and, if so, identify the segments and how was the data adjusted?</td>
<td>2</td>
<td>Look for anomalies in the data that should be addressed. For example, is there an extreme loss event in the data? If other processes were used to load rates for specific loss events, how is the impact of those losses considered? Examples of losses that can contribute to anomalies in the data are large losses, flood, hurricane or severe convective storm models for PPA comprehensive or home losses.</td>
</tr>
<tr>
<td><strong>A.3.b</strong></td>
<td>Identify adjustments that were made to raw data, e.g., transformations, binning and/or categorizations. If any, identify the name of the characteristic/variable and obtain a description of the adjustment.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>A.3.c</strong></td>
<td>Ask for aggregated data (one data set of pre-adjusted/scrubbed data and one data set of post-adjusted/scrubbed data) that allows the regulator to focus on the univariate distributions and compare raw data to adjusted/binned/transformed/etc. data.</td>
<td>3</td>
<td>This is most relevant for variables that have been &quot;scrubbed&quot; or adjusted. Though most regulators may never ask for aggregated data and do not plan to rebuild any models, a regulator may ask for this aggregated data or subsets of it. It would be useful to the regulator if the percentage of exposures and premium for missing information from the model data by category were provided. This data can be displayed in either graphical or tabular formats.</td>
</tr>
<tr>
<td><strong>A.3.d</strong></td>
<td>Determine how missing data was handled.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>A.3.e</strong></td>
<td>If duplicate records exist, determine how they were handled.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>A.3.f</strong></td>
<td>Determine if there were any data outliers identified and subsequently adjusted during the scrubbing process. Get a list (with description) of the outliers and determine what adjustments were made to these outliers.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

### 4. Data Organization

| **A.4.a** | Obtain documentation on the methods used to compile and organize data, including procedures to merge data from different sources and a description of any preliminary analyses, data checks, and logical tests performed on the data and the results of those tests. | 2 | This should explain how data from separate sources was merged. |
| A.4.b | Obtain documentation on the process for reviewing the appropriateness, reasonableness, consistency and comprehensiveness of the data, including a discussion of the intuitive relationship the data has to the predicted variable. | 2 | An example is when by-peril or by-coverage modeling is performed; the documentation should be for each peril/coverage and make intuitive sense. For example, if “murder” or “theft” data are used to predict the wind peril, provide support and an intuitive explanation of their use. |
| A.4.c | Identify material findings the company had during their data review and obtain an explanation of any potential material limitations, defects, bias or unresolved concerns found or believed to exist in the data. If issues or limitations in the data influenced modeling analysis and/or results, obtain a description of those concerns and an explanation how modeling analysis was adjusted and/or results were impacted. | 1 | |

Draft: 6/14/19
As adopted by the Casualty Actuarial and Statistical (C) Task Force on XX/XX/XX

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## Building the Model

<table>
<thead>
<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Importance to Regulator’s Review</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.1.a</td>
<td>Identify the type of model (e.g. Generalized Linear Model – GLM, decision tree, Bayesian Generalized Linear Model, Gradient-Boosting Machine, neural network, etc.). Understand the model’s role in the rating system and provide the reasons why that type of model is an appropriate choice for that role.</td>
<td>1</td>
<td>There should be an explanation of why the model (using the variables included in it) is appropriate for the line of business. If by-peril or by-coverage modeling is used, the explanation should be by-peril/coverage.</td>
</tr>
<tr>
<td>B.1.b</td>
<td>Identify the software used for model development. Obtain the name of the software vendor/developer, software product and a software version reference.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>B.1.c</td>
<td>Obtain a description how the available data was divided between model training, test and validation datasets. The description should include an explanation why the selected approach was deemed most appropriate, and whether the company made any further subdivisions of available data and reasons for the subdivisions (e.g., a portion separated from training data to support testing of components during model building). Determine if the validation data was accessed before model training was completed and, if so, obtain an explanation how and why that came to occur.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>B.1.d</td>
<td>Obtain a brief description of the development process, from initial concept to final model and filed rating plan (in less than three pages of narrative).</td>
<td>1</td>
<td>The narrative should have the same scope as the filing.</td>
</tr>
<tr>
<td>B.1.e</td>
<td>Obtain a narrative on whether loss ratio, pure premium or frequency/severity analyses were performed and, if separate frequency/severity modeling was performed, how pure premiums were determined.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>B.1.f</td>
<td>Identify the model’s target variable.</td>
<td>1</td>
<td>A clear description of the target variable is key to understanding the purpose of the model.</td>
</tr>
<tr>
<td>Draft: 12/7/19</td>
<td>As adopted by the Casualty Actuarial and Statistical (C) Task Force on XX/XX/XX</td>
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</tbody>
</table>

| B.1.g | Obtain a detailed description of the variable selection process. | 1 | The narrative regarding the variable selection process may address matters such as the criteria upon which variables were selected or omitted, identification of the number of preliminary variables considered in developing the model versus the number of variables that remained, and any statutory or regulatory limitations that were taken into account when making the decisions regarding variable selection. |
| B.1.h | In conjunction with variable selection, obtain a narrative on how the Company determine the granularity of the rating variables during model development. | 1 | |
| B.1.i | Determine if model input data was segmented in any way, e.g., was modeling performed on a by-coverage, by-peril, or by-form basis. If so, obtain a description of data segmentation and the reasons for data segmentation. | 1 | The regulator would use this to follow the logic of the modeling process. |
| B.1.j | If adjustments to the model were made based on credibility considerations, obtain an explanation of the credibility considerations and how the adjustments were applied. | 2 | Adjustments may be needed given models do not explicitly consider the credibility of the input data or the model’s resulting output; models take input data at face value and assume 100% credibility when producing modeled output. |

### 2. Medium-Level Narrative for Building the Model

| B.2.a | At crucial points in model development, if selections were made among alternatives regarding model assumptions or techniques, obtain a narrative on the judgment used to make those selections. | 2 | |
| B.2.b | If post-model adjustments were made to the data and the model was rerun, obtain an explanation on the details and the rationale for those adjustments. | 2 | Evaluate the addition or removal of variables and the model fitting. It is not necessary for the company to discuss each iteration of adding and subtracting variables, but the regulator should gain a general understanding how these adjustments were done, including any statistical improvement measures relied upon. |
| B.2.c | Obtain a description of univariate balancing and testing performed during the model-building process, including an explanation of the thought processes involved. | 2 | Further elaboration from B.2.b. |
### B.2.2 Obtaining the GLM

**B.2.d** Obtain a description of the 2-way balancing and testing that was performed during the model-building process, including an explanation of the thought processes of including (or not including) interaction terms.  

**B.2.e** For the GLM, identify the link function used. Identify which distribution was used for the model (e.g., Poisson, Gaussian, log-normal, Tweedie). Obtain an explanation why the link function and distribution were chosen. Obtain the formulas for the distribution and link functions, including specific numerical parameters of the distribution.  

**B.2.f** Obtain a narrative on the formula relationship between the data and the model outputs, with a definition of each model input and output. The narrative should include all coefficients necessary to evaluate the predicted pure premium, relativity or other value, for any real or hypothetical set of inputs.  

**B.2.g** If there were data situations in which GLM weights were used, obtain an explanation of how and why they were used.

#### 3. Predictor Variables

**B.3.a** Obtain a complete data dictionary, including the names, types, definitions and uses of each predictor variable, offset variable, control variable, proxy variable, geographic variable, geodemographic variable and all other variables in the model (including sub-models and external models).  

**B.3.b** Obtain a list of predictor variables considered but not used in the final model, and the rationale for their removal.  

**B.3.c** Obtain a correlation matrix for all predictor variables included in the model and sub-model(s).  

**B.3.d** Obtain an intuitive explanation for why an increase in each predictor variable should increase or decrease frequency, severity, loss costs, expenses, or any element or characteristic being predicted.

---

Further elaboration from B.2.a and B.2.b.  

B.4.1 and B.4.2 will show the mathematical functions involved and could be used to reproduce some model predictions.  

Investigate whether identical records were combined to build the model.

Types of variables might be continuous, discrete, Boolean, etc. Definitions should not use programming language or code. For any variable(s) intended to function as a control or offset, obtain an explanation of their rationale and impact.

The rationale for this requirement is to identify variables that the company finds to be predictive but ultimately may reject for reasons other than loss-cost considerations (e.g., price optimization).

While GLMs accommodate collinearity, the correlation matrix provides more information about the magnitude of correlation between variables.

The explanation should go beyond demonstrating correlation. Considering possible causation is relevant, but proving causation is neither practical nor expected. If no intuitive explanation can be provided, greater scrutiny may be appropriate.
If the modeler made use of one or more dimensionality reduction techniques, such as a Principal Component Analysis (PCA), obtain a narrative about that process, an explanation why that technique was chosen, and a description of the step-by-step process used to transform observations (usually correlated) into a set of linearly uncorrelated variables. In each instance, obtain a list of the pre-transformation and post-transformation variable names, and an explanation how the results of the dimensionality reduction technique was used within the model.

### 4. Adjusting Data, Model Validation and Goodness-of-Fit Measures

<table>
<thead>
<tr>
<th>B.3.e</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain a description of the methods used to assess the statistical significance/goodness of fit of the model to validation data, such as lift charts and statistical tests. Compare the model's projected results to historical actual results and verify that modeled results are reasonably similar to actual results from validation data.</td>
<td>1</td>
</tr>
</tbody>
</table>

For models that are built using multi-state data, validation data for some segments of risk is likely to have low credibility in individual states. Nevertheless, some regulators require model validation on State-only data, especially when analysis using state-only data contradicts the countrywide results. State-only data might be more applicable but could also be impacted by lower credibility for some segments of risk. Look for geographic stability measures, e.g., across states or territories within state.

<table>
<thead>
<tr>
<th>B.4.a</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain a description of any adjustments that were made in the data with respect to scaling for discrete variables or binning the data.</td>
<td>2</td>
</tr>
</tbody>
</table>

A.3.f addresses pre-modeling adjustments to data. In the mid-level narrative context, B.2.a addresses judgments of any kind made during modeling. Only choices made at "crucial points in model development" need be discussed.

<table>
<thead>
<tr>
<th>B.4.b</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain a description of any transformations made for continuous variables.</td>
<td>2</td>
</tr>
</tbody>
</table>

A.3.f addresses pre-modeling transformations to data. In the mid-level narrative context, B.2.a addresses transformations of any kind made during modeling. Only choices made at "crucial points in model development" need be discussed.

To build a unique model with acceptable goodness-of-fit to the training data, important steps have been taken. Such steps may have been numerous, and at least some of the judgments involved may be difficult to describe and explain. Nevertheless, neither the model filer nor the reviewer can assume these steps are immaterial, generally understood, or implied by the model's generic form. The model filer should anticipate regulatory concerns in its initial submission by identifying and explaining the model fitting steps it considers most important. If a reviewer has regulatory concerns not resolved by the initial submission, appropriate follow up inquiries are likely to depend on the particular circumstances.
| **B.4.d** | For each discrete variable level, review the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. Determine if model development data, validation data, test data or other data was used for these tests. | Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model, e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model. Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an A01 curve might be more than what is needed. |
| **B.4.e** | Identify the threshold for statistical significance and explain why it was selected. Obtain a reasonable and appropriately supported explanation for keeping the variable for each discrete variable level where the p-values were not less than the chosen threshold. | Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model, e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model. Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an A01 curve might be more than what is needed. |
| B.4.f | For overall discrete variables, review type 3 chi-square tests, p-values, F tests and any other relevant and material test. Determine if model development data, validation data, test data or other data was used for these tests. | 2 | Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model, e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model. Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed. |
| B.4.g | Obtain evidence that the model fits the training data well, for individual variables, for any relevant combinations of variables and for, the overall model. | 2 | For a GLM, such evidence may be available using chi-square tests, p-values, F tests and/or other means. The steps taken during modeling to achieve goodness-of-fit are likely to be numerous and laborious to describe, but they contribute much of what is generalized about GLM. We should not assume we know what they did and ask "how?". Instead, we should ask what they did and be prepared to ask follow up questions. |
| B.4.h | For continuous variables, provide confidence intervals, chi-square tests, p-values and any other relevant and material test. Determine if model development data, validation data, test data or other data was used for these tests. | 2 | Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model, e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model. Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed. |
| B.4.i | Obtain a description how the model was tested for stability over time. | 2 | Evaluate the build/test/validation datasets for potential model distortions (e.g., a winter storm in year 3 of 5 can distort the model in both the testing and validation datasets). Obsolescence over time is a model risk. If a model being introduced now is based on losses from years ago, the reviewer should be interested in knowing whether that model would be predictive in the proposed context. Validation using recent data from the proposed context might be requested. Obsolescence is a risk even for a new model based on recent and relevant loss data. What steps, if any, were taken during modeling to prevent or delay obsolescence? What controls will exist to measure the rate of obsolescence? What is the plan and timeline for updating and ultimately replacing the model? |
| B.4.j | Obtain a narrative on how were potential concerns with overfitting were addressed. | 2 | Visual review of plots of actual errors is usually sufficient. The reviewer should look for a conceptual narrative covering these topics: How does this particular GLM work? Why did the rate filer do what it did? Why employ this design instead of alternatives? Why choose this particular distribution function and this particular link function? |
| B.4.k | Obtain support demonstrating that the GLM assumptions are appropriate. | 2 | |
| B.4.l | Obtain 5-10 sample records with corresponding output from the model for those records. | 3 | |

5. “Old Model” Versus “New Model”

| B.5.a | Obtain an explanation why this model is an improvement to the current rating plan. If it replaces a previous model, find out why it is better than the one it is replacing; determine how the company reached that conclusion and identify metrics relied on in reaching that conclusion. Look for an explanation of any changes in calculations, assumptions, parameters, and data used to build this model from the previous model. | 1 | Regulators should expect to see improvement in the new class plan’s predictive ability or other sufficient reason for the change. |
| B.5.b | Determine if two Gini coefficients were compared and obtain a narrative on the conclusion drawn from this comparison. | 3 | One example of a comparison might be sufficient. |
| B.5.c | Determine if double lift charts analyzed and what conclusion was drawn from this analysis? | 2 | One example of a comparison might be sufficient. |
### Draft: 8/14/2019

As adopted by the Casualty Actuarial and Statistical (C) Task Force on [XX/XX/XX](#)

| B.5.d | If replacing an existing model, obtain a list of any predictor variables used in the old model that are not used in the new model. Obtain an explanation why these variables were dropped from the new model. Obtain a list of all new predictor variables in the model that were not in the prior model. | 2 | Useful to differentiate between old and new variables so the regulator can prioritize more time on factors not yet reviewed. |
| 6. Modeler Software |  |
| B.6.a | Request access to SMEs (e.g., modelers) who led the project, compiled the data, built the model, and/or performed peer review. | 3 | The filing should contain a contact that can put the regulator in touch with appropriate SMEs to discuss the model. |
### C. The Filed Rating Plan

<table>
<thead>
<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Regulatory Review</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. General Impact of Model on Rating Algorithm</td>
<td>In the actuarial memorandum or explanatory memorandum, for each model and sub-model (including external models), look for a narrative that explains each model and its role in the rating system.</td>
<td>1</td>
<td>This item is particularly important, if the role of the model cannot be immediately discerned by the reviewer from a quick review of the rate and/or rule pages. (Importance is dependent on state requirements and ease of identification by the first layer of review and escalation to the appropriate review staff.)</td>
</tr>
<tr>
<td>C.1.a</td>
<td>Obtain an explanation of how the model was used to adjust the rating algorithm.</td>
<td>1</td>
<td>Models are often used to produce factor-based indications, which are then used as the basis for the selected changes to the rating plan. It is the changes to the rating plan that create impacts. Consider asking for an explanation of how the model was used to adjust the rating algorithm.</td>
</tr>
<tr>
<td>C.1.b</td>
<td>Obtain a complete list of characteristics/variables used in the proposed rating plan, including those used as input to the model (including sub-models and composite variables) and all other characteristics/variables (not input to the model) used to calculate a premium. For each characteristic/variable, determine if it is only input to the model, whether it is only a separate univariate rating characteristic, or whether it is both input to the model and a separate univariate rating characteristic. The list should include transparent descriptions (in plain language) of each listed characteristic/variable.</td>
<td>1</td>
<td>Examples of variables used as inputs to the model and used as separate univariate rating characteristics might be criteria used to determine a rating tier or household composite characteristic.</td>
</tr>
<tr>
<td>C.1.c</td>
<td>Obtain a narrative how the characteristics/rating variables, included in the filed rating plan, logically and intuitively relate to the risk of insurance loss (or expense) for the type of insurance product being priced.</td>
<td>2</td>
<td>The narrative should include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense). The narrative should include a logical and intuitive relationship to cost, and model results should be consistent with the expected direction of the relationship. This explanation would not be needed if the connection between variables and risk of loss (or expense) has already been illustrated.</td>
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### 3. Comparison of Model Outputs to Current and Selected Rating Factors

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Points</th>
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</thead>
<tbody>
<tr>
<td>C.3.a</td>
<td>Compare relativities indicated by the model to both current relativities and the insurer's selected relativities for each risk characteristic/variable in the rating plan.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>“Significant difference” may vary based on the risk characteristic/variable and context. However, the movement of a selected relativity should be in the direction of the indicated relativity; if not, an explanation is necessary as to why the movement is logical.</td>
<td></td>
</tr>
<tr>
<td>C.3.b</td>
<td>Obtain documentation and support for all calculations, judgments, or adjustments that connect the model's indicated values to the selected values.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>The documentation should include explanations for the necessity of any such adjustments and explain each significant difference between the model's indicated values and the selected values. This applies even to models that produce scores, tiers, or ranges of values for which indications can be derived. This information is especially important if differences between model indicated values and selected values are material and/or impact one consumer population more than another.</td>
<td></td>
</tr>
<tr>
<td>C.3.c</td>
<td>For each characteristic/variable used as both input to the model (including sub-models and composite variables) and as a separate univariate rating characteristic, obtain a narrative how each was tempered or adjusted to account for possible overlap or redundancy in what the characteristic/variable measures.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Modeling loss ratio with these characteristics/variables as control variables would account for possible overlap. The insurer should address this possibility or other considerations, e.g., tier placement models often use risk characteristics/variables that are also used elsewhere in the rating plan. One way to do this would be to model the loss ratios resulting from a process that already uses univariate rating variables. Then the model/composite variables would be attempting to explain the residuals.</td>
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</table>

### 4. Responses to Data, Credibility and Granularity Issues

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.4.a</td>
<td>Determine what, if any, consideration was given to the credibility of the output data.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>At what level of granularity is credibility applied. If modeling was by-coverage, by-form or by-peril, explain how these were handled when there was not enough credible data by coverage, form or peril to model.</td>
<td></td>
</tr>
<tr>
<td>C.4.b</td>
<td>If the rating plan is less granular than the model, obtain an explanation why.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>This is applicable if the insurer had to combine modeled output in order to reduce the granularity of the rating plan.</td>
<td></td>
</tr>
<tr>
<td>C.4.c</td>
<td>If the rating plan is more granular than the model, obtain an explanation why.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>A more granular rating plan implies that the insurer had to extrapolate certain rating treatments, especially at the tails of a distribution of attributes, in a manner not specified by the model indications.</td>
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</table>
## 5. Definitions of Rating Variables

<p>| | |</p>
<table>
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<tbody>
<tr>
<td>C.5.a</td>
<td>Obtain a narrative on adjustments made to raw data, e.g., transformations, binning and/or categorizations. If adjustments were made, obtain the name of the characteristic/variable and a description of the adjustment.</td>
</tr>
<tr>
<td>C.5.b</td>
<td>Obtain a complete list and description of any rating tiers or other intermediate rating categories that translate the model outputs into some other structure that is then presented within the rate and/or rule pages.</td>
</tr>
</tbody>
</table>

## 6. Supporting Data

<p>| | |</p>
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</thead>
<tbody>
<tr>
<td>C.6.a</td>
<td>Obtain aggregated state-specific, book-of-business-specific univariate historical experience data, separately for each year included in the model, consisting of, at minimum, earned exposures, earned premiums, incurred losses, loss ratios and loss ratio relativities for each category of model output(s) proposed to be used within the rating plan. For each data element, obtain an explanation whether it is raw or adjusted and, if the latter, obtain a detailed explanation for the adjustments.</td>
</tr>
<tr>
<td>C.6.b</td>
<td>Obtain an explanation of any material (especially directional) differences between model indications and state-specific univariate indications.</td>
</tr>
</tbody>
</table>

- For example, were losses developed/undeveloped, trended/untrended, capped/uncapped, etc?

Univariate indications should not necessarily be used to override more sophisticated multivariate indications. However, they do provide additional context and may serve as a useful reference.

- Multivariate indications may be reasonable as refinements to univariate indications, but possibly not for bringing about significant reversals of those indications. For instance, if the univariate indicated relativity for an attribute is 1.5 and the multivariate indicated relativity is 1.25, this is potentially a plausible application of the multivariate techniques. If, however, the univariate indicated relativity is 0.7 and the multivariate indicated relativity is 1.25, a regulator may question whether the attribute in question is negatively correlated with other determinants of risk. Credibility of state data should be considered when state indications differ from modeled results based on a broader data set. However, the relevance of the broader data set to the risks being priced should also be considered. Borderline reversals are not of as much concern.
| C.7.a | Obtain a listing of the top five rating variables that contribute the most to large swings in premium, both as increases and decreases. | 2 | These rating variables may represent changes to rate relativities, be newly introduced to the rating plan, or have been removed from the rating plan. |
| C.7.b | Determine if the insurer performed sensitivity testing to identify significant changes in premium due to small or incremental change in a single risk characteristic. If such testing was performed, obtain a narrative that discusses the testing and provides the results of that testing. | 3 | One way to see sensitivity is to analyze a graph of each risk characteristic’s/variable’s possible relativities. Look for significant variation between adjacent relativities and evaluate if such variation is reasonable and credible. |
| C.7.c | For the proposed filing, obtain the impacts on expiring policies and describe the process used by management, if any, to mitigate those impacts. | 2 | Some mitigation efforts may substantially weaken the connection between premium and expected loss and expense, and hence may be viewed as unfairly discriminatory by some states. |
| C.7.d | Obtain a rate disruption/dislocation analysis, demonstrating the distribution of percentage impacts on renewal business (create by rerating the current book of business). | 2 | The analysis should include the largest dollar and percentage impacts arising from the filing, including the impacts arising specifically from the adoption of the model or changes to the model as they translate into the proposed rating plan. |
| C.7.e | Obtain exposure distributions for the model’s output variables and show the effects of rate changes at granular and summary levels. | 3 | See Appendix C for an example of an exposure distribution. |
### C.7.f
Identify policy characteristics, used as input to a model or sub-model, that remain "static" over a policy's lifetime versus those that will be updated periodically. Obtain a narrative on how the company handles policy characteristics that are listed as "static," yet change over time.

- **3**
  - Some examples of "static" policy characteristics are prior carrier tenure, prior carrier type, prior liability limits, claim history over past X years, or lapse of coverage. These are specific policy characteristics usually set at the time new business is written, used to create an insurance score or to place the business in a rating/underwriting tier, and often fixed for the life of the policy. The reviewer should be aware, and possibly concerned, how the company treats an insured over time when the insured's risk profile based on "static" variables changes over time but the rate charged, based on a new business insurance score or tier assignment, no longer reflect the insured's true and current risk profile.
  - A few examples of "non-static" policy characteristics are age of driver, driving record and credit information (FCRA related). These are updated automatically by the company on a periodic basis, usually at renewal, with or without the policyholder explicitly informing the company.

### C.7.g
Obtain a means to calculate the rate charged a consumer.

- **3**
  - The filed rating plan should contain enough information for a regulator to be able to validate policy premium. However, for a complex model or rating plan, a score or premium calculator via Excel or similar means would be ideal, but this could be elicited on a case-by-case basis. Ability to calculate the rate charged could allow the regulator to perform sensitivity testing when there are small changes to a risk characteristic/variable. Note that this information may be proprietary.

### 8. Accurate Translation of Model into a Rating Plan

#### C.8.a
Obtain sufficient information to understand how the model outputs are used within the rating system and to verify that the rating plan, in fact, reflects the model output and any adjustments made to the model output.

- **1**
VIII. PROPOSED CHANGES TO THE PRODUCT FILING REVIEW HANDBOOK

TBD — placeholder to include best practices for review of predictive models and analytics filed by insurers to justify rates.

The Task Force was charged to propose modifications to the 2016 Product Filing Review Handbook to reflect best practices for the regulatory review of predictive analytics. The following are the titled sections in Chapter Three “The Basics of Property and Casualty Rate Regulation.” Proposed changes are shown as tracked changes.


CHAPTER THREE

The Basics of Property and Casualty Rate Regulation

No changes are proposed to the following sections at the beginning of Chapter Three: Introduction; Rating Laws; Rate Standards; Rate Justification and Supporting Data; Number of Years Historical Data; Segregation of Data; Data Adjustments; Premium Adjustments; Losses and LAE (perhaps just DCC) Adjustments; Catastrophe or Large Loss Provisions; Loss Adjustment Expenses; Data Quality; Rate Justification: Overall Rate Level; Contingency Provision; Credibility; Calculation of Overall Rate Level Need: Methods (Pure Premium and Loss Ratio Methods); Rate Justification: Rating Factors; Calculation of Deductible Rating Factors; Calculation of Increased Limit Factors; and Credibility for Rating Factors.

Interaction between Rating Variables (Multivariate Analysis)

If the pricing of rating variables is evaluated separately for each rating variable, there is potential to miss the interaction between rating variables. Care should be taken to have a multivariate analysis when practical. In some instances, a multivariate analysis is not possible. But, with computing power growing exponentially, insurers are finding many ways to improve their operations and competitiveness through use of often very complex predictive models in all areas of their insurance business.

Approval of Classification Systems

With rate changes, companies sometimes propose revisions to their classification system. Because the changes to classification plans can be significant and have large impacts on the consumers’ rates, regulators should focus on these changes.

Some items of proposed classification can sometimes be deemed to be against public policy, such as the use of education or occupation. You should be aware of your state’s laws and regulations regarding which rating factors are allowed. Finding rating or underwriting characteristics that may violate public policy is becoming more difficult for regulators with the increasing and innovative ways insurers use predictive models.

Rating Tiers

Some states allow an insurer to have multiple rate levels, or rating tiers, within a single company. These rating tiers are another way of classifying risks for rating purposes. Typically, there are requirements for rating tiers: the underwriting rules for each tier should be mutually exclusive, clear, and objective; there should be a distinction between the expected losses or expenses for each tier; and the placement process should be auditable. Tiers within a company are mainly seen in personal lines products.

One particular concern with rating tiers would be the analyses of whether a plan produces unfair discrimination. Questions arise around the time-sensitive aspects of the underwriting criteria and any related re-evaluation of the tiers upon renewal. For example, consider two tiers where the insured is placed in the “high” tier because of a lapse of insurance in the prior 12 months. The question is: What happens upon renewal after there has no longer been a lapse of insurance for 12 months? Does the insured get slotted in the “low” tier as he would if he was new business? Some statutes limit the amount of time that violations, loss history, or insurance scores can be used, and some statutes might only allow credit history to be used for re-
rating at the policyholder’s request. Regulators should consider the acceptability of differences in rates between existing and new policyholders when they have the same current risk profile.

Insurers also can create different rating levels by having separate companies within a group. While regulators should examine rating tiers within an insurer to a high degree of regulatory scrutiny, there tends to be less scrutiny with differences in rates that exist between affiliated companies. Workers’ compensation insurers are more likely to obtain rating tiers using separate companies.

Rate Justification: New Products – (No change is proposed.)

Predictive Modeling

The ability of computers to process massive amounts of data has led to the expansion of the use of predictive modeling in insurance ratemaking. Predictive models have enabled insurers to build rating, marketing, underwriting and claim models with significant segmentation-predictive power and are increasingly being applied in such areas as claims modeling and used in helping insurers to price risks more effectively.

Key new rating variables that are being incorporated into insurers’ predictive models include homeowners’ rates by policy, homeowners rating by building characteristics, vehicle history, usage-based auto insurance, and credit characteristics.

Data quality and communication about models are of key importance with predictive modeling. Depending on definitional boundaries, predictive modeling can sometimes overlap with the field of machine learning. In the modeling space, predictive modeling is often referred to as predictive analytics.

Insurers’ use of predictive analytics along with big data has significant potential benefits to both consumers and insurers. Predictive analytics can reveal insights into the relationship between consumer behavior and the cost of insurance, lower the cost of insurance for many, and provide incentives for consumers to better control and mitigate loss. However, predictive analytic techniques are evolving rapidly and leaving many regulators without the necessary tools to effectively review insurers’ use of predictive models in insurance applications. To aid the regulator in the review of predictive models, best practices have been developed along with specific information that will aid the regulator in their review of predictive models (specifically generalized linear models or “GLMs”) for private passenger automobile and homeowners’ insurance applications.

The term “predictive model” refers to a set of models that use statistics to predict outcomes. When applied to insurance, the model is chosen to estimate the probability or expected value of an outcome given a set amount of input data; for example, models can predict the frequency of loss, the severity of loss, or the pure premium.

To further complicate regulatory review of models in the future, modeling methods are evolving rapidly and are not limited just to GLMs. As computing power grows exponentially, it is opening up the modeling world to more sophisticated forms of data acquisition and data analysis. Insurance actuaries and data scientists seek increased predictiveness by using even more complex predictive modeling methods. Examples of these are predictive models utilizing random forests, decision trees, neural networks, or combinations of available modeling methods (often referred to as ensembles). These evolving techniques will make the regulators’ understanding and oversight of filed rating plans incorporating predictive models even more challenging.

A. Generalized Linear Models

The generalized linear model (GLM) is a commonly used predictive model in insurance applications, particularly in building an insurance product’s rating plan. Because of this and the fact most Property and Casualty regulators are most concerned about personal lines, NAIC has developed a white paper for guidance2 in reviewing GLMs for Home and private passenger automobile insurance.

Before GLMs became vogue, rating plans were built using univariate methods. Univariate methods were considered rational and easy to demonstrate the relationship to costs (loss and/or expense). However, many consider univariate methods too simplistic since they do not take into account the interaction (or dependencies) of the selected input variables. GLMs introduce significant improvements over univariate-based rating plans by automatically adjusting for correlations among

2 Refer to NAIC’s white paper titled Regulatory Review of Predictive Models, found at the NAIC website.
input variables. Today, the majority of predictive models used in private passenger automobile and home insurance rating plans are GLMs. But, GLM results are not always rational and the relationship to costs may be difficult to explain.

A GLM consists of three elements:

- Each component of $Y$ is independent and a probability distribution from the exponential family, or more generally, a selected variance function and dispersion parameter,
- A linear predictor $\eta = X\beta$,
- A link function $g$ such that $E(Y) = \mu = g^{-1}(\eta)$.

As can be seen in the description of the three GLM components above, it may take more than a casual introduction to statistics to comprehend the construction of a GLM. As stated earlier, a downside to GLMs is that it is more challenging to interpret the GLMs output than with univariate models.

B. Credibility of Model Output

GLM software provides point estimates and allows the modeler to consider standard errors and confidence intervals. GLM output is typically assumed to be 100% credible no matter the size of the underlying data set. If some segments have little data, the resulting uncertainty would not be reflected in the GLM parameter estimates themselves (although it might be reflected in the standard errors, confidence intervals, etc.). Even though the process of selecting relatives often includes adjusting the raw GLM output, the resultant selections are not then credibility-weighted with any complement of credibility. Nevertheless, selected relatives based on GLM model output may differ from GLM point estimates.

Because of this presumption in credibility, which may or may not be valid in practice, the modeler and the regulator reviewing the model would need to engage in thoughtful consideration when incorporating GLM output into a rating plan to ensure that model predictiveness is not compromised by any lack of actual credibility. Therefore, to mitigate the risk that model credibility or predictiveness is lacking, a complete filing for a rating plan that incorporates GLM output should include validation evidence for the rating plan, not just the statistical model.

C. What is a “Best Practice”?

A best practice is a form of peer group evaluation in public policy. At its most basic level, a practice is a “tangible and visible behavior… [based on] an idea about how the actions… will solve a problem or achieve a goal.”10 Best practices can maintain quality as an alternative to mandatory legislated standards and can be based on self-assessment or benchmarking.11 Therefore, a best practice represents an effective method of problem solving. The “problem” regulators want to solve is probably better posed as seeking an answer to this question: How can regulators determine that predictive models, as used in rate filings, are compliant with state laws and regulations? However, best practices are not intended to create standards for filings that include predictive models.

Best practices are based on the following principles that promote a comprehensive and coordinated review of predictive models across states:

- State insurance regulators will maintain their current rate regulatory authority.
- State insurance regulators will be able to share information to aid companies in getting insurance products to market more quickly.
- State insurance regulators will share expertise and discuss technical issues regarding predictive models.
- State insurance regulators will maintain confidentiality, where appropriate, regarding predictive models.

D. Regulatory Review of Predictive Models

The knowledge needed to review predictive models, and guidance regarding GLMs for personal automobile and home insurance may be transferable when the review involves GLMs applied to other lines of business. Modeling depends on context, so the GLM reviewer has to be alert for data challenges and business applications that differ from the most familiar personal lines. For example, compared to personal lines, modeling for rates in commercial lines is more likely to encounter

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low volumes of historical data, dependence on advisory loss costs, unique large accounts with some large deductibles and products that build policies from numerous line-of-business and coverage building blocks. Commercial lines commonly use individual risk modifications following experience, judgment, and/or expense considerations. A regulator may never see commercial excess and surplus lines filings. The legal and regulatory constraints (including state variations) are likely to be more evolved, and challenging, in personal lines. A GLM rate model for personal lines in 2019 is either an update or a late-adopter's defensive tactic. Adopting GLM for commercial lines has a shorter history.

 Guidance offered here might be useful (with deeper adaptations) when starting to review different types of predictive models. If the model is not a GLM, some listed items might not apply. Not all predictive models generate p-values or F-tests. Depending on the model type, other considerations might be important. When transferring guidance to other lines of business and other types of model, unique considerations may arise depending on the context in which a predictive model is proposed to be deployed, the uses to which it is proposed to be put, and the potential consequences for the insurer, its customers and its competitors. This guidance does not delve into these possible considerations but regulators should be prepared to address them as they arise.

 Best practices will help the regulator understand if a predictive model is cost-based, if the predictive model is compliant with state law, and how the model improves the company’s rating plan. Best practices can also, make the regulator's review more consistent across states and more efficient, and assist companies in getting their products to market faster. With this in mind, the regulator's review of predictive models should:

1. Ensure that the factors developed based on the model produce rates that are not excessive, inadequate, or unfairly discriminatory.
   a. Review the overall rate level impact of the revisions proposed based on the predictive model output in comparison to rate level indications provided by the filer.
   b. Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers.
   c. Review the individual input characteristics and output factors from the predictive model (and its sub-models), as well as, associated selected relatitives to ensure they are not unfairly discriminatory.

2. Thoroughly review all aspects of the model including the source data, assumptions, adjustments, variables, and resulting output.
   a. Determine that individual input characteristics to a predictive model are related to the expected loss or expense differences in risk. Each input characteristic should have an intuitive or demonstrable actual relationship to expected loss or expense.
   b. Determine that the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values and outliers are handled.
   c. Determine that any adjustments to the raw data are handled appropriately, including but not limited to, trending, development, capping, removal of catastrophes, and rating factors.
   d. Determine that rating factors from a predictive model are related to expected loss or expense differences in risk. Each rating factor should have a demonstrable actual relationship to expected loss or expense.
   e. Obtain a clear understanding how often each risk characteristic, used as input to the model, is updated and whether the model is periodically rerun, so model output reflects changes to non-static risk characteristics.

3. Evaluate how the model interacts with and improves the rating plan.
   a. Obtain a clear understanding of the characteristics that are input to a predictive model (and its sub-models), their relationship to each other and their relationship to non-modeled characteristics/variables used to calculate a risk’s premium.
   b. Obtain a clear understanding of how the selected predictive model was built and why the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.
   c. Obtain a clear understanding of how model output interacts with non-modeled characteristics/variables used to calculate a risk’s premium.
   d. Obtain a clear understanding of how the predictive model was integrated into the insurer’s state rating plan and how it improves that plan.
   e. For predictive model refreshes, determine whether sufficient validation was performed to ensure the model is still a good fit.
4. Enable competition and innovation to promote the growth, financial stability, and efficiency of the insurance marketplace.
   a. Enable innovation in the pricing of insurance though acceptance of predictive models, provided they are actuarially sound and in compliance with state laws.
   b. Protect the confidentiality of filed predictive models and supporting information in accordance with state law.
   c. Review predictive models in a timely manner to enable reasonable speed to market.

E. Information Needed to Follow Best Practices

To assist the regulator in following each best practice, the Casualty Actuarial and Statistical Task Force created a white paper titled Regulatory Review of Predictive Models. The paper contains a list of information elements and considerations that should be useful during the review of a model underlying a rating plan. To further assist the regulator, the information elements were mapped into the best practices listed above in Section XV of the paper.

F. Confidentiality

Regulatory reviewers are required to protect confidential information in accordance with applicable State law. However, insurers should be aware that a rate filing might become part of the public record. Each state determines the confidentiality of a rate filing, supplemental material to the filing, when filing information might become public, the procedure to request that filing information be held confidentially, and the procedure by which a public record request is made. It is incumbent on an insurer to be familiar with each state’s laws regarding the confidentiality of information submitted with their rate filing.

Advisory Organizations – (No change is proposed.)

Workers’ Compensation Special Rules – (No change is proposed.)

**Premium Selection Decisions**

- Indicated Rate Change vs. Selected Rate Change

After applying credibility, the indicated rate change should reflect the company’s best estimate of their premium needs given their current or expected book of business. However, insurance companies also have other business considerations including competition, marketing, legal concerns, impact of the rate change on retention, etc. A company might wish to deviate from their indicated rate change and should justify those decisions, within the constraints of the law.

- Capping and Transition Rules

With advances in technology, it is possible for companies to introduce capping of rates on individual policies with an aim toward gradually increasing policyholders’ rates, rather than making large modifications all at one time. Similarly, premiums are often proposed to be modified when an insurer acquires another company’s book of business or decides to move from or to an advisory organization’s plan. These types of proposed capping are sometimes called “renewal premium capping,” “rate capping,” “a rate stability program,” or “transition rules.”

Transition rules for individual policyholders can get quite complex and you need to be aware of your state’s positions on premium capping rules. Any premium capping and transition rules require weighing the pros and cons of the potential for unfair discrimination (with some customers not paying the rate commensurate with the risks they have) vs. rate stability for existing policyholders.

If premium capping or transition rules are allowed, additional decisions will need to be made:

- Which rates should get capped?
- Do rate decreases get capped? If so, what is the impact if the policyholder asks to be quoted as new business?
- Do all rate increases get capped or only above a certain percentage?
- How much time will lapse or how many renewal cycles will occur before the new rates are in place or different rating plans are merged?
- Should the insured be told what the final premium will be once no more capping is applied?
- How would exposure change be addressed? If the policyholder buys a new car or changes their liability limits, what is the impact on their rate capping?
How many rate-capping rules can be implemented at any given time?

When premium capping or transition rules have been incorporated, future indicated rate changes and rating factor analyses need to properly reflect the fully approved rate changes. If the overall approved rate change was +10%, yet capping resulted in only 8% being implemented in the first year, the remaining amount to recognize the full 10% should be reflected in the premium on-level adjustment. Otherwise, the indicated rate would be redundant.

Some states encourage more frequent filing of rate changes that can help to avoid the need of premium capping and transition rules. Some states might prefer capping of individual rating variables, rather than capping for individual policyholders.

Installment Plans – (No change is proposed.)

Policy Fees – (No change is proposed.)

Potential Questions to Ask Oneself as a Regulator

Every filing will be different and will result in different regulatory analyses. But the following are some questions the regulator might ask oneself in a rate filing review:

1. Regarding data:
   a. Is the data submitted with the filing enough information for a regulatory review?
   b. Is the number of years of experience appropriate?
   c. Did the company sufficiently analyze and control their quality of data?

2. Regarding the support and justification of rates:
   a. Did they propose rate changes without justification?
   b. Are proposals based on judgment or competitive analysis? If so, are the results reasonable and acceptable? Are there inappropriate marketing practices?
   c. Are the assumptions (loss development, trend, expense load, profit provision, credibility etc.) used to develop the rate indication appropriate? Are they supported with data and are deviations from data results sufficiently explained?
   d. Is the weighting of data by year (or credibility) properly justified or does it appear random?
      • Is there more weight being placed on data in one year solely because it produces a higher indicated rate change?
      • If there are two indications being weighted together and one is for a rate increase and one is a rate decrease, is the weighting justified?
   e. Is there satisfactory explanation about why a proposed rate change deviates from the indicated rate change?

3. Regarding differences in assumptions from previous filings:
   a. Have methodologies changed significantly?
   b. Are assumptions for the weighting of years or credibility significantly different? Or does there appear to be some manipulation to the rate indication?

4. Is there unfair discrimination?
   a. Do classifications comply with state requirements?
   b. Are proposed rates established so that different classes will produce the same underwriting results?
Draft: 12/7/19
As adopted by the Casualty Actuarial and Statistical (C) Task Force on XX/XX/XX

3. If predictive models are used in the rating plan, are there concerns related to input variables that are prohibited or proxies for prohibited variables?

5. What do you need to communicate?
   a. Can you explain why you are taking a specific action on the filing?
   b. What do you need to tell the Consumer Services Department?
      • Can you explain the impact of the rate change on current business? How big is the company and how much of the market is impacted?
      • What are the biggest changes in the filing (and the ones on which consumer calls might be expected)?
      • What is the maximum rate change impact on any one policyholder?

Questions to Ask a Company

If you remain unsatisfied that the company has satisfactorily justified the rate change, then consider asking additional questions of the company. Questions should be asked of the company when they have not satisfied statutory or regulatory requirements in the state or when any current justification is inadequate and could have an impact on the rate change approval or the amount of the approval.

If there are additional items of concern, the company can be notified so they will make appropriate modifications in future filings.

The CASTF white paper, Regulatory Review of Predictive Models, documents questions that a regular may want to ask when reviewing a model. These questions are listed in the Predictive Model – Information for Regulatory Review section of the white paper. Note that although the white paper focuses on GLMs for home and private passenger auto insurance, some of the concepts may be transferable to other types of models and/or other lines of business.

Additional Ratemaking Information

The Casualty Actuarial Society (CAS) and the Society of Actuaries (SOA) have extensive examination syllabi that contain a significant amount of ratemaking information, on both the basic topics covered in this chapter and on advanced ratemaking topics. The CAS and SOA websites contain links to many of the papers included in the syllabus. Recommended reading is the Foundations of Casualty Actuarial Science, which contains chapters on ratemaking, risk classification, and individual risk rating.

Other Reading

Some additional background reading is recommended:

  o Chapter 1: Introduction
  o Chapter 3: Ratemaking
  o Chapter 6: Risk Classification
  o Chapter 9: Investment Issues in Property-Liability Insurance
  o Chapter 10: Only the section on Regulating an Insurance Company, pp. 777-787
- Casualty Actuarial Society (CAS) Statements of Principles, especially regarding property and casualty ratemaking.
- Association of Insurance Compliance Professionals: “Ratemaking—What the State Filer Needs to Know.”
- Review of filings and approval of insurance company rates.

Summary

Commented [DK10]: Page 36 of the Handbook
Commented [DK11]: REFERENCES INCLUDED IN THE WHITE PAPER WILL BE ADDED
Commented [DK12]: Page 37 of the Handbook
Rate regulation for property/casualty lines of business requires significant knowledge of state rating laws, rating standards, actuarial science, statistical modeling and many data concepts.

- Rating laws vary by state, but the rating laws are usually grouped into prior approval, file and use or use and file (competitive), no file (open competition), and flex rating.
- Rate standards typically included in the state rating laws require that “Rates shall not be inadequate, excessive, or unfairly discriminatory.”
- A company will likely determine their indicated rate change by starting with historical years of underwriting data (earned premiums, incurred loss and loss adjustment expenses, general expenses) and adjusting that data to reflect the anticipated ultimate level of costs for the future time period covered by the policies. Numerous adjustments are made to the data. Common premium adjustments are on-level premium, audit, and trend. Common loss adjustments are trend, loss development, Catastrophe/large loss provisions, and an adjusting and other (A&O) loss adjustment expense provision. A profit/contingency provision is also calculated to determine the indicated rate change.
- Once an overall rate level is determined, the rate change gets allocated to the classifications and other rating factors.
- Individual risk rating allows manual rates to be modified by an individual policyholder’s own experience.
- Advisory organizations provide the underlying loss costs for companies to be able to add their own expenses and profit provisions (with loss cost multipliers) to calculate their insurance rates.
- Casualty Actuarial Society’s Statement of Principles Regarding Property and Casualty Insurance Ratemaking provides guidance and guidelines for the numerous actuarial decisions and standards employed during the development of rates.
- NAIC model laws also include special provisions for workers’ compensation business, penalties for not complying with laws, and competitive market analysis to determine whether rates should be subject to prior approval provisions.
- Best practices for reviewing predictive models are provided the CASTF white paper titled Regulatory Review of Predictive Models. Although the white paper focuses on GLMs for home and private passenger automobile insurance, some of the concepts may be transferable to other types of models and/or other lines of insurance.

While this chapter provides an overview of the rate determination/actuarial process and regulatory review, state statutory or administrative rule may require the examiner to adopt different standards or guidelines than the ones described.

No additional changes are proposed to the Product Filing Review Handbook.

**IX. PROPOSED STATE GUIDANCE**

TBD – placeholder for guidance for rate filings that are based on predictive model

This paper acknowledges that different states will apply the guidance within it differently, based on variations in the legal environment pertaining to insurance regulation in those states, as well as the extent of available resources, including staff members with actuarial and/or statistical expertise, the workloads of those staff members, and the time that can be reasonably allocated to predictive-model reviews. States with prior-approval authority over personal-lines rate filings often already require answers in connection with many of the information elements expressed in this paper. However, states—including those with and without prior-approval authority—may also use the guidance in this paper to choose which model elements to focus on in their reviews and/or to train new reviewers, as well as to gain an enhanced understanding of how predictive models are developed, supported, and deployed in their markets. Ultimately, the insurance regulators within each state will decide how best to tailor the guidance within this paper to achieve the most effective and successful implementation, subject to the framework of statutes, regulations, precedents, and processes that comprise the insurance regulatory framework in that state.

**X. OTHER CONSIDERATIONS**

During the development of this guidance, topics arose that are not addressed in this paper. These topics may need addressing during the regulator’s review of a predictive model. A few of these issues may be discussed elsewhere within NAIC. All of these issues, if addressed, will be handled by each state on a case-by-case basis. A sampling of topics for consideration in this section include:
XI. RECOMMENDATIONS GOING FORWARD

The following are examples of topics that may be included in the recommendations:

- TBD: Discuss confidentiality as it relates to filings submitted via SERFF
- TBD: Discuss confidentiality as it relates to state statutes and regulations.
- TBD: Discuss policyholder disclosure when complex predictive model underlies a rating plan.
- TBD: Discuss the need for NAIC to update and strengthen information-sharing platforms and protocols.
- TBD: Determine the means available to a consumer to correct or contest individual data input values that may be in error.
- TBD: Given an insurer’s rating plan relies on a predictive model and knowing all characteristics of a risk, discuss a regulator's ability/need to audit/calculate the risk’s premium without consultation with the insurer.
- Other TBDs
XII. APPENDIX A – BEST PRACTICE DEVELOPMENT

Best-practices development is a method for reviewing public policy processes that have been effective in addressing particular issues and could be applied to a current problem. This process relies on the assumptions that top performance is a result of good practices and these practices may be adapted and emulated by others to improve results\(^\text{1}^\). The term “best practice” can be a misleading one due to the slippery nature of the word “best”. When proceeding with policy research of this kind, it may be more helpful to frame the project as a way of identifying practices or processes that have worked exceptionally well and the underlying reasons for their success. This allows for a mix-and-match approach for making recommendations that might encompass pieces of many good practices\(^\text{1}^\).

Researchers have found that successful best-practice analysis projects share five common phases:

A. **Scope**

   The focus of an effective analysis is narrow, precise and clearly articulated to stakeholders. A project with a broader focus becomes unwieldy and impractical. Furthermore, Bardach urges the importance of realistic expectations in order to avoid improperly attributing results to a best practice without taking into account internal validity problems.

B. **Identify Top Performers**

   Identify outstanding performers in this area to partner with and learn from. In this phase, it is key to recall that a best practice is a tangible behavior or process designed to solve a problem or achieve a goal (i.e. reviewing predictive models contributes to insurance rates that are not unfairly discriminatory). Therefore, top performers are those who are particularly effective at solving a specific problem or regularly achieve desired results in the area of focus.

C. **Analyze Best Practices**

   Once successful practices are identified, analysts will begin to observe, gather information and identify the distinctive elements that contribute to their superior performance. Bardach suggests it is important at this stage to distill the successful elements of the process down to their most essential idea. This allows for flexibility once the practice is adapted for a new organization or location.

D. **Adapt**

   Analyze and adapt the core elements of the practice for application in a new environment. This may require changing some aspects to account for organizational or environmental differences while retaining the foundational concept or idea. This is also the time to identify potential vulnerabilities of the new practice and build in safeguards to minimize risk.

E. **Implementation and evaluation**

   The final step is to implement the new process and carefully monitor the results. It may be necessary to make adjustments, so it is likely prudent to allow time and resources for this. Once implementation is complete, continued evaluation is important to ensure the practice remains effective.

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XIII. APPENDIX B - GLOSSARY OF TERMS

Adjusting Data - TBD

Control Factor - TBD

Data source - TBD

Double-lift chart - TBD

Exponential Family - TBD

Fair Credit Reporting Act – The Fair Credit Reporting Act (FCRA), 15 U.S.C. § 1681 (FCRA) is U.S. Federal Government legislation enacted to promote the accuracy, fairness and privacy of consumer information contained in the files of consumer reporting agencies. It was intended to protect consumers from the willful and/or negligent inclusion of inaccurate information in their credit reports. To that end, the FCRA regulates the collection, dissemination and use of consumer information, including consumer credit information.\(^{14}\) Together with the Fair Debt Collection Practices Act (FDCPA), the FCRA forms the foundation of consumer rights law in the United States. It was originally passed in 1970 and is enforced by the US Federal Trade Commission, the Consumer Financial Protection Bureau and private litigants.

Generalized Linear Model - TBD

Geodemographic - Geodemographic segmentation (or analysis) is a multivariate statistical classification technique for discovering whether the individuals of a population fall into different groups by making quantitative comparisons of multiple characteristics with the assumption that the differences within any group should be less than the differences between groups. Geodemographic segmentation is based on two principles:

Home Insurance – TBD

Insurance Data - TBD

Linear Predictor - TBD

Link Function - TBD

Non-Insurance Data - TBD

Offset Factor – TBD

Overfitting - TBD

1. People who live in the same neighborhood are more likely to have similar characteristics than are two people chosen at random.

2. Neighborhoods can be categorized in terms of the characteristics of the population that they contain. Any two neighborhoods can be placed in the same category, i.e., they contain similar types of people, even though they are widely separated.

PCA Approach (Principal Component Analysis) – The method creates multiple new variables from correlated groups of predictors. Those new variables exhibit little or no correlation between them—thereby making them potentially more useful in a GLM. A PCA in a filing can be described as “a GLM within a GLM.” One of the more common applications of PCA is geodemographic analysis, where many attributes are used to modify territorial differentials on, for example, a census block level.

Private Passenger Automobile Insurance – TBD

Probability Distribution - TBD

Rating Algorithm – TBD

As adopted by the Casualty Actuarial and Statistical (C) Task Force on 12/7/19

Rating Plan – TBD
Rating System – TBD
Scrubbing data - TBD
Sub-Model - any model that provides input into another model.
Univariate Model - TBD
Etc.
XIV. APPENDIX C – SAMPLE RATE-DISRUPTION TEMPLATE

<table>
<thead>
<tr>
<th>State Division of Insurance - EXAMPLE for Rate Disruption</th>
<th>Template Updated October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum % Change</td>
<td>-30.000%</td>
</tr>
<tr>
<td>Maximum % Change</td>
<td>30.000%</td>
</tr>
<tr>
<td>Total Number of Insureds (Auto-Calculated)</td>
<td>1994</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent-Change Range</th>
<th>Uncapped Rate Disruption</th>
<th>Capped Rate Disruption (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Insureds in Range</td>
<td>Number of Insureds in Range</td>
<td>Number of Insureds in Range</td>
</tr>
<tr>
<td>-30% to &lt; -25%</td>
<td>2</td>
<td>-15% to &lt; -10%</td>
</tr>
<tr>
<td>-25% to &lt; -20%</td>
<td>90</td>
<td>-10% to &lt; -5%</td>
</tr>
<tr>
<td>-20% to &lt; -15%</td>
<td>130</td>
<td>-5% to &lt; 0%</td>
</tr>
<tr>
<td>-15% to &lt; -10%</td>
<td>230</td>
<td>Exactly 0%</td>
</tr>
<tr>
<td>-10% to &lt; -5%</td>
<td>340</td>
<td>&gt;0% to &lt;5%</td>
</tr>
<tr>
<td>-5% to &lt;0%</td>
<td>245</td>
<td>5% to &lt;10%</td>
</tr>
<tr>
<td>Exactly 0%</td>
<td>12</td>
<td>10% to &lt;15%</td>
</tr>
<tr>
<td>&gt;0% to &lt;5%</td>
<td>150</td>
<td>15% to &lt;20%</td>
</tr>
<tr>
<td>5% to &lt;10%</td>
<td>160</td>
<td></td>
</tr>
<tr>
<td>10% to &lt;15%</td>
<td>401</td>
<td></td>
</tr>
<tr>
<td>15% to &lt;20%</td>
<td>201</td>
<td></td>
</tr>
<tr>
<td>20% to &lt;25%</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>25% to &lt;30%</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>30% to &lt;35%</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

EXAMPLE Uncapped Rate Disruption

Number of Insureds in Range
EXAMPLE Capped Rate Disruption

<table>
<thead>
<tr>
<th>Percentage Increase</th>
<th>Corresponding Dollar Increase (If Insured Receives Largest Percentage Increase)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncapped Change</td>
<td>30.00%</td>
</tr>
<tr>
<td>Capped Change (if applicable)</td>
<td>15.00%</td>
</tr>
<tr>
<td>Capped $ Change (if applicable)</td>
<td>$82.50</td>
</tr>
</tbody>
</table>

Characteristics of Policy (Fill In Below)

- For Auto Insurance: At minimum, identify the age and gender of each named insured, limits by coverage, territory, make / model of vehicle(s), prior accidents, violations, licenses, claims, claims history, and other key attributes. Wholesome information, are allowed by this filing.
- For Home Insurance: At minimum, identify age and gender of each named insured, amount of insurance, territory, construction type, protection class, any prior loss history, and any other key attributes whose treatments are affected by this filing.

Automobile policy: Three insured male (age 38), female (age 46), and male (age 28). Territory Las Vegas, ZIP Code 89103.

<table>
<thead>
<tr>
<th>Vehicle:</th>
<th>BI Limits:</th>
<th>PD Limits:</th>
<th>UMB/UMB Limits:</th>
<th>MED Limits:</th>
<th>COMP Deductible:</th>
<th>COLL Deductible:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000 Ford Focus</td>
<td>$50,000 / $100,000</td>
<td>$50,000 / $100,000</td>
<td>$5,000</td>
<td>$500</td>
<td>$1,000</td>
<td></td>
</tr>
<tr>
<td>2003 Honda Accord</td>
<td>$75,000 / $50,000</td>
<td>$10,000</td>
<td>$12,000 / $50,000</td>
<td>$5,000</td>
<td>$1,000</td>
<td></td>
</tr>
</tbody>
</table>

No prior accidents, 3 prior speeding violations for 25-year-old male. Policy receives EFT discount and loyalty discount.

Primary impacts are the increases to the relativities for the age of insured, ZIP Code 89103, COLL Deductible of $1,000, and symbol for 2003 Honda Accord.

Must Significant Impacts to This Policy (Identify attributes - e.g., base-rate change or changes to individual rating variables)

NOTE: If capping is proposed to apply for this policy, include the impact of capping at the end, after displaying uncapped impacts by attribute. Add rows as needed. Total percent and dollar impacts should reconcile to the values presented above in this exhibit.

<table>
<thead>
<tr>
<th>Attribute</th>
<th>% Impact (Uncapped)</th>
<th>Dollar Impact (Uncapped)</th>
<th>What lengths of policy terms does the insurer offer in this book of business?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured Age (40/25)</td>
<td>12.00%</td>
<td>$60.65</td>
<td>Check all options that apply below.</td>
</tr>
<tr>
<td>COLL Deductible ($1,000)</td>
<td>10.00%</td>
<td>$63.60</td>
<td>12-Month Policies</td>
</tr>
<tr>
<td>Territory (89105)</td>
<td>4.00%</td>
<td>$27.20</td>
<td>6-Month Policies</td>
</tr>
<tr>
<td>Vehicle Symbol (2003 Honda Accord)</td>
<td>1.46%</td>
<td>$40.20</td>
<td>3-Month Policies</td>
</tr>
<tr>
<td>Effect of capping</td>
<td>-11.54%</td>
<td>-$62.35</td>
<td>Other (SPECIFY)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25.00%</td>
<td>$82.50</td>
<td></td>
</tr>
</tbody>
</table>

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State Division of Insurance - EXAMPLE for Largest Dollar Increase

Template Updated October 2018

Largest Dollar Increase

<table>
<thead>
<tr>
<th>Uncovered Change</th>
<th>Current Premium</th>
<th>$306.60</th>
<th>Uncapped Percent Change</th>
<th>12.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capped Change (If Applicable)</td>
<td>Proposed Premium</td>
<td>$306.60</td>
<td>Capped Percent Change (If Applicable)</td>
<td>12.00%</td>
</tr>
</tbody>
</table>

Characteristics of Policy (Fill in Below)

- For Auto Insurers: At minimum, identify the age and gender of each named insured, limits by coverage, territory, model of vehicle(s), prior accident/violation history, and any other key attributes whose treatments are affected by this filing.

- For Home Insurers: At minimum, identify age and gender of each named insured, amount of insurance, territory, construction type, protection class, any prior loss history, and any other key attributes whose treatments are affected by this filing.

Table: Automobile Policy: Two Insurers - Male (Age 35), Female (Age 32), Territory: Rhode, ZIP Code 89504

<table>
<thead>
<tr>
<th>Vehicle:</th>
<th>BI Limits:</th>
<th>$200,000 / $600,000</th>
<th>PO Limits:</th>
<th>$50,000</th>
<th>UM/UM Limits:</th>
<th>$200,000 / $600,000</th>
<th>MED Limits:</th>
<th>$10,000</th>
<th>COMP Deductible:</th>
<th>$2,500</th>
<th>COLL Deductible:</th>
<th>$1,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Tesla Model S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015 Mercedes-Benz C-Class</td>
<td>$200,000 / $600,000</td>
<td>$50,000</td>
<td>$200,000 / $600,000</td>
<td>$10,000</td>
<td>$2,500</td>
<td>$1,500</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 prior at-fault accident for 50-year-old female. Policy receives EFT discount and loyalty discount.

Primary impacts are the increases to the relative impacts for the age of insured, symbol for 2015 Mercedes-Benz C-Class, and increased-limit factors for Property Damage and Medical Payments coverage.

Most Significant Impacts to This Policy (Identify attributes - e.g., base-rate change or changes to individual rating variables)

<table>
<thead>
<tr>
<th>Attribute</th>
<th>% Impact (Uncapped)</th>
<th>Dollar Impact (Uncapped)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured Age (M/31)</td>
<td>3.15%</td>
<td>$86.64</td>
</tr>
<tr>
<td>Insured Age (F/32)</td>
<td>3.23%</td>
<td>$85.13</td>
</tr>
<tr>
<td>Vehicle Symbol (2015 Mercedes-Benz C-Class)</td>
<td>2.45%</td>
<td>$66.61</td>
</tr>
<tr>
<td>Increased Limit Factor for PD</td>
<td>1.55%</td>
<td>$45.30</td>
</tr>
<tr>
<td>Increased Limit Factor for MED</td>
<td>1.10%</td>
<td>$31.34</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12.00%</td>
<td>$306.60</td>
</tr>
</tbody>
</table>

Note: If capping is proposed to a policy, include the impact of capping at the end, after displaying uncapped impacts by attribute. Add rows as needed. Total percent and dollar impacts should reconcile to the values presented above in this exhibit.

XV. APPENDIX D – INFORMATION NEEDED BY REGULATOR MAPPED INTO BEST PRACTICES

TBD

XVI. APPENDIX E – REFERENCES

TBD

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Re: CASTF Regulatory Review of Predictive Models White Paper

Ms. DeFrain,

Several members of the CAS Ratemaking Research Committee have discussed the draft white paper on “Regulatory Review of Predictive Models”.

We thank you for the work that the CASTF is doing to address the regulatory challenge inherent in reviewing the use of predictive models in insurance. These techniques are only likely to increase in use and a framework which may accommodate their implementation is something which is in the best interest of regulators, the insurance industry and consumers.

We have made the following comments:

• Product Filing Review Handbook
  o The following statement appears in Chapter 3: Data Adjustments of the handbook: “Because the insurance contracts will be written to cover future accident periods, the past data needs to be adjusted to reflect the anticipated future premiums and costs. These adjustments will provide a profit/loss picture if no rate change occurs. Calculations can then be made to determine the overall rate need (or indication).”
  o Making adjustments to the data bakes assumptions into the adjusted data. The uncertainty of those assumptions, after being baked in, cannot be recognized. Some modern statistical modeling methodologies allow adjustments such as trend to be modeled. This allows the parameter estimates and the uncertainty around the parameter estimates to be understood better, which allows better decision making to take place. A more appropriate wording would be “may need to be adjusted”.

• VIII. PROPOSED CHANGES TO THE PRODUCT FILING REVIEW HANDBOOK
  o Section titled “Interaction between Rating Variables (Multivariate Analysis)” states “If the pricing of rating variables is evaluated separately for each rating variable, there is potential to miss the interaction between rating variables.”
  o We would rephrase this as “If each rating variable is evaluated separately, statistically significant interactions between rating variables will not be identified and thus, not included in the rating plan.”
  o It is quite possible for models (specifically neural net and tree-based models such as random forest or xgboost) to contain relationships between variables for which an intuitive explanation is not immediately obvious. Further, such models can also include hundreds of such relationships.
CHAPTER THREE - The Basics of Property and Casualty Rate Regulation

Section: “Interaction between Rating Variables (Multivariate Analysis)”
  - It seems as though the term “interaction” is not being used in its technical sense. Rather, it appears to refer to multivariate modeling generally and not to the more precise use of the term “interaction” in a linear modeling context. Later, the word “interaction” is used in a way that suggests it is synonymous with correlation.

Section: “Approval of Classification System”
  - “You should be aware of your state’s laws and regulations regarding which rating factors are allowed.” We would suggest adding to that sentence, “, and you should require definitions of all data elements that can affect the charged premium.”
  - The sentence “Finding rating or underwriting characteristics that may violate public policy is becoming more difficult for regulators with the increasing and innovative ways insurers use predictive models.” was added. We feel this sentence warrants further explanation. The draft states that identification of public policy violations “is becoming more difficult”. How is this so?
  - Further, the phrase “increasing and innovative ways insurers use predictive models” leaves one with the sense that insurers would willingly game or obfuscate their models to circumvent compliance. While the reviewers are aware that proxy variables (which the draft references later) may inadvertently enter an insurer’s model, this does not happen as part of an effort to contravene public policy.

Section: “Predictive Modeling”, part A “Generalized Linear Models”
  - We again note that there is a singular emphasis on GLMs. We will reiterate our concern that other models like neural networks, generalized additive models, gradient boosting machines, etc. are addressed only superficially. Insurers may develop the impression that these models will not get a fair or informed reception. Also, regulators may conclude that other kinds of models are inherently inappropriate for use.

  - Bullet 1
    - Part (a) should also be based on the impact from any selected factors. GLMs could include selected factors within the offset.
    - Also in part (a), if the insurer is using any selected factors, they should examine them in light of the factors suggested by the model.
    - Part (b) requests the regulator should “Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers.” Reviewing the disruption for individual policyholders could require sharing significant amounts of data, and the insurer may have contractual limitations regarding the ability to share such data.
    - For part (b), we feel that regulators should be asking for a histogram of rate changes, with the expectation that there are not a lot of outliers. An explanation of individual changes feels like overreach. Moreover, this level of detail does not aid speed to market.
Bullet 2 - “Thoroughly review all aspects of the model including the source data, assumptions, adjustments, variables, and resulting output.”

- We are troubled by the use of the word “thoroughly”, particularly with respect to data. Actuaries and data scientists would consider a “thorough” review of the source data to require direct access to the data and include exploratory data analysis beyond the capabilities of most DOIs. Additionally, insurers historically are usually not asked to provide such detailed data for a rate filing. Suggested rewording “Obtain a clear understanding of the data used to build and validate the model, and thoroughly review all other aspects of the model, including assumptions, adjustments, variables, and resulting output.”

- We presume that response to bullets a-e is done by response to a request from a DOI. The DOI should ask for information rather than carrying out the analysis themselves.

- We are not clear on the difference between items (a) and (d). Item (d) could be eliminated via some re-wording of item (a).

- In item (a), we again note the use of the word “intuitive”. In this context, the word “or” has been added, which we presume considers the fact that insurers may have fair and accurate models for which there is no ready intuitive explanation (see similar point above).

Bullet 3

- Item (b) references “private passenger automobile or homeowner’s insurance”. We feel that specific lines of business do not need to be mentioned. None of the other items in this outline specify lines of business.

- We are not wholly clear on item (c). Examination of “non-modeled characteristics” can be very broad.

- Page 28, section “Capping and Transition Rules”
  - How does the regulatory position on min-max rates affect capping and transition?

- Top of page 30, item 4c
  - “If predictive models are used in the rating plan, are there concerns related to input variables that are prohibited or proxies for prohibited variables?” We feel this is a fair question.

Once again, we thank you for your consideration of these points and welcome the opportunity to discuss with you or any members of the CASTF.

Regards,

Ron Lettofsky
Dan Closter
Aditya Khanna
Greg Frankowiak
Sandra Callanan
Brian Fannin
Re: 8/8/19 Draft White Paper on Best Practices

Dear Ms. DeFrain,

Insurance Services Office, Inc. (ISO) is a countrywide licensed rating/advisory organization serving the property/casualty market. We have extensive experience and expertise in the development of advisory insurance pricing tools including prospective loss costs, rating plans and predictive analytics, including related regulatory issues.


Generally, we think it is premature to start drafting the changes to the “Product Review Handbook” while the best practices themselves are still in draft form and could materially change.

That being said, here are some detailed comments on the draft.

- There are a few places in the draft where the text provides opinion or conjecture that would not be relevant to reviewing a filing containing a predictive model. For example, on the top of page 27 the following statement appears – “A GLM rate model for personal lines in 2019 is either an update or a late adopter's defensive tactic. “
- On page 26 in the GLM bullet-list, the first bullet states “each component of Y is independent...” but “Y” is never introduced nor defined.
- This statement “Best practices can, also, make the regulator's review more consistent across states and more efficient, and assist companies in getting their products to market
"Best practices can also increase the consistency among the regulatory review processes used across states and improve the efficiency of each regulator’s review thereby assisting companies in getting their products to market faster."

Respectfully Submitted,

Stephen C. Clarke, CPCU
### General, Non-Specific Comments by Third-Parties on Best Practices for Regulatory Review of Predictive Analytics White Paper

**Text from 5-14-2019 Exposure**

<table>
<thead>
<tr>
<th>Commenter</th>
<th>Commenter’s Suggestion</th>
<th>Final Ad Hoc Team Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAMIC</td>
<td>NAMIC would again thank the Task Force for its thorough consideration of this area of regulation. However, while positive intentions were unquestionably exhibited in this second exposure draft, significant concerns remain. There is legitimate thought that these best practices will be adopted as standard practice by regulators, and the amount of time and energy needed to provide this level of detail will still be significant as well as directly impact the industry’s ability to develop and implement models in a timely manner. NAMIC would implore the Task Force to consider these comments in drafting further exposures of this white paper. NAMIC looks forward to continuing to work with the Task Force on this critical effort.</td>
<td>No change recommended. We believe that there is a misunderstanding between the terms “best practices” and “information elements” that have been identified in this paper. Many comments appear to interpret “information elements” to mean “best practices” and as such have concerns. We believe the concerns raised in this and other similar comments is with the “information elements” that regulators may find helpful when applying the “best practices.” We believe each information element listed can be useful to a regulator’s understanding of a filed predictive model. However, we will continue to revisit the importance of each informational element and revise the level of importance as needed.</td>
</tr>
</tbody>
</table>

| NAMIC     | As mentioned in our prior comments, there are still overarching concerns about 1. the prescriptive nature of these best practices, 2. the scope and requirements of the paper, 3. the exposure of sensitive data to release even when not specifically required, 4. confidentiality and proprietary concerns, and 5. removal of regulator discretion to ascertain their baseline needs to approve a filing. NAMIC believes the best practices are somewhat drafted in a vacuum of extreme best-case actuarial perfection as opposed to real world needs of regulators and protection of consumers. | No change recommended. 1. The best practices are not prescriptive but are the informational elements that may be needed by the regulator to address the best practice that are, and should be, prescriptive. 2. The scope of the charges leading to this white paper were broad. By necessity, the scope of this paper was narrowed to GLMs and for point of reference purposes, those used in personal auto and home rate filings. We believe that the best practices, in general, are transferable to other types of models and apply to all lines of business. However, such analysis will be addressed in the future as needed. 3. A component of rate regulation is for the regulator to understand the rating plan in sufficient detail to determine that it meets the statutory requirements of their state, including whether the rating plan produces rates that are inadequate, excessive, or unfairly discriminatory and does not use rating variables otherwise prohibited by state law. The use of increasingly complex rating plans requires each state regulator to decide what information they need to evaluate the rating plan in accordance with their state laws. This white paper assists the regulator by providing areas that may be of importance (best practices) to understanding any filed rating plan. 4. As is currently the case, sensitive data that the regulator may receive in the review of a rate filing is subject to the confidentiality laws of each state. Both insurers and regulators must continue to handle sensitive data in accordance with state law. 5. We do not believe the white paper removes regulator discretion as to what information they require in order for the regulator to review a rate filing in accordance with state law. We do believe that the white paper will assist regulators in performing more informed rate plan reviews. 6. We believe that there is a misunderstanding between the terms “best practices” and “information elements” that have been identified in the white paper. Many comments appear to interpret “information elements” to mean “best practices” and therefore have a concern. The concern raised in this and similar comments is with the “information elements” that regulators may find helpful when addressing the “best practices.” We believe all “information elements” listed in the paper can be useful to a regulator’s understanding of a filed predictive model and will result in a more efficient review of a filing that includes a model. However, we will continue to revisit the importance of each informational element and revise the |
## General, Non-Specific Comments by Third-Parties on Best Practices for Regulatory Review of Predictive Analytics White Paper

**Text from 5-14-2019 Exposure**

<table>
<thead>
<tr>
<th>Commenter Name</th>
<th>Commenter’s Suggestion</th>
<th>Final Ad Hoc Team Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAMIC</td>
<td>The entire concept of the paper seems to suggest a one-size-fits-all approach. Insurers should be able to develop proprietary business models that shouldn’t necessarily raise alarms or flags to regulators. NAMIC believes that there should be baseline threshold analysis to allow the regulator to perform their mandated tasks, but the paper creates a super paradigm as opposed to baseline needs. Certainly, however, a regulator would be free to ask for more information where there is a demonstrated need or concern. No change recommended.</td>
<td></td>
</tr>
<tr>
<td>NAMIC</td>
<td>There is concern about statements that all of the data regardless of a concern or need should be submitted initially to avoid delay. Causing the accumulation of vast quantities of data that might only be potentially reviewed, not only wastes time, capital, and human effort for speculative need but allows for other unintended consequences. Additionally, it exposes this sensitive and proprietary data to breaches and other data releases. As this information is being requested by the regulator, there is an enormous duty to protect the information from exposure. Therefore, the efficacy of the all in approach should be revised, reviewed, and potentially removed as a policy and as mentioned or inferred in the paper. No change recommended.</td>
<td></td>
</tr>
<tr>
<td>CT DOI</td>
<td>There are different standards, programming tools, and criteria used in evaluating the effectiveness in developing models. We would encourage an in-person focus on the insurance company’s peer review processes and internal documents regarding consistency, correlation, converging criteria, etc. in model building. This focus could be more effective use of regulators limited resources. No change recommended.</td>
<td></td>
</tr>
<tr>
<td>CAS</td>
<td>The volume and complexity of the proposed guidelines seems counter to the desire to improve “speed to market” mentioned several times in the paper. Consumer protection is not secondary to speed to market. If a state requires that filers provide documentation with the initial submission of the filing, this should alleviate protracted interrogatories and increase speed to market. No change recommended.</td>
<td></td>
</tr>
</tbody>
</table>

The white paper does not create a one-size-fits-all for model development or regulatory review. There is regulator discretion as to what information they require in order for the regulator to review a rate filing in accordance with state law. The white paper will assist regulators in performing more informed rate plan reviews. We believe that there is a misunderstanding between the terms “best practices” and “information elements” identified in this paper. The concern raised in this and similar comments is with the “information elements” that regulators may find helpful when applying the “best practices.” We believe all “information elements” listed in the paper can be useful to a regulator’s understanding of a filed predictive model. We will continue to revisit the importance of each informational element and revise the level of importance as needed.

The intent is not to waste time, capital or human effort. Not all “information elements” need to be submitted initially. As with the current state-based regulatory scheme, each state will decide the information needed initially and as the need arises. We believe each information element listed can be useful to the regulator’s understanding of a filed predictive model. We will continue to revisit the importance of each informational element and revise the level of importance as needed.

The purpose of this white paper is to provide best practices. Each state can tailor how it approaches a specific company’s rate review.
<table>
<thead>
<tr>
<th>Commenter Name</th>
<th>Commenter’s Suggestion</th>
<th>Final Ad Hoc Team Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDIA</td>
<td>We are not convinced that including CBIS in this type of review is mission critical. Yet, if this review needs to be in the process, CDIA recommends the establishment of highly specific rules to protect confidentiality and proprietary information. Additionally, a separate review process of sub-models as an optional request with defined valid concerns making it mandatory would help in addressing concerns.</td>
<td>No change recommended. Review of CBIS models is &quot;mission critical&quot; for understanding the impacts of a rating plan that utilizes credit information and evaluating the fairness of the credit-based treatments for consumers. Many states have been reviewing CBIS models in detail for 1-2 decades and have already established appropriate confidentiality protections where consistent with state law.</td>
</tr>
<tr>
<td>CDIA</td>
<td>There is already a large regulatory review presence on the industry. It is already overseen at the federal level by the Consumer Financial Protection Bureau (CFPB) and Federal Trade Commission (FTC), along with several states implementing their own regulations and the Conference of State Banking Commissioners looking into the industry as well. This increased regulation not only hurts the industry, but the consumers it serves. It will significantly hamper speed to market for the products consumers need and does not appear to add much, if any, benefit to the outcome for the industry and its consumer.</td>
<td>No change recommended. Neither the CFPB nor the FTC appear to have delved in depth into the specific workings of CBIS models at the level of scrutinizing support for particular variables and not just the model as a whole. General federal consumer protection requirements, aimed at FCRA compliance and accuracy of credit-report information, do not by themselves achieve the objective of reviewing whether credit-based rating treatments and the types of variables used are fair to consumers, reasonably related to the risk of insurance loss, and not unfairly discriminatory. Insurance is regulated on the state level; each State is responsible for and has the prerogative to engage in additional model reviews as appropriate to protect its consumer constituencies.</td>
</tr>
<tr>
<td>Ad Hoc</td>
<td>Change references &quot;private passenger automobile&quot; or &quot;PP A&quot; and 'homeowner's' to &quot;personal automobile&quot; and &quot;home&quot; throughout paper.</td>
<td>Change references &quot;private passenger automobile&quot; or &quot;PP A&quot; and 'homeowner's' to &quot;personal automobile&quot; and &quot;home&quot; throughout paper.</td>
</tr>
</tbody>
</table>

Text from 5-14-2019 Exposure

I. INTRODUCTION

Insurers' use of predictive analytics along with big data has significant potential benefits to both consumers and insurers. Predictive analytics can reveal insights into the relationship between consumer behavior and the cost of insurance, lower the cost of insurance for many, and provide incentives for consumers to better control and mitigate loss. However, predictive analytic techniques are evolving rapidly and leaving many regulators without the necessary tools to effectively review insurers' use of predictive models in insurance applications.

When a rate plan is truly innovative, the insurer must anticipate or imagine the reviewers’ interests because reviewers will respond with unanticipated questions and have unique educational needs. Insurers can learn from the questions, teach the reviewers, and so forth.

This paper will identify best practices when reviewing predictive models and analytics filed by insurers to promote the art of reviewing predictive models within a rate filing. Upon adoption of this paper, insurance companies filing rating plans that incorporate predictive models will have a guide to state insurance departments in their review of predictive models underlying rating plans. There were two key regulatory principles outlined in the white paper.

This paper will identify best practices when reviewing predictive models and analytics filed by insurers to meet or exceed reviewers' needs and expectations. Hopefully, this paper helps bring more consistency and to the art of reviewing predictive models within a rate filing.

WHAT IS A "BEST PRACTICE?"

A best practice is a form of program evaluation in public policy. At its most basic level, a best practice is a "tangible and visible behavior… [based on] an idea about how the actions…will solve a problem or achieve a goal" [2]. Best practices are used to benchmark. [3] Therefore, a best practice represents an effective method of problem solving. The "problem" regulators face is whether models, as used in rate filings, are compliant with state laws and regulations?

In this paper, best practices are presented in the form of guidance to regulators who review predictive models and analytics filed by insurers with regulators to justify rates and provide state guidance for review of rate filings based on predictive models. This paper is intended to serve as a guide to state insurance departments in their review of predictive models filed by insurers to justify rates and provide state guidance for review of rate filings based on predictive models.

Guidance will identify specific information where appropriate, provide insight as to when the information might identify an issue the regulator needs to be aware of or state regulatory principles.

In this paper, best practices are based on the following principles that promote a comprehensive and coordinated review of predictive models:

1. Risk/Regulatory Principles

2. Insurers' own models and analytics are to be handled in a future draft of the white paper.
The term "predictive model" refers to a set of models that use statistics to predict outcomes. GLMs (Generalized Linear Models) are commonly used predictive models in insurance applications, particularly in building an insurance product's rating plans. Before GLMs became vogue, rating plans were built using univariate methods. Univariate methods were considered intuitive and easy to demonstrate the relationship to costs (loss and/or expense). Today, many insurers consider univariate methods too simplistic since they do not take into account the interaction (or dependencies) of the selected input variables. The GLMs introduce significant improvements over the use of univariate methods.

As can be seen in the description of the three GLM components above, it may take more than a casual introduction to statistics to comprehend the construction of a GLM. As stated earlier, a downside to GLMs is that it is more challenging to select relativities without much data. The paper's intent is not to restrict regulator discretion. Maybe the best way to address/clarify this is to revisit the levels of importance definitions and assignments, and to create a core set of information elements that should be in every filing that includes a model. GLMs effectively assume that the underlying datasets are 100% data, the resulting uncertainty would not be reflected in the GLM parameter estimates themselves (although it might be reflected in the output if some segments have little data, the resulting uncertainty would not be reflected in the GLM parameter estimates themselves (although it might be reflected in the output). GLM software provides point estimates and allows the modeler to consider standard errors and confidence intervals. GLM output is typically seen as a baseline for the industry, and relatively easier to explain than the underlying data. GLM results are not always intuitive, and the relationship may be difficult to explain. This is a primary reason regulators can benefit from best practices. GLM results are not always intuitive, and the relationship may be difficult to explain. This is a primary reason regulators can benefit from best practices.
<table>
<thead>
<tr>
<th>Page</th>
<th>Commenter Name</th>
<th>Commenter's Suggestion</th>
<th>Final Ad Hoc Team Recommendation</th>
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<tbody>
<tr>
<td>3/12</td>
<td>NAMEC</td>
<td>Further discursion in this area would state, for instance on page 5, where it states that GLM is a source of 100% credibility. Could provide confidence intervals and confidence, methods and etc. There are techniques such as partial real regression that tend credibility with a list and impose a model’s ability to generalise (not mentioned in the paper). Consequently, there is a concern of the following via perspective with statements concerning expectations therein.</td>
<td></td>
</tr>
<tr>
<td>3/12</td>
<td>CT DOI</td>
<td>In a GLM, the credibility is embedded in parameter calculation and the resulting certainty in the parameter is defined by confidence intervals and standard errors. The phrase ‘GLM output is typically assumed to be 100% credible…’ on page 3 of the exposure might have different implications and therefore interpretation.</td>
<td></td>
</tr>
<tr>
<td>3/12</td>
<td>California Department of Insurance</td>
<td>Because of this presumption in credibility, which may or may not be valid in practice, the modeler and the regulator reviewing the model would need to engage in thoughtful consideration when incorporating GLM output into a rating plan to ensure that model predictiveness is not compromised by a lack of actual credibility. Another consideration is the availability of big data, both internal and external, and may result in the selection of predictor variables that have spuriously correlated with the target variable. Therefore, to mitigate the risk that model credibility or predictiveness is lacking, a complete filing for a rating plan that incorporates GLM output should include validation evidence for the rating plan, not just the statistical model.</td>
<td></td>
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<tr>
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<td>CT DOI</td>
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<td></td>
<td>See NAMEC, new above sentence.</td>
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<td>California Department of Insurance</td>
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<td>3/14</td>
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<td>See response to CT’s comment on paragraph above.</td>
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<td>4/1</td>
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<td>See response to CT’s comment on paragraph above.</td>
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<td>1/4</td>
<td></td>
<td></td>
<td>See response to CT’s comment on paragraph above.</td>
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</table>
Ad Hoc Team recommendation to expose comments as of 10-14-2019

Text from 5-14-2019 Exposure

Exposed Sections I to VII (Intro) Commenter Name Commenter’s Suggestion Final Ad Hoc Team Recommendation

Page fn/5

include logistic regression, Poisson regression, gamma regression and multinomial regression.

fn/6 [6] More information on model elements can be found in most statistics' books.

Revise text to:

actuarial support or have limited resources to contract out for support when reviewing rate filings that include use of

Η/ŶĂĚĚŝƚŝŽŶƚŽƚŚĞŐƌŽǁŝŶŐĐŽŵƉůĞdžŝƚLJŽĨƉƌĞĚŝĐƚŝǀĞŵŽĚĞůƐ͕ŵĂŶLJƐƚĂƚĞŝŶƐƵƌĂŶĐĞĚĞƉĂƌƚŵĞŶƚƐĚŽŶŽƚŚĂǀĞšŶͲŚŽƵƐĞĂĐƚƵĂƌŝĂůƐƵƉƉŽƌƚŽƌƉƌĞĚŝĐƚșǀĞŵŽĚĞůƐ͍/ƚŵšŐŚƚďĞ

It might be better to ask this question another way: Are best practices in the review of predictive models of value to regulators and insurance companies? The answer is "yes" to both questions. Best practices will aid regulatory reviewers by raising their level of model understanding. With regard to scorecard models and the model algorithm, there is often not sufficient support for relative weight, parameter values, or scores of each variable. Best practices can potentially aid in addressing this problem.

Best practices merely provide guidance to regulators in their essential and authoritative role over the rating plans in their state.

· Best practices will lead to improved quality in predictive model reviews across states, aiding speed to market and competitiveness of the state marketplace.

· Best practices will aid training of new regulators and/or regulators new to reviewing predictive models. (This is especially useful for those regulators who do not actively participate in NACIC discussions related to the subject of predictive models.)

· Each regulator adopting best practices will be better able to identify the resources needed to assist their state in the review of predictive models.

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Best Practices for Regulatory Review of Predictive Analytics

Week 5: 3-9-2019 Exposure

Third-Party Comments on 5-3: Exposure of Complex/Model Best Practices White Paper

Final Ad Hoc Team Recommendation

Page 1

Paragraph

Exposed Pages 1 to 49 (in red)

Commenter Name

Commenter’s Suggestion

California Department of Insurance

The focus of this paper will be on GLMs used to create personal automobile and home insurance rating plans.

California Department of Insurance

The focus of this paper will be on GLMs used to create personal automobile and home insurance rating plans.

Note text:

Paragraph

California

The focus of this paper will be on GLMs used to create personal automobile and home insurance rating plans.

CT DOI

Although GLMs are a common form of predictive modeling techniques, some optimal models are

California Department of Insurance

Also, the legal antecedents constraints (including state variations) are likely to be more prevalent, and challenging, in personal lines. This paper's guidance is based on the focus of personal lines in 2014 to either a醒目 or an ante-adopters' defensive tactics. Adopting GLM for commercial lines has a shorter history.

Paragraph

California Department of Insurance

Also, the legal antecedents constraints (including state variations) are likely to be more prevalent, and challenging, in personal lines. This paper's guidance is based on the focus of personal lines in 2014 to either a醒目 or an ante-adopters' defensive tactics. Adopting GLM for commercial lines has a shorter history.
### Best Practices for Regulatory Review of Predictive Analytics White Paper

**Task Force 5-14-2019 Exposure**

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<tr>
<td>5/4</td>
<td>NAMIC</td>
<td>Confidentiality, Proprietary Information, Trade Secrets, Competitive Terms, and Information Sharing</td>
<td><em>Add a reminder to the introduction of information elements:</em> “When information elements identified are possibly confidential, proprietary or trade secret and should be treated as such according to requirements subjects the regulator to increased Freedom of Information Act requests, subpoenas, and other types of litigation when there has been demonstrated harm to others or triggers for the inquiry. Additionally, some proprietary models may have contractual terms that prevent disclosure of the information in the model.”</td>
<td>Add new paragraph with footnote: “Regulators should be aware of this state law on confidentiality when requesting data from insurers that may be proprietary or trade secret. For example, some proprietary models may have contractual terms that the insurer may not release to the public. Without these necessary protections, the data may have to be disseminated without an appropriate level of protection.”</td>
</tr>
<tr>
<td>5/5</td>
<td>VI. GUIDANCE FOR REGULATORY REVIEW OF PREDICTIVE MODELS (BEST PRACTICES)</td>
<td>NAMIC</td>
<td><em>Revise text as follows:</em> “Many information elements listed below are probably confidential, proprietary or trade secret and should be treated as such according to requirements subjects the regulator to increased Freedom of Information Act requests, subpoenas, and other types of litigation when there has been demonstrated harm to others or triggers for the inquiry. Additionally, some proprietary models may have contractual terms that prevent disclosure of the information in the model.”</td>
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<td>5/16</td>
<td>Expose the individual input characteristics to be used and output factor from the model to insured and its submodel(s) as well as, if a correlated/interrelated relationship to expected loss or expense.</td>
<td>California Department of Insurance</td>
<td>Determine whether the data used in relation to the model is compatible with practices allowed in the jurisdiction and do not reflect prohibited characteristics prohibited in the state for the purposes of rate-making.</td>
<td>No change recommended.</td>
</tr>
<tr>
<td>5/19</td>
<td>Revise text to: California Department of Insurance</td>
<td>2. As an input into construction of the levels of variables included in the model, or in other capacities related to the model (or the rating plan it supports), and evaluate the compatibility of the use of such data with practices allowed in the state.</td>
<td>No change recommended.</td>
<td></td>
</tr>
<tr>
<td>5/23</td>
<td>Determine whether any external data be beneficial in building the model.</td>
<td>California Department of Insurance</td>
<td>Intuitive is not an actuarial standard. Different actuaries and data scientists have different experiences, and intuition is subjective and not an actuarial standard. To determine whether an input is beneficial to the model is not intuitive. If there are other actuarial standards (e.g., the fair and equitable standard), should be used instead of intuition.</td>
<td>Merge 2. into C, in order to determine whether inputs related to loss or expense differences in risk.</td>
</tr>
<tr>
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<tr>
<td>5/12</td>
<td>GMMRC</td>
<td></td>
<td>+ in item (a), we recommend the use of the word “intuitive” in this context, the word “or” has been added, which sometimes creates the fact that insurers may have fair and accurate models for which there is no ready intuitive explanation (see similar point above).</td>
<td>See CT001onas necessity for must text.***</td>
</tr>
<tr>
<td>5/12</td>
<td>Allstate</td>
<td></td>
<td>See sections 2.a and 2.c similar and could be combined.</td>
<td>No change recommended. We believe that 2.a and 2.c are different.</td>
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<tr>
<td>5/13</td>
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<td></td>
<td>We believe that 2.a and 2.c are different.</td>
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<td>5/14</td>
<td></td>
<td></td>
<td>b. Determine that the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values and outliers are handled.</td>
<td>In order to determine that inputs are reliable the regulator must check if a cost and factor (causal or otherwise) is used from the model. Therefore, we refer to 3.a and 3.b if different.</td>
</tr>
<tr>
<td>5/15</td>
<td></td>
<td></td>
<td>c. Determine that any adjustments to the raw data are handled appropriately, including but not limited to, trending, development, capping or removal of catastrophic.</td>
<td>Determine whether the data used in relation to the model is compatible with practices allowed in the jurisdiction and do not reflect characteristics prohibited in the state.</td>
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<tr>
<td>5/15</td>
<td></td>
<td></td>
<td>d. Determine that rating factors from a predictive model are related to expected loss or expense differences in risk. Each rating factor should have a demonstrable actual relationship to expected loss or expense.</td>
<td>Determine whether the data used in relation to the model is compatible with practices allowed in the jurisdiction and do not reflect characteristics prohibited in the state.</td>
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<tr>
<td>6/1</td>
<td></td>
<td></td>
<td>e. Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated and whether the model is related to the rating plan.</td>
<td>Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated and whether the model is related to the rating plan.</td>
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<td>6/2</td>
<td></td>
<td></td>
<td>California Department of Insurance understanding of how the selected predictive model was built.</td>
<td>California Department of Insurance understanding of how the selected predictive model was built and why the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.</td>
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<td>6/3</td>
<td></td>
<td></td>
<td>California Department of Insurance split 3.b into 2.f and 3.b best practices:</td>
<td>California Department of Insurance split 3.b into 2.f and 3.b best practices:</td>
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<td>6/4</td>
<td></td>
<td></td>
<td>California Department of Insurance split 3.b into 2.f and 3.b best practices:</td>
<td>California Department of Insurance split 3.b into 2.f and 3.b best practices:</td>
</tr>
</tbody>
</table>

**Note:**

- **Split 3.b into 2.f and 3.b best practices:**
  - 2.f. Obtain a clear understanding of how the selected predictive model was built.
  - 3.b. Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated and whether the model is related to the rating plan. In addition, why the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.

- **No change recommended:**
  - There is no potential for significant confusion. The goal of the regulator is to understand how the individual components of the rating plan interact to produce a consumer’s premium.披露 of premium information should be confidential from the regulator. Information that the “Disclosure of Premium Information” is essential to understanding the construction of the CBS models, their validity, and their justification. Many regulators already routinely request and examine this information.

**Text from 5-14-2019 Exposure of Complex Model Best Practices White Paper**

### Third-Party Comments on 5-14-2019 Exposure of Complex Model Best Practices White Paper

<table>
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<td>Item (b) references “private passenger automobile or homeowner’s insurance”.</td>
<td>GSBRC</td>
<td>“Item (b) references &quot;private passenger automobile or homeowner’s insurance&quot;.”</td>
<td>See text above for revised text.</td>
</tr>
<tr>
<td>We feel that specific lines of business do not need to be mentioned. None of the other items in this outline specify lines of business.</td>
<td>GSBRC</td>
<td>“Item (b) references &quot;private passenger automobile or homeowner’s insurance&quot;.”</td>
<td>See text above for revised text.</td>
</tr>
<tr>
<td>Split 3.b into 2.f and 3.b: “2.f. Obtain a clear understanding of how the selected predictive model was built.”</td>
<td>GSBRC</td>
<td>“2.f. Obtain a clear understanding of how the selected predictive model was built.”</td>
<td>See text above for revised text.</td>
</tr>
<tr>
<td>“3.b. Obtain a clear understanding of how the selected predictive model was built and insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.”</td>
<td>GSBRC</td>
<td>“3.b. Obtain a clear understanding of how the selected predictive model was built.”</td>
<td>See text above for revised text.</td>
</tr>
<tr>
<td>Calculate a risk’s premium.</td>
<td>GSBRC</td>
<td>“d. Obtain a clear understanding of how the predictive model was integrated into the insurer’s state rating plan and how it improves that plan.”</td>
<td>See text above for revised text.</td>
</tr>
<tr>
<td>e. For predictive model refreshes, determine whether sufficient validation was performed to ensure the model is still a good fit.</td>
<td>GSBRC</td>
<td>“e. For predictive model refreshes, determine whether sufficient validation was performed to ensure the model is still a good fit.”</td>
<td>See text above for revised text.</td>
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</table>

### VII. PREDICTIVE MODELS – INFORMATION FOR REGULATORY REVIEW

We are not expanding the context of the paper beyond personal auto and home insurance.

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<tbody>
<tr>
<td>NAMIC</td>
<td>“a. Enable innovation in the pricing of insurance through acceptance of predictive models, provided they are actuarially sound and in compliance with state laws.”</td>
</tr>
<tr>
<td>NAMIC</td>
<td>“b. Protect the confidentiality of filed predictive models and supporting information in accordance with state law.”</td>
</tr>
</tbody>
</table>

For review by NAMC there is concern that without that topic addressed, this paper may not lend further amendments in the future and not provide specific direction as opposed to the general nature of the discussion.

*Changes made to WP 101419*
### Best Practices for Regulatory Review of Predictive Analytics White Paper

#### Text from 5-14-2019 Exposure

**Exposure Sections 1 to 10 (Intro)**

Table: Best Practices for Regulatory Review of Predictive Analytics White Paper

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<tr>
<td>6/10</td>
<td>Add this descriptive paragraph: Documentation of the design and operational details of the model is required to ensure business level of management or key function at which it is intended to be used. Documentation should be sufficiently detailed and complete to enable a third party to form a sound judgment on the suitability of the model for the intended purpose. This includes a review of methodologies, software and empirical basis of the model, as well as the data used in developing and improving the model. Relevant testing and ongoing performance need to be documented, as well as model limitations and overrides that need to be followed by stakeholders under the circumstances under which the model does not satisfy. Detailed documentation should be provided and be consistent with the model results and findings. Major changes to the model need to be documented in a timely manner and documented, and IT controls should be in place, such as access to versions, change control and access to models.</td>
</tr>
<tr>
<td>6/10</td>
<td>Though the list seems long, the reviewer should schedule a formal documentation on the model more than half of the time the list is used. The remaining items on the list require either minor tracking (approximately 25%), or deeper analysis to generate the information or a regular review (approximately 25%).</td>
</tr>
<tr>
<td>6/10</td>
<td>The “importance to regulator’s review” ranking of information a regulator may need to review is based on the following hierarchy:</td>
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<tr>
<td>6/10</td>
<td><strong>Level 1</strong> - This information is necessary to begin the review of a predictive model. These data elements pertain to basic information about the model and its intended use, such as the assumptions and methodologies, the goodness of fit. Ideally, this information would be included in the filing documentation with the initial submission of a filing made based on a predictive model. If filings are delayed due to unnecessary regulatory review and redundancies, that delay ultimately harms consumers as market competition is reduced. Commentary in the Level 2 criteria states that insurers are required to include this information in the filing documentation, leaving the issue without specific clarification. Insurers and regulators are now unclear as to what is required in the filing documentation.</td>
</tr>
<tr>
<td>6/10</td>
<td><strong>Level 2</strong> - This information is necessary to continue the review of all but the most basic models, such as those that only address the fair internal data and only including variables that are in the filing rating plan. These data elements provide more detailed information about the model, and are often used for initial submission, unless specifically requested in a particular jurisdiction. It is typically required only if the reviewer has serious concerns about the model and does not necessarily need to be included by the initial submission, unless specifically requested in a particular jurisdiction. It is typically required only if the reviewer has serious concerns about the model limitation and overrides need to be followed by stakeholders under the circumstances under which the model does not satisfy. Detailed documentation should be provided and be consistent with the model results and findings. Major changes to the model need to be shared in a timely manner and documented, and IT controls should be in place, such as access to versions, change control and access to models.</td>
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**Commenter Name**

Add Hoc: “Documentation of the design and operational details of the model is required to ensure business level of management or key function at which it is intended to be used. Documentation should be sufficiently detailed and complete to enable a third party to form a sound judgment on the suitability of the model for the intended purpose. This includes a review of methodologies, software and empirical basis of the model, as well as the data used in developing and improving the model. Relevant testing and ongoing performance need to be documented, as well as model limitations and overrides that need to be followed by stakeholders under the circumstances under which the model does not satisfy. Detailed documentation should be provided and be consistent with the model results and findings. Major changes to the model need to be shared in a timely manner and documented, and IT controls should be in place, such as access to versions, change control and access to models.”

**Final Ad Hoc Team Recommendation**

Add this descriptive paragraph: Documentation of the design and operational details of the model is required to ensure business level of management or key function at which it is intended to be used. Documentation should be sufficiently detailed and complete to enable a third party to form a sound judgment on the suitability of the model for the intended purpose. This includes a review of methodologies, software and empirical basis of the model, as well as the data used in developing and improving the model. Relevant testing and ongoing performance need to be documented, as well as model limitations and overrides that need to be followed by stakeholders under the circumstances under which the model does not satisfy. Detailed documentation should be provided and be consistent with the model results and findings. Major changes to the model need to be shared in a timely manner and documented, and IT controls should be in place, such as access to versions, change control and access to models.”
### General, Non-Specific Comments by Third-Parties on Section VII.A to VII.C Content

#### Commenter: NAMIC

**Exposed Section VII.A to VII.C**

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### Third-Party Comments on Exposure of Complex Model Best Practices White Paper

#### Commenter: NAMIC

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**Suggestion: Additional concerns related to the use of a particular data set as a regulatory tool**

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<td>NAMIC recommends considering: 4. What is meant by “raw data”? Data files can be enormous. There are concerns about data breaches and technology differences. It might be better to have a time limit requirement on how long carriers keep data and then provide access if needed. An ability to reconcile data used in predictive models with external other audited sources.</td>
</tr>
<tr>
<td>5. Accuracy of insurance data should be reviewed as well. Aggregated data is straight from the insurer’s data banks without modification (e.g., not scrubbed or transformed). The dataset would not be adjusted for data selection or model building. The company should provide some form of reasonability check that the data makes sense when checked against data processing procedures.</td>
<td>NAMIC</td>
<td>NAMIC recommends considering: 5. Accuracy of insurance data should be reviewed as well. Aggregated data is straight from the insurer’s data banks without modification (e.g., not scrubbed or transformed). The dataset would not be adjusted for data selection or model building. The company should provide some form of reasonability check that the data makes sense when checked against data processing procedures.</td>
<td>NAMIC recommends considering: 5. Accuracy of insurance data should be reviewed as well. Aggregated data is straight from the insurer’s data banks without modification (e.g., not scrubbed or transformed). The dataset would not be adjusted for data selection or model building. The company should provide some form of reasonability check that the data makes sense when checked against data processing procedures.</td>
</tr>
<tr>
<td>6. We are not recommending raw policy level data to be provided, rather that the raw data that feeds the model reconciles to external reports, which are typically at an aggregate level. Garbage in, garbage out. Wouldn’t this be the first thing to check before going into other model assumptions?</td>
<td>NAMIC</td>
<td>NAMIC recommends considering: We are not recommending raw policy level data to be provided, rather that the raw data that feeds the model reconciles to external reports, which are typically at an aggregate level. Garbage in, garbage out. Wouldn’t this be the first thing to check before going into other model assumptions?</td>
<td>NAMIC recommends considering: We are not recommending raw policy level data to be provided, rather that the raw data that feeds the model reconciles to external reports, which are typically at an aggregate level. Garbage in, garbage out. Wouldn’t this be the first thing to check before going into other model assumptions?</td>
</tr>
<tr>
<td>7. With the below changes, there is no need to define “raw insurance data” in the Glossary. However, “aggregated insurance data” should be added to the Glossary.</td>
<td>NAMIC</td>
<td>NAMIC recommends adding: “aggregated insurance data” to the Glossary.</td>
<td>NAMIC recommends adding: “aggregated insurance data” to the Glossary.</td>
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<tr>
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<td>Exposure Section VII.A to VII.C</td>
<td>Commenter Name</td>
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<td>7/7 A.1.c</td>
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<td>Change level of importance to a “2.”</td>
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<td>Change level of importance to a “2.”</td>
<td>Merge with A.1.a, or merge A.1.a.</td>
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<tr>
<td>7/8 A.1.d</td>
<td></td>
<td>AZDOI</td>
<td>This is redundant to A.1.a</td>
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<tr>
<td></td>
<td></td>
<td>Allstate</td>
<td>1. Remove section A.1.d due to its overlap with A.1.a.</td>
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<td>Commenter also mentioned to differentiate between new model and refresh as well as external vs. internal data.</td>
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<td>2. Sub-Models</td>
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<td>1. Sub-Models</td>
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<td>Calculate the existence of e.g., inferences based on digging data or variables used in the model and in sub-models.</td>
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<td>2. Sub-Models</td>
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<td>Conformance Code models</td>
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<td>Examples of such sub-models include financial scoring algorithms, and hierarchical decision tree models.</td>
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<td>1. Sub-Models</td>
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<td>The regulator needs to have some name of the third party vendor and a contact for additional information should it be needed.</td>
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<td>2. Sub-Models</td>
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<td>Example of such sub-models include financial scoring algorithms, and hierarchical decision tree models.</td>
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<td>Page/Paragraph</td>
<td>Name</td>
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<td>Final Ad Hoc Team Recommendation</td>
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</tr>
<tr>
<td>8/3 A.2.b</td>
<td></td>
<td>Contact person for a vendor’s submodel should be provided by filer as placing onus on regulator could lengthen approval process.</td>
<td>Revise comment to: “Contact information should be confidential and is proprietary.”</td>
</tr>
<tr>
<td>8/4 A.2.c</td>
<td>NAMIC</td>
<td>If using catastrophe model output, identify the vendor and the model. Doing so could cause distortions in the modeled results by double counting such losses when determining relativities or loss loads in the filed rating plan. For example, redundant losses in the data adjusted.</td>
<td>Add to comment: “If a wind losses are included in the GLM under review, verify whether loss associated with the modeled experience associated with the same model currently under review. If approved, verify when and by the regulatory agency.”</td>
</tr>
<tr>
<td>9/1 A.3.a</td>
<td>NAMIC</td>
<td>Premium and/or cost data are large losses or flood, hurricane or severe convective storm losses models capped) and, if so, how? Do the adjustments vary for different experience associated with the same model currently under review? If approved, verify when and by the regulatory agency.</td>
<td>No change recommended.</td>
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### A.2.1

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<th>NAIC’s Comment</th>
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<td>Contact person for a vendor’s submodel should be provided by filer as placing onus on regulator could lengthen approval process.</td>
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<td>Contact person for a vendor’s submodel should be provided by filer as placing onus on regulator could lengthen approval process.</td>
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<td>A.3.a</td>
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<td>9/1</td>
<td>A.3.a</td>
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<td>9/1</td>
<td>A.3.b</td>
<td>NAMIC</td>
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<td>A.3.c</td>
<td>AZDOI</td>
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<td>9/1</td>
<td>A.3.c</td>
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<td>9/1</td>
<td>A.3.c</td>
<td>NAMIC</td>
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<td>9/1</td>
<td>A.3.d</td>
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<td>A.3.f</td>
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<td>2</td>
<td>9/8 A.4.a</td>
<td>Obtain documentation on the methods used to compile and merge data, including procedures to merge data from different sources and a description of any preliminary analyses, data checks, and logical tests performed on the data and the results of those tests.</td>
</tr>
<tr>
<td>2</td>
<td>9/8 A.4.a</td>
<td>Obtain documentation on the methods used to compile and merge data, including procedures to merge data from different sources</td>
</tr>
<tr>
<td>3/1</td>
<td>9/8 A.4.a</td>
<td>Obtain documentation on the process for reviewing the appropriateness, reasonableness, consistency, and comprehensiveness of the data, including a discussion of the insurer’s process for reviewing the appropriateness, reasonableness, consistency and comprehensiveness of the data.</td>
</tr>
<tr>
<td>3/1</td>
<td>9/8 A.4.b</td>
<td>Correlation does not mean causation. Is this a request for each and every variable/input or just items that are unusual? Who decides what is intuitive? This could be biased by the personal views of a reviewer and not the results from the model. This information is not contained in a single document today for most companies. Additionally, the vast majority of rating variables used in a class plan have been used for decades. Adding such a comprehensive document would add onerous, an easy to explain intuitive relationship may not exist.</td>
</tr>
<tr>
<td>3/1</td>
<td>9/8 A.4.c</td>
<td>Material findings the company had during their data review and/or results, obtain a description of those concerns and an explanation how modeling analysis was adjusted and/or results were impacted.</td>
</tr>
<tr>
<td>3/1</td>
<td>9/8 A.4.c</td>
<td>Casually actuarial and statistical (C) Task Force</td>
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### Exposure Section VII.A to VII.C

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<th>Commenter's Suggestion</th>
<th>Real Ad Hoc Team Recommendation</th>
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### Section

#### B. Building the Model

**1. High-level Narrative for Building the Model**

- **R.1.a**
  - **Information Element**: Software Used for Model Development
  - **Comments**: Obtaining a description ofGLM and other model types of the software used for model development is important in determining whether the model meets regulatory standards.

- **R.1.b**
  - **Information Element**: Software in Use During Model Development
  - **Comments**: It is important to understand if the model in question is a GLM, and therefore these best practices are applicable or, if it is some other model type, in which case other reasonable circumstances apply. It is important to understand if the model in question is a GLM, and therefore these best practices are applicable or, if it is some other model type, in which case other reasonable circumstances apply.

- **R.1.c**
  - **Information Element**: Data Definitions
  - **Comments**: Understanding the data definitions is crucial in ensuring that the model is appropriately used for the purpose it was intended.

#### B.1.a

- **1. High-Level Narrative for Building the Model**
  - **Information Element**: Model Development
  - **Comments**: It is important to understand if the model in question is a GLM, and therefore these best practices are applicable or, if it is some other model type, in which case other reasonable circumstances apply. It is important to understand if the model in question is a GLM, and therefore these best practices are applicable or, if it is some other model type, in which case other reasonable circumstances apply.

- **2. Dataset Definitions**
  - **Information Element**: Model Development
  - **Comments**: Understanding the data definitions is crucial in ensuring that the model is appropriately used for the purpose it was intended.

### Third-Party Comments on 5-14-2019 Exposure of Complex Model Best Practices White Paper

- **Exposed Section VII.A to VII.C**
  - **Commenter**: Exposed Section VII.A to VII.C
  - **Commenter's Suggestion**: We would propose that we add a note to indicate the level of importance for each section.
  - **Real Ad Hoc Team Recommendation**: No change recommended.

In order to ensure that rates are not unfairly discriminatory, regulators have an obligation to understand the models we review as well as the process by which they are built. In the absence of the level of importance information, there is no way to tell whether the model is a GLM or other model type. Each state can adjust the level of importance as they see fit.

#### Exposed Section VII.A to VII.C

1. **R.1.a**
   - **Information Element**: Software Used for Model Development
   - **Comments**: It is important to understand if the model in question is a GLM, and therefore these best practices are applicable or, if it is some other model type, in which case other reasonable circumstances apply. It is important to understand if the model in question is a GLM, and therefore these best practices are applicable or, if it is some other model type, in which case other reasonable circumstances apply.
   - **Real Ad Hoc Team Recommendation**: No change recommended.

2. **R.1.b**
   - **Information Element**: Software in Use During Model Development
   - **Comments**: It is important to understand if the model in question is a GLM, and therefore these best practices are applicable or, if it is some other model type, in which case other reasonable circumstances apply. It is important to understand if the model in question is a GLM, and therefore these best practices are applicable or, if it is some other model type, in which case other reasonable circumstances apply.
   - **Real Ad Hoc Team Recommendation**: No change recommended.

3. **R.1.c**
   - **Information Element**: Data Definitions
   - **Comments**: Understanding the data definitions is crucial in ensuring that the model is appropriately used for the purpose it was intended.
   - **Real Ad Hoc Team Recommendation**: No change recommended.

Add to comment field: It is important to understand if the model in question is a GLM, and therefore these best practices are applicable or, if it is some other model type, in which case other reasonable circumstances apply. It is important to understand if the model in question is a GLM, and therefore these best practices are applicable or, if it is some other model type, in which case other reasonable circumstances apply.

- **III. Complex Model Best Practices White Paper**
  - **Exposed Section VII.A to VII.C**
  - **Commenter**: Exposed Section VII.A to VII.C
  - **Commenter's Suggestion**: We would propose that we add a note to indicate the level of importance for each section.
  - **Real Ad Hoc Team Recommendation**: No change recommended.
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<th>Commenter’s Suggestion</th>
<th>Final Ad Hoc Team Recommendation</th>
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<tr>
<td>11/6</td>
<td>B.1.c</td>
<td>California</td>
<td>Determine if the validation data was accessed before model training was completed and, if so, obtain an explanation for how and why that was done.</td>
<td>No change recommended.</td>
</tr>
<tr>
<td>11/7</td>
<td>B.1.d</td>
<td>Department of Insurance</td>
<td>Obtain a brief description of the development process, from initial concept to final model and filed rating plan (in less than three pages of narrative).</td>
<td>No change recommended.</td>
</tr>
<tr>
<td>11/8</td>
<td>B.1.e</td>
<td>California</td>
<td>Obtain a narrative on whether loss ratio, pure premium or frequency/severity analyses were performed and, if separate frequency/severity modeling was performed, how pure premiums and frequency were determined.</td>
<td>No change recommended.</td>
</tr>
<tr>
<td>11/9</td>
<td>B.1.f</td>
<td>1</td>
<td>Identify the model’s target variable. A clear description of the target variable is key to understanding the purpose of the model. It may also prove useful to obtain a sample calculation of the target variable in Excel format, starting with the raw data for a policy, or a small sample of policies, depending on the complexity of the target variable calculation.</td>
<td>No change recommended.</td>
</tr>
<tr>
<td>12/1</td>
<td>B.1.g</td>
<td>1</td>
<td>Obtain a detailed description of the variable selection process.</td>
<td>No change recommended.</td>
</tr>
<tr>
<td>12/2</td>
<td>B.1.h</td>
<td>Company</td>
<td>In conjunction with variable selection, obtain a narrative on how the company determine the granularity of the rating variables during model development. Comment: This discussion should include discussion of how credibility was considered in the process of determination of the level of granularity of the variables selected.</td>
<td>No change recommended.</td>
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<td>California Department of Insurance</td>
<td>Obtain a description of data segmentation and the reasons for data segmentation.</td>
<td>Obtain a description of data segmentation and the reasons for data segmentation.</td>
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<td>B.2.d</td>
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Ad Hoc Team recommendations to exposures comments as of 10-14-2019 (Text in redaction items to be handled in a future draft of the white paper.)

**Exposure Section VII A as V-C**

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### Paragraph 13/1B.2.d

_NAMIC_ 

_NAMIC_ suggested the following changes:

1. The link function used in the GLM should be identified, and the distribution used for the model (e.g., Poisson, Gaussian, Tweedie) should be specified. An explanation should be provided as to why the link function and distribution were chosen.

2. The formulas for the distribution and link functions should be obtained.

3. An explanation should be obtained for the convergence criterion used.

4. The formula relationship between the data and model outputs, with a definition of each model input and output, should be provided.

5. If there were data situations in which GLM weights were used, an explanation of how and why they were used should be provided.

Revise information element to:

- **model**
- **distribution**
- **convergence criterion**
- **formula relationship**
- **weights**

### Paragraph 13/2B.2.e

_NAMIC_ 

_NAMIC_ suggested the following changes:

1. The formulas for the distribution and link functions, including the applicable convergence criterion, should be obtained.

2. An explanation should be obtained for the convergence criterion selected.

3. Obtain a narrative on the formula relationship between the data and model outputs, with a definition of each model input and output.

Revise information element to:

- **distribution**
- **link function**
- **convergence criterion**
- **formula relationship**

### Paragraph 13/3B.2.f

_NAMIC_ 

_NAMIC_ suggested the following changes:

1. Obtain a complete data dictionary, including the names, types, definitions and uses of each predictor variable, offset variable, control variable, proxy variable, geographic variable, geodemographic variable and all other variables in the model; used on their own, or as an input to other variables.

2. Types of variables might be continuous, discrete, Boolean, etc. Definitions should not use programming language or code. For any variable(s) intended to function as a control or offset, obtain an explanation of their role and impact. Also, for any use of interaction between variables, obtain an explanation of its rationale and impact.

Revise information element to:

- **data dictionary**
- **types of variables**
- **control variable**
- **offset variable**
- **interaction between variables**

### Paragraph 13/4B.2.g

_NAMIC_ 

_NAMIC_ suggested the following changes:

1. If there were data situations in which GLM weights were used, an explanation of how and why they were used should be provided.

2. Obtain a complete data dictionary, including the names, types, definitions and uses of each predictor variable, offset variable, control variable, proxy variable, geographic variable, geodemographic variable and all other variables in the model; used on their own, or as an input to other variables.

3. Types of variables might be continuous, discrete, Boolean, etc. Definitions should not use programming language or code. For any variable(s) intended to function as a control or offset, obtain an explanation of their role and impact. Also, for any use of interaction between variables, obtain an explanation of its rationale and impact.

Revise information element to:

- **data dictionary**
- **types of variables**
- **control variable**
- **offset variable**
- **interaction between variables**
<table>
<thead>
<tr>
<th>Page</th>
<th>Exposed Section VI A 1 to 2 C</th>
<th>Commenter Name</th>
<th>Commenter’s Suggestion</th>
<th>Real Ad Hoc Team Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-7</td>
<td>A 2 b 1</td>
<td>The explanation should be based on demonstrating causal relationships. Correlations provide no causation. In insurance, the best way to see if an exposure variable is related to a predictor variable is to gather data on a large number of policyholders.</td>
<td>CAA</td>
<td>The explanation should be based on demonstrating causal relationships. Correlations provide no causation. In insurance, the best way to see if an exposure variable is related to a predictor variable is to gather data on a large number of policyholders.</td>
</tr>
<tr>
<td>16-7</td>
<td>B 3 b 1</td>
<td>Obtain a list of predictor variables considered but not used in the final model. The list of variables considered but not used in the final model is an important tool for identifying areas for further research and development. The list would be especially valuable if the model is updated periodically. A stand-alone list of variables considered but not used in the final and proposed models could provide managers and directors with important insights about the research process.</td>
<td>CDD</td>
<td>The explanation should be based on demonstrating causal relationships. Correlations provide no causation. In insurance, the best way to see if an exposure variable is related to a predictor variable is to gather data on a large number of policyholders.</td>
</tr>
<tr>
<td>16-7</td>
<td>C 2</td>
<td>Obtain a correlation matrix for all predictor variables included in the causal relationship. Interpretation of information about the magnitude of correlation is not sufficient.</td>
<td>M et al</td>
<td>The explanation should be based on demonstrating causal relationships. Correlations provide no causation. In insurance, the best way to see if an exposure variable is related to a predictor variable is to gather data on a large number of policyholders.</td>
</tr>
<tr>
<td>16-7</td>
<td>C 2 1</td>
<td>Obtain a correlation matrix for all predictor variables included in the causal relationship. Interpretation of information about the magnitude of correlation is not sufficient.</td>
<td>M et al</td>
<td>The explanation should be based on demonstrating causal relationships. Correlations provide no causation. In insurance, the best way to see if an exposure variable is related to a predictor variable is to gather data on a large number of policyholders.</td>
</tr>
</tbody>
</table>
### 4. Adjusting Data, Model Validation and Goodness-of-Fit Measures

<table>
<thead>
<tr>
<th>Paragraph</th>
<th>Action Item</th>
<th>Recommended Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.2.b</td>
<td>None</td>
<td>Change recommended. Each of the three information elements address slightly different relationships.</td>
</tr>
<tr>
<td>B.3.d</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>B.4.b</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>B.4.c</td>
<td>None</td>
<td>Delete B.4.b information element: Obtain a description of any adjustments that were made in the data with respect to scaling for discrete variables or binning the data.</td>
</tr>
<tr>
<td>B.4.d</td>
<td>None</td>
<td>Delete B.4.c. information element: Obtain a description of any transformations made for continuous variables.</td>
</tr>
<tr>
<td>B.4.e</td>
<td>None</td>
<td>Delete B.4.d information element: Get a list of the data transformations used in the model and explain how the results of the transformations were used within the model.</td>
</tr>
</tbody>
</table>

#### Ad Hoc Team recommendation to exposure comments as of 10-14-2019

- **Paragraph** | **Action Item** | **Recommended Action** |
- **B.2.b** | None | No change recommended. Each of the three information elements address slightly different relationships. |

#### 2. Concern vendors may overuse this point to justify their contractual existence.

- If the modeler made use of one or more dimensionality reduction chosen, and a description of the process used to transform observations (usually correlated) into a set of linearly uncorrelated variables. In each instance, obtain a list of the transformation and variable names, and an explanation how the results of the dimensionality reduction technique was used within the model.

#### 2. Concern if state specific. Concern that some regulators may expect excessive

- Nevertheless, some regulators require model validation on regulatory approach.

---

**Changes made to WP 101419**

- **Delete B.4.b information element:** Obtain a description of any adjustments that were made in the data with respect to scaling for discrete variables or binning the data.
- **Delete B.4.c. information element:** Obtain a description of any transformations made for continuous variables.
- **Delete B.4.d information element:** Get a list of the data transformations used in the model and explain how the results of the transformations were used within the model.
<table>
<thead>
<tr>
<th>Page</th>
<th>Commented Draft</th>
<th>Consumer Name</th>
<th>Consumer’s Suggestion</th>
<th>Real Ad Hoc Team Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCV</td>
<td>6.4.4</td>
<td>Typically, a level greater than 5% is large and should be questioned. As available for some areas, this level should be provided to support the change. However, when all candidate variables are considered, it may be challenging to obtain variance around the model’s predictions. For example, confidence intervals, parameter estimates, and level of an AOI may need to be met or exceeded. This suggests the threshold for statistical significance should be more than what is needed.</td>
<td>No change recommended.</td>
<td>No change recommended.</td>
</tr>
<tr>
<td>SCV</td>
<td>6.4.4</td>
<td>Typically, a level greater than 5% is large and should be questioned. As available for some areas, this level should be provided to support the change. However, when all candidate variables are considered, it may be challenging to obtain variance around the model’s predictions. For example, confidence intervals, parameter estimates, and level of an AOI may need to be met or exceeded. This suggests the threshold for statistical significance should be more than what is needed.</td>
<td>No change recommended.</td>
<td>No change recommended.</td>
</tr>
<tr>
<td>SCV</td>
<td>6.4.4</td>
<td>A.3.b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Page</td>
<td>Commenter Name</td>
<td>Commenter’s Suggestion</td>
<td>Final Ad Hoc Team Recommendation</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>----------------</td>
<td>------------------------</td>
<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td>28.7</td>
<td></td>
<td>This section is about discrete variables.</td>
<td>No change recommended.</td>
<td></td>
</tr>
<tr>
<td>28.7</td>
<td></td>
<td>For variables that are modeled continuously, it may be less likely that a level contributes much to the overall model.</td>
<td>No change recommended.</td>
<td></td>
</tr>
<tr>
<td>28.7</td>
<td></td>
<td>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may want to conduct a more expansive test on whether the variable is needed.</td>
<td>No change recommended.</td>
<td></td>
</tr>
<tr>
<td>28.7</td>
<td></td>
<td>Grouping is not directly addressed but is implicitly addressed/discussed by the information element.</td>
<td>No change recommended.</td>
<td></td>
</tr>
<tr>
<td>28.7</td>
<td></td>
<td>Reasonableness of the model, e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</td>
<td>No change recommended.</td>
<td></td>
</tr>
<tr>
<td>28.7</td>
<td></td>
<td>There is no requirement for a level to be grouped with other levels in that factor.</td>
<td>No change recommended.</td>
<td></td>
</tr>
</tbody>
</table>

*Note: The changes are marked by highlighting the existing text in the table.*
<table>
<thead>
<tr>
<th>Page</th>
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<th>Commentor Name</th>
<th>Consumer's Suggestion</th>
<th>Real Ad Hoc Team Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>17/4</td>
<td>B.4.3</td>
<td>This section is about continuous variables.</td>
<td>Delete this following line: &quot;This section is about continuous variables.&quot;</td>
<td>Seeenders, C., to move up discussion topic A.5.20. and deleting remaining all terminology element to emphasis ^</td>
</tr>
<tr>
<td>Page/Paragraph</td>
<td>Exposed Section VII A or VII C</td>
<td>Commenter Name</td>
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<td>----------------</td>
<td>-------------------------------</td>
<td>----------------</td>
<td>------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>17/5 B.4.l</td>
<td></td>
<td>Ad Hoc</td>
<td>Change level of importance to a “4.”</td>
<td>Change level of importance to a “4.”</td>
</tr>
<tr>
<td>17/5</td>
<td></td>
<td></td>
<td>Obtain an explanation why this model is an improvement to the current rating plan.</td>
<td></td>
</tr>
<tr>
<td>17/6 B.5.a</td>
<td></td>
<td></td>
<td>If it replaces a previous model, find out why it is better than the previous model.</td>
<td>NAMIC determines how the company reached that conclusion and identifies metrics relied on in reaching that conclusion. Look for an explanation of any changes in calculations, assumptions, parameters, and data used to build the new model relative to the prior model.</td>
</tr>
<tr>
<td>17/8 B.5.c</td>
<td></td>
<td></td>
<td>Determine if double lift charts were drawn from this analysis.</td>
<td>One example of a comparison might be sufficient. NAMIC requests a comparison of Gini coefficient from the prior model to the Gini coefficient of the proposed model. It is expected that there should be improvement in the Gini coefficient. A higher Gini coefficient indicates greater differentiation produced by the model and how well the model fits that data. This comparison is not applicable to initial model introduction.</td>
</tr>
<tr>
<td>18/3 B.6.a</td>
<td></td>
<td></td>
<td>Obtain access to the modeler(s), e.g., modeling who led the project, compiled the data, built the model, and/or performed peer review.</td>
<td>NAMIC contact information should be confidential and is proprietary.</td>
</tr>
</tbody>
</table>
| 19/1 | | | | |}

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**Best Practices for Regulatory Review of Predictive Analytics White Paper**

**Third-Party Comments on 5-14-2019 Exposure of Complex Model Best Practices White Paper**

**Ad Hoc Team recommendation to exposure comments as of 10-14-2019**

**NAIC Proceedings – Fall 2019**

**Attachment Two-B**

**Casualty Actuarial and Statistical (C) Task Force**

**12/7/19**
<table>
<thead>
<tr>
<th>Section</th>
<th>Element</th>
<th>Commenter</th>
<th>Suggestion</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.2.a</td>
<td>Information Element</td>
<td>NAMIC</td>
<td>This item is particularly important. If the role of the model cannot be understood by the reviewer from a quick review of the rating system, then the model should be identified in the rating system.</td>
<td>revise information element: “The role of the model” relates to how the model integrates into the rating plan as a whole and where the effects of the model are manifested within the various components of the rating system.</td>
</tr>
<tr>
<td>3.1.2.a</td>
<td></td>
<td>NAMIC</td>
<td>This item is particularly important if the role of the model cannot be immediately discerned by the reviewer from a quick review of the rate and/or rule pages. (Importance is dependent on state requirements and ease of identification by the first layer of review.)</td>
<td>The role of the model must be clearly identified in the rate and/or rule pages. (Importance is dependent on state requirements and ease of identification by the first layer of review.)</td>
</tr>
<tr>
<td>3.1.2.b</td>
<td></td>
<td>NAMIC</td>
<td>The narrative should include a discussion of the relevance and materiality of the rating variables and how they relate to the risk of loss.</td>
<td>The narrative should include a discussion of the relevance and materiality of the rating variables and how they relate to the risk of loss.</td>
</tr>
<tr>
<td>3.1.2.b</td>
<td></td>
<td>NAMIC</td>
<td>This statement should be included in the rate and/or rule pages. The narrative should clearly identify the importance of the model and its role in the rating system.</td>
<td>This statement should be included in the rate and/or rule pages. The narrative should clearly identify the importance of the model and its role in the rating system.</td>
</tr>
<tr>
<td>3.1.3.a</td>
<td></td>
<td>NAMIC</td>
<td>The model results should be consistent with the expected direction of the risk of loss.</td>
<td>The model results should be consistent with the expected direction of the risk of loss.</td>
</tr>
<tr>
<td>3.1.3.a</td>
<td></td>
<td>NAMIC</td>
<td>This will be addressed when “intuitive” is replaced with a more appropriate term, e.g., “rational” or “reasonable.”</td>
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</tr>
<tr>
<td>3.2.a</td>
<td></td>
<td>NAMIC</td>
<td>These variables can be used as a basis for the model's role in the rating system.</td>
<td>These variables can be used as a basis for the model's role in the rating system.</td>
</tr>
</tbody>
</table>

**Best Practices for Regulatory Review of Predictive Analytics White Paper**

**Third-Party Comments as of 5-14-2019 Exposure of Complex Model Best Practices White Paper**

**Ad Hoc Team Recommendations to Exposure Comments as of 5-14-2019**

(Final in red is considered to be handled in a future draft of the white paper.)
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</tr>
</thead>
<tbody>
<tr>
<td>20/1</td>
<td>C.3.a.</td>
<td>Paragraph</td>
<td>19/8 C.2.a. NAMIC</td>
<td>This will be addressed when &quot;intuitive&quot; is replaced with a more appropriate term, e.g., &quot;rational&quot;.</td>
</tr>
<tr>
<td>20/1</td>
<td>C.3.b.</td>
<td>Paragraph</td>
<td>19/8 C.2.a. AZDOi</td>
<td>ΈƌĞŐĂƌĚŝŶŐŚŽǁΗ͗hƐĞŽĨƚŚĞǁŽƌĚŝŶƚƵŝƚŝǀĞůLJ͍ŚĂŶŐĞƚŽŵĂƚĐŚĐŚŽƐĞŶǀĞƌďșĂŐĞͲ</td>
</tr>
<tr>
<td>20/2</td>
<td>C.3.a.</td>
<td>Paragraph</td>
<td>19/8 C.2.a. CDIA</td>
<td>Each of the three information elements (A.4.b, B.3.d and C.2.a) address slightly different rational relationships. No change recommended.</td>
</tr>
<tr>
<td>20/2</td>
<td>C.4.a.</td>
<td>Paragraph</td>
<td>19/8 C.2.a.</td>
<td>No change recommended.</td>
</tr>
<tr>
<td>20/2</td>
<td>C.4.b.</td>
<td>Paragraph</td>
<td>20/1 C.2.a.</td>
<td>If the company is using a model to predict loss but then modifying the output by judgment for the filed rating plan, the company needs to explain what it did and that it is consistent with state law.</td>
</tr>
<tr>
<td>20/3</td>
<td>C.3.b.</td>
<td>Paragraph</td>
<td>20/2 C.3.a.</td>
<td>Obtain documentation and support for all calculations, judgments, or conclusions, even if the information is not included in the filing. This applies even to models that produce scores, tiers, or ranges of values for which indications can be derived. This information is necessary to temper or adjust model output, if necessary, to account for possible overlap or redundancy in what the characteristic/variable measures. No change recommended.</td>
</tr>
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<td>C.3.b.</td>
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<td>C.4.a.</td>
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<td>C.4.a.</td>
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</tr>
</tbody>
</table>

33

Paper/Paragraph

Exposed Section VII.A to VII.C

Exposures from 5-14-2019 Exposure

Commenter Name

Consumer’s Suggestion

Real Ad Hoc Team Recommendation

JULY C.5.a

Block a narrative on adjustments made to raw data, e.g., transformations, binning and/or rating model output, the rate and/or rule pages should present these rating tiers or categories. The company should within the rate and/or rule pages.

NAIC

The table could be used as well and be in a split of internal support for a C.5.a, description for content that needs to be had and include with a C.5.a to be able to find for a more intent with a better or in another entirely.

JULY C.5.a

Block C.5.a is related to the rating model output. For each variable in the model, the rate and/or rule pages should present these rating tiers or categories. If adjustments were made, obtain the name of the category involved and a description of any rating categories that translate the model outputs into categories.

ETIO

Block C.5.a is a list (permutations made to a data set for the model output(s) proposed to be used within the rating plan. For each data element, obtain an explanation whether it is raw or adjusted and, if the latter, a detailed explanation for the adjustments. If adjustments were made, obtain the name of the rating categories that translate the model outputs into categories.

JULY C.6.a

Block C.5.a is related to the rating model output. For each variable in the model, the rate and/or rule pages should present these rating tiers or categories. If adjustments were made, obtain the name of the rating categories that translate the model outputs into categories.

1 NAIC

Block C.6.a is related to the rating model output. For each variable in the model, the rate and/or rule pages should present these rating tiers or categories. If adjustments were made, obtain the name of the rating categories that translate the model outputs into categories.

3 NAIC

Block C.6.a is related to the rating model output. For each variable in the model, the rate and/or rule pages should present these rating tiers or categories. If adjustments were made, obtain the name of the rating categories that translate the model outputs into categories.

JULY C.6.a

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4 NAIC

Block C.6.a is related to the rating model output. For each variable in the model, the rate and/or rule pages should present these rating tiers or categories. If adjustments were made, obtain the name of the rating categories that translate the model outputs into categories.

5 NAIC

Block C.6.a is related to the rating model output. For each variable in the model, the rate and/or rule pages should present these rating tiers or categories. If adjustments were made, obtain the name of the rating categories that translate the model outputs into categories.

6.  Supporting Data

Block C.6.a is related to the rating model output. For each variable in the model, the rate and/or rule pages should present these rating tiers or categories. If adjustments were made, obtain the name of the rating categories that translate the model outputs into categories.

REVISE

Block C.6.a is related to the rating model output. For each variable in the model, the rate and/or rule pages should present these rating tiers or categories. If adjustments were made, obtain the name of the rating categories that translate the model outputs into categories.

REVISE

Block C.6.a is related to the rating model output. For each variable in the model, the rate and/or rule pages should present these rating tiers or categories. If adjustments were made, obtain the name of the rating categories that translate the model outputs into categories.
Multivariate indications may be reasonable as refinements to univariate indications, but possibly not for bringing about significant reversals of those indications. For instance, if the univariate indicated relativity for an attribute is 1.5 and the contemplate the adjustments made in a multivariate GLM. This could lead to multivariate indicated relativity is 1.25, this is potentially a incorrect conclusions as the modeled indication considers all other items in the plausible application of the multivariate techniques. If, however, the univariate relativity for an attribute is 0.7 and the multivariate indications do not consider correlations between variables. Also, there is a differences between model indications and state-specific univariate indications. The “Supporting Data” section, specifically Secs. C.6.a and C.6.b, on “Obtain an explanation of any material (especially directional) differences between model indications and state-specific univariate indications.” pose some concerns for CRAs and could interfere with the insurance process for consumers. These rating variables may represent changes to rate relativities, be newly introduced to the rating plan, or have been removed from the rating plan. One way to see sensitivity is to describe the process used by management, if any, to mitigate those differences. Determining if the insurer performed sensitivity testing to identify significant changes in premium due to small or incremental change in a single risk characteristic. If such testing was performed, obtain a narrative that discusses the testing and provides the results of that analysis.
### Best Practices for Regulatory Review of Predictive Analytics White Paper

#### Exposed Section VII.A to VII.C

<table>
<thead>
<tr>
<th>Page</th>
<th>Exposed Section VII.A to VII.C</th>
<th>Commenter Name</th>
<th>Commenter’s Suggestion</th>
<th>Final Ad Hoc Team Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>22/6</td>
<td>C.7.e Obtain exposure distributions for the model's output variables and show the effects of rate changes at granular and summary levels. 3</td>
<td>OPA</td>
<td>&quot;The rate charged should be adequate to cover losses and expenses, and should be reasonable in relation to the insurer's experience. The rate charged should be calculated on a periodic basis, taking into account any adjustment for the policy period. The rate charged should be subject to annual review, and adjustments should be made if necessary.&quot;</td>
<td>No change recommended.</td>
</tr>
<tr>
<td>22/6</td>
<td>C.7.e CT DOI</td>
<td>OPA</td>
<td>&quot;The rate charged should be adequate to cover losses and expenses, and should be reasonable in relation to the insurer's experience. The rate charged should be calculated on a periodic basis, taking into account any adjustment for the policy period. The rate charged should be subject to annual review, and adjustments should be made if necessary.&quot;</td>
<td>No change recommended.</td>
</tr>
<tr>
<td>23/1</td>
<td>C.7.f In regard to Level 3 assignment: &quot;The level assigned to this component may be updated periodically. Obtain a narrative on how the company handles policy characteristics that are listed as &quot;static,&quot; yet change over time. The reviewer should be aware, and possibly concerned, how the company treats an insured over time when the insured's risk profile changes. The rate charged should be calculated on a periodic basis, taking into account any adjustment for the policy period. The rate charged should be subject to annual review, and adjustments should be made if necessary.&quot;</td>
<td>OPA</td>
<td>&quot;The rate charged should be adequate to cover losses and expenses, and should be reasonable in relation to the insurer's experience. The rate charged should be calculated on a periodic basis, taking into account any adjustment for the policy period. The rate charged should be subject to annual review, and adjustments should be made if necessary.&quot;</td>
<td>No change recommended.</td>
</tr>
</tbody>
</table>

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**Ad Hoc Team recommendation to exposure comments as of 10-14-2019**

**Best Practices for Regulatory Review of Predictive Analytics White Paper**

**Exposed Section VII.A to VII.C**

- The analysis should include the largest dollar and percentage impacts arising from the filing, including the impacts arising specifically from the adoption of the model or changes to the model as they translate into the proposed rating plan.
- Obtain a rate disruption/dislocation analysis, demonstrating the distribution of percentage impacts on renewal business (created by rerating the current book of business), and specific effects of rate changes if there is concern about particular significant impacts that have otherwise yet to be substantiated.
- No change recommended.

**Exposed Section VIII.**

- The filed rating plan should contain enough information for a regulator to be able to validate policy premiums. However, for a small changes to a risk characteristic/variable. Note that this information may be proprietary.
- Add C.7.h information element:
  - "clarification is needed to inquire as to how consumers can verify their data and correct errors."
<table>
<thead>
<tr>
<th>Page</th>
<th>Exposed Section VII A or VII C</th>
<th>Commenter Name</th>
<th>Commenter's Suggestion</th>
<th>Real Ad Hoc Team Recommendation</th>
</tr>
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<tbody>
<tr>
<td>23/4</td>
<td>C.8.a</td>
<td>NAIC</td>
<td>Should be consistent and not conflict with updates and improvements.</td>
<td>No change recommended.</td>
</tr>
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<td>23/4</td>
<td>Ad Hoc</td>
<td>NAIC</td>
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<tr>
<td>23/4</td>
<td>C.8.a</td>
<td>Ad Hoc</td>
<td>&quot;Obtain sufficient information to understand how the model outputs are used within the rating system and to verify that the rating plan, in fact, reflects the model output and any adjustments made to the model output.&quot;</td>
<td>Add to comment field: &quot;The regulator can review the rating plan's manual to see that modeled output is properly reflected in the manual's factors, rates, tables, etc.&quot;</td>
</tr>
<tr>
<td>Page</td>
<td>Exposure &amp; Commentary</td>
<td>Commenter Name</td>
<td>Commenter’s Suggestion</td>
<td>Final Ad Hoc Team Recommendation</td>
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<tr>
<td>8-182</td>
<td>V Eli PROPOSED CHANGES TO THE PRODUCT FILING REVIEW HANDBOOK</td>
<td>24/1</td>
<td>Generally, we think it is premature to start drafting changes to the &quot;Product Review Handbook&quot; while the best practices themselves are still in draft form and could naturally change.</td>
<td>We do not believe this is premature. Some issues were need to be addressed. The sections from the handbook and white paper will need to be synchronized at the end of the paper's development.</td>
</tr>
<tr>
<td>8-182</td>
<td>24/2</td>
<td>NEW</td>
<td>The Task Force was charged to propose modifications to the 2016 Product Filing Review Handbook to reflect best practices for the regulatory review of predictive analytics. The following are the titled sections in Chapter Three &quot;The Basics of Property and Casualty Rate Regulation.&quot; Proposed changes are shown as tracked changes.</td>
<td>Text from 5-14-2019 Exposure Page/Parag. 24/1/NEW/WATCH TABLE</td>
</tr>
<tr>
<td>8-182</td>
<td>24/2</td>
<td>No changes are proposed to the following sections at the beginning of Chapter Three: “Innovations,” “Rating Laws and Standards,” “Rate Justification and Supporting Data,” “Number of Years of Data,” “Data Segmentation,” “Data Adjustments,” “Premium Adjustments,” “Loss Adjustments,” “Loss Adjustments (provisions),” “Loss Adjustment Expenses,” “Data Quality,” “Rate Justification: Overall Rate (sts),” “Contingent Provisions,” “Enabling Calculation of Expected Net and Net Methodology (Extract Premium and/or Extract Methods),” “Rate Justification: Rating Factors,” “Calculation of Overall Rate,” “Rating Factors,” and “Enabling for Rating Factors.”</td>
<td>No changes are proposed to the following sections at the beginning of Chapter Three: “Innovations,” “Rating Laws and Standards,” “Rate Justification and Supporting Data,” “Number of Years of Data,” “Data Segmentation,” “Data Adjustments,” “Premium Adjustments,” “Loss Adjustments,” “Loss Adjustments (provisions),” “Loss Adjustment Expenses,” “Data Quality,” “Rate Justification: Overall Rate (sts),” “Contingent Provisions,” “Enabling Calculation of Expected Net and Net Methodology (Extract Premium and/or Extract Methods),” “Rate Justification: Rating Factors,” “Calculation of Overall Rate,” “Rating Factors,” and “Enabling for Rating Factors.”</td>
<td>No changes are recommended. No changes are recommended. No changes are recommended.</td>
</tr>
<tr>
<td>8-182</td>
<td>24/2</td>
<td>NEW</td>
<td>The following statement appears in Chapter 3: Data Adjustments of the handbook: &quot;Because the insurance contracts will be written to cover future accident periods, the past data needs to be adjusted to reflect the anticipated future premiums and costs. These adjustments will provide a profit/loss picture if no rate change occurs. Calculations can then be made to determine the overall rate need (or indication).&quot;</td>
<td>The following statement appears in Chapter 3: Data Adjustments of the handbook: &quot;Because the insurance contracts will be written to cover future accident periods, the past data needs to be adjusted to reflect the anticipated future premiums and costs. These adjustments will provide a profit/loss picture if no rate change occurs. Calculations can then be made to determine the overall rate need (or indication).&quot;</td>
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<td>8-182</td>
<td>24/2</td>
<td>NEW</td>
<td>If the pricing of rating variables is evaluated separately for each rating variable, there is potential to miss the interaction between rating variables. Conversely, evaluating the entire universe of rating variables in one model would allow for an examination of the interaction between variables.</td>
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<tr>
<td>8-182</td>
<td>24/2</td>
<td>NEW</td>
<td>From page 28, eliminate what appears to be more commentary than guidance.</td>
<td>From page 28, eliminate what appears to be more commentary than guidance.</td>
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The following statement appears in Chapter 3: Data Adjustments of the handbook: "Because the insurance contracts will be written to cover future accident periods, the past data needs to be adjusted to reflect the anticipated future premiums and costs. These adjustments will provide a profit/loss picture if no rate change occurs. Calculations can then be made to determine the overall rate need (or indication)."
### Best Practices for Regulatory Review of Predictive Analytics White Paper

<table>
<thead>
<tr>
<th>Text from 5-14-2019 Exposure of Complex Model Best Practices White Paper</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advisor Team recommendation to expose comments as of 10-14-2019</strong></td>
</tr>
<tr>
<td>(Text in red are action items to be handled in a future draft of the white paper.)</td>
</tr>
</tbody>
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<td><strong>NEW</strong> Section 10.2.1, Interaction between Rating Variables (Multivariate Analysis):** states &quot;If the pricing of rating variables is evaluated sequentially for each rating variable, there is potential to miss the interaction between rating variables.&quot; We would rephrase this as &quot;If each rating variable is evaluated sequentially, statistically significant interactions between rating variables will not be identified and thus, not included in the rating plan.&quot;</td>
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<td><strong>NEW</strong> &quot;It is possible for models specifically trained for non-linear and non-based models, such as random forests or ensemble to contain relationships between variables for which an intuitive explanation is not immediately obvious. Further, such models can also indicate hundreds of such relationships.&quot;</td>
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<tr>
<td><strong>NEW</strong> &quot;Ad Hoc Team recommendation to exposure comments as of 10-14-2019. We would suggest adding to that sentence, &quot;and you should require definitions of all data elements that can affect the charged premium.&quot;&quot;</td>
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<tr>
<td><strong>NEW</strong> &quot;The sentence &quot;Finding rating or underwriting characteristics that may violate public policy is becoming more difficult for regulators with the increasing and innovative ways insurers use predictive models.&quot; was added. We feel this sentence warrants further explanation. The draft states that identification of public policy violations &quot;is becoming more difficult.&quot; How is this so? It is more difficult to review a filing for many reasons, including but not limited to: the complexity of predictive models, requires more extensive review before the nature of their treatments and qualifications are disclosed, and there are elements within the predictive model, e.g., certain variables, whose connection to insurance risk is not readily apparent and must be made clear to the satisfaction of the regulator.&quot;</td>
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<td><strong>NEW</strong> &quot;Further, the phrase &quot;increasing and innovative ways insurers use predictive models&quot; was added here with the note that insurers would willingly provide or disclose that models disclose outcomes with limited public policy. While other insurers are assuming this variable, we would not disclose it. The draft note is misleadingly worded. This means that, this does not happen in part of an effort to streamline public policy needs. No changes recommended. We see the commenter is reading too much into this paragraph. We don't think the phrase implies obfuscation. Lack of transparency may lead to deeper inquiries, but it is not believed that a company is intentionally creating models that aren’t stated law.</td>
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<td><strong>NEW</strong> &quot;From page 26, deinterlace what appears to be more commentary than guidance. Finding rating or underwriting characteristics that may violate public policy is becoming more difficult for regulators with the increasing and innovative ways insurers use predictive models.&quot;</td>
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<td><strong>NEW</strong> &quot;We would rephrase this as &quot;If each rating variable is evaluated sequentially, statistically significant interactions between rating variables will not be identified and thus, not included in the rating plan.&quot;&quot;</td>
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**NEW** Approval of Classification Systems - page 30 of Handbook

With rate changes, companies sometimes propose revisions to their classification system. Because the changes to the classification plan can be significant and have large impacts on the consumers' rates, regulators should focus on these changes.

**NEW** "You should be aware of your state's demanding regulations regarding which rating factors are allowed. Findings regarding underwriting characteristics that may violate public policy is becoming more difficult for regulators with the increasing and innovative ways insurers use predictive models." We would add the following sentence, "and you should require definitions of all data elements that can affect the charged premium." |

**NEW** "The sentence "Finding rating or underwriting characteristics that may violate public policy is becoming more difficult for regulators with the increasing and innovative ways insurers use predictive models." was added. We feel this sentence warrants further explanation. The draft states that identification of public policy violations "is becoming more difficult." How is this so? It is more difficult to review a filing for many reasons, including but not limited to: the complexity of predictive models, requires more extensive review before the nature of their treatments and qualifications are disclosed, and there are elements within the predictive model, e.g., certain variables, whose connection to insurance risk is not readily apparent and must be made clear to the satisfaction of the regulator." |

**NEW** "Further, the phrase "increasing and innovative ways insurers use predictive models" was added here with the note that insurers would willingly provide or disclose that models disclose outcomes with limited public policy. While other insurers are assuming this variable, we would not disclose it. The draft note is misleadingly worded. This means that, this does not happen in part of an effort to streamline public policy needs. No changes recommended. We see the commenter is reading too much into this paragraph. We don't think the phrase implies obfuscation. Lack of transparency may lead to deeper inquiries, but it is not believed that a company is intentionally creating models that aren’t stated law.

**NEW** From page 26, deinterlace what appears to be more commentary than guidance. Finding rating or underwriting characteristics that may violate public policy is becoming more difficult for regulators with the increasing and innovative ways insurers use predictive models."
### Best Practices for Regulatory Review of Predictive Analytics White Paper

#### Text From 5-14-2019 Exposure

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<td>NEW</td>
<td>Some states allow insurers to have multiple rate levels, or rating tiers, within a single company. These rating tiers are another way of classifying risks for rating purposes. Typically, there are arrangements for rating tiers with the underwriting standards for each tier. From a regulatory perspective, underwriting standards vary significantly from one insurer to another. Additionally, the underwriting standards for each tier should be mutually exclusive, clear, and objective, so there should be a division between the expected losses or expenses for each tier and the premium rates should be sustainable. Tiers within a company are mainly seen in personal lines products.</td>
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<td>NEW</td>
<td>One particular concern with rating tiers would be failure of analysis of whether applying certain characteristics of the customer. Question arises around the time when a customer is placed in a tier. The underwriting standards are only established at the time of entry into the tier. This is because of a type of insurance in the prior 12 months. The question is, What happens upon renewal after there has been no longer been a period of insurance for 12 months? Now the underwriting standards are established so that would be new business. Some standards limit the amount of time that rating tiers, losses, history, or insurance scores can be used, while some experts might allow credit history to be useful in rating at the policyholder’s request. Regulators should consider the acceptability of differences in rates between same-aged new and older policyholders when they have the same current income profile.</td>
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<tr>
<td>NEW</td>
<td>Insurers also use a simplified rating approach, having separate rating tiers within a group. While regulators should examine warning fees within an insurer to a high degree of scrutiny for techniques, there tends to be less scrutiny with differences in rates that exist between affiliated companies. Regulators’ compensation insurers are more likely to obtain rating fees using separate companies.</td>
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<td>NEW</td>
<td>#1 Justification: New Products – (No Change proposed)</td>
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<td>NEW</td>
<td>Predictive Modeling – page 31 of Handbook</td>
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<td>NEW</td>
<td>The list of computers to process massive amounts of data has led to the exponential use of predictive modeling in insurance rating. Predictive models have enabled insurers to build rating, marketing, underwriting, and claim models with significant predictiveness, predictive power, and ability to understand customer behaviors.</td>
<td></td>
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<td>NEW</td>
<td>Insurers’ usual procedures on paying claims, including data from past claims, has a significant potential benefit to both consumers and insurers. Predictive analytics can reveal insights into the relationship between claims behavior and the cost of claims. For example, the average cost of a collision claim is $3,500, but the cost can vary significantly across different models. But as the cost of claims is reduced, the cost of premiums also decreases. This is because of a type of insurance in the prior 12 months. The question is, What happens upon renewal after there has been no longer been a period of insurance for 12 months? Now the underwriting standards are established so that would be new business. Some standards limit the amount of time that rating tiers, losses, history, or insurance scores can be used, while some experts might allow credit history to be useful in rating at the policyholder’s request. Regulators should consider the acceptability of differences in rates between same-aged new and older policyholders when they have the same current income profile.</td>
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<td>NEW</td>
<td>The term “predictive model” refers to a set of models that use statistics to predict the future outcome of an event. Predictive models are useful in many areas, including marketing, sales forecasting, and risk management.</td>
<td></td>
<td>Predictive models are useful in many areas, including marketing, sales forecasting, and risk management.</td>
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<tr>
<td>NEW</td>
<td>To further explore this review of models in the future, modeling methods are evolving rapidly and not limited just to GLMs. As computing power grows exponentially, it is improving the modeling world to more sophisticated forms of data acquisition and data analysis. As a result, predictive analytics are evolving rapidly, allowing more complex models to predict the future outcomes of events. New models are being developed with specific information that will allow the regulator to review and understand the output of the model.</td>
<td></td>
<td>Predictive models are useful in many areas, including marketing, sales forecasting, and risk management.</td>
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We again note that there is a singular emphasis on GLMs. We will reiterate our concern that other models like neural networks, genetic algorithms, or rule-based systems are not addressed. We suggest doing a bit of research. All regulatory systems are context dependent and the risk of models is inherently insurmountable.

NEW

A. Generalized Linear Models

LJARCE

Section "Predictive Modeling," part A "Generalized Linear Models".

We again note that there is a singular emphasis on GLMs. We will reiterate our concern that other models like neural networks, genetic algorithms, or rule-based systems are not addressed. We suggest doing a bit of research. All regulatory systems are context dependent and the risk of models is inherently insurmountable.

No changes recommended.

NEW

The generalized linear model (GLM) is a commonly used predictive model in insurance applications, particularly in building insurance products’ strategies. Because auto and home insurers are most concerned about personal lines, NAIC has developed a white paper for guidance[1] in reviewing GLMs for personal automobile and home insurance.

A/HC

generally use beyond GLMs

The generalized linear model (GLM) is a commonly used predictive model in insurance applications, particularly in building insurance products’ strategies. Because auto and home insurers are most concerned about personal lines, NAIC has developed a white paper for guidance[1] in reviewing GLMs for personal automobile and home insurance.

No changes recommended.

NEW

Before GLMs became vogue, rating plans were built using univariate methods. Univariate methods were considered rational and easy to demonstrate the relationship to costs (loss and/or expense). However, many consider univariate methods too simplistic since they do not take into account the interaction (or dependencies) of the selected input variables. GLM introduces significant improvements over univariate-based rating plans by automatically adjusting correlations among input variables. Today, there are many predictive models used in private passenger automobile and home insurance rating plans are GLMs. But, GLM results are not always rational and the relationship to costs may be difficult to explain.

Allstate

On pages 8-9, the white paper says: "Univariate methods were considered rational...

In this section, it is not clear what is meant by the term "rational." For example, many consider univariate methods too simplistic since they do not consider the interaction or dependencies of the selected input variables. GLM introduces significant improvements over univariate-based rating plans by automatically adjusting correlations among input variables. Today, there are many predictive models used in private passenger automobile and home insurance rating plans are GLMs. But, GLM results are not always rational and the relationship to costs may be difficult to explain.

No changes recommended.

NEW

Before GLMs became vogue, rating plans were built using univariate methods. Univariate methods were considered rational and easy to demonstrate the relationship to costs (loss and/or expense). However, many consider univariate methods too simplistic since they do not take into account the interaction or dependencies of the selected input variables. GLM introduces significant improvements over univariate-based rating plans by automatically adjusting correlations among input variables. Today, there are many predictive models used in private passenger automobile and home insurance rating plans are GLMs. But, GLM results are not always rational and the relationship to costs may be difficult to explain.

A/HC

Generally use beyond GLMs

The generalized linear model (GLM) is a commonly used predictive model in insurance applications, particularly in building insurance products’ strategies. Because auto and home insurers are most concerned about personal lines, NAIC has developed a white paper for guidance[1] in reviewing GLMs for personal automobile and home insurance.

No changes recommended.

NEW

A GLM consists of three elements:

- Each component of the GLM is independent and probability distribution from the exponential family, or more generally, a saturated variance function and dispersion parameter.

NEW

A/HC

On pages 26 in the GLM, it states "the first bullet states" each component of Y is independent... "but Y" is never introduced nor defined.

Replace with:

- "A target variable, Y, is a random variable that is independent and follows probability distribution from the exponential family, defined by the selected variance function and dispersion parameters."
### Best Practices for Regulatory Review of Predictive Analytics White Paper

**Ad Hoc Commented Draft 4/2/2019 v1**

**Text from 5-14-2019 Exposure**

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<tr>
<td>VIII to XVI</td>
<td><strong>NEW</strong></td>
<td>All data</td>
<td>We agree. If the underlying data is not credible no model will improve that credibility, and some segmentation methods could make credibility worse.</td>
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<td></td>
<td><strong>NEW</strong></td>
<td>Allstate</td>
<td>On page 26, in the section “B. Credibility of Model Output”, there should be acknowledgement that if a GLM method lacks credibility, then other methods will also lack credibility. A lack of credibility is not an issue that is unique to GLMs. In other segments, there is little data, the resulting uncertainty would not be reflected in the GLM parameter estimates themselves (along with it might be reflected in the standard errors/coefficients interval). Even though the process of selecting relativities often includes adjusting the raw GLM output, the resulting relativities contain credibility weighted with any component of credibility. Nevertheless, selected relativities based on GLM output may differ from GLM point intervals.</td>
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<td><strong>NEW</strong></td>
<td>APCA</td>
<td>From page 26, B. Credibility of Model Output, delete sentence: &quot;GLM output is typically assumed to be 100% credible no matter the context or uncertainty, and all other methods can only improve that credibility.&quot; GLM software provides point estimates and allows the modeler to consider standard confidence intervals. Modelers may apply judgment to make selections that consider the parameter estimates from the GLM model, the conditions around the parameter estimates, the business problem at hand, and credibility. The performance of the final rating factors, which may include parameter estimates directly from the GLM model as well as selections, should be measured through a new model validation technique.</td>
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<td><strong>NEW</strong></td>
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<td>Because of this presumption in credibility, which may or may not be valid in practice, the modeler and the regulator reviewing the model would need to engage in thoughtful consideration when incorporating GLM output into a rating plan to ensure that model predictiveness is not compromised by any lack of actual credibility. Therefore, it is important that the modeler not take for granted that GLM output is always credible, and must include validation evidence for the rating plan, not just the statistical model.</td>
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<td></td>
<td><strong>NEW</strong></td>
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<td><strong>NEW</strong> What is a &quot;Best Practice&quot;? A best practice is a form of program evaluation in public policy. At its most basic level, a practice is a &quot;tangible and visible behavior… [based on] an idea about how the actions... will solve a problem or achieve some goal?&quot; Best practices can maintain quality on an alternative to any authorized legal standards and can be based on self-assessment or benchmarking. Therefore, a best practice represents an effective method of problem solving. The &quot;problem&quot; regulators want to solve is probably better posed as asking an answer to this question: How can regulators determine that predictive models, as used in rate filings, are compliant with state laws and regulations? However, best practices are not intended to codify standards for filings that include predictive models.</td>
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<td><strong>NEW</strong></td>
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<td><strong>NEW</strong> Best practices are based on the following principles that promote a comprehensive and coordinated review of predictive models:</td>
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<td>• State insurance regulators will maintain their current regulatory authority.</td>
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<td>• State insurance regulators will provide information to aid companies in getting insurance products to market more quickly.</td>
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<td>• State insurance regulators will share expertise and discuss technical issues regarding predictor models.</td>
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<td>• State insurance regulators will maintain confidentiality, where appropriate, regarding predictor models.</td>
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*Fn2* Nolthenius, C. (2014,) Solving the Eightfold Path to More Effective Problem Solving, Thou and Dick, Falls Church, VA.

### Best Practices for Regulatory Review of Predictive Analytics White Paper

**Exposed Sections VIII to XVI Commenter's Suggestion Final Ad Hoc Team Recommendation**

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<td>NEW</td>
<td>The knowledge needed to review predictive models, and guidance regarding GLMs for personal automobile and home insurance may be transferrable when the review involves GLMs applied to other lines of business. Modeling depends on context, so the GLM reviewer has to be alert for data challenges and business applications that differ from the more familiar personal lines. For example, a comparison of personal and commercial lines, modeling for rates in commercial lines is more likely to encounter lower volumes of historical data, dependence on advisory loss costs, unique accounts, and products that build upon lines of business and coverage building blocks.</td>
<td>There are a few places in the draft where the text provides guidance on how to compare personal and commercial lines. The GLM reviewer has to be alert for data challenges and business applications that differ from the more familiar personal lines. For example, compared to personal lines, modeling for rates in commercial lines is more likely to encounter lower volumes of historical data, dependence on advisory loss costs, unique accounts, and products that build upon lines of business and coverage building blocks.</td>
</tr>
<tr>
<td>NEW</td>
<td>The legal and regulatory constraints (including state variations) are likely to be more evolved, and challenging, for personal automobile and home insurance. ... modeling for rates in commercial lines is more likely to encounter lower volumes of historical data, dependence on advisory loss costs, unique accounts, and products that build upon lines of business and coverage building blocks.</td>
<td>Through review of these filings, the legal and regulatory constraints (including state variations) are likely to be more evolved, and challenging, in personal lines. A GLM rate model for personal lines in 2019 is either an update or a late adopter's defensive tactic.</td>
</tr>
<tr>
<td>NEW</td>
<td>Guidance offered here might be useful (with deeper adaptations) when starting to review different types of predictive models. If the model is not a GLM, some listed items might not apply. Not all of predictive models generate p-values or F-test. Depending on the model type other considerations might be important. When transferring guidance to other lines of business and other types of model, unique considerations may arise depending on the context in which a predictive model is proposed to be deployed, the issues which is of interest to put and the potential consequences for the insurer, its customers and competitors. This guidance does not delve into these possible considerations but regulators should be prompt to address them as they arise.</td>
<td>This statement &quot;Best practices can, also, make the regulator's review more consistent across states and more efficient, and assist companies in getting their products to market faster.&quot; appears on page 35 in the &quot;What is a Best Practice&quot; section. The statement is warranted, but sound only if it is not overly prescriptive, as regulatory authorities are not always able to perform the processes as outlined.</td>
</tr>
<tr>
<td>NEW</td>
<td>Best practices will help the regulator understand if a predictive model is cost based if the model is not a GLM, some listed items might not apply. Not all of predictive models generate p-values or F-tests. Depending on the model type other considerations might be important. When transferring guidance to other lines of business and other types of model, unique considerations may arise depending on the context in which a predictive model is proposed to be deployed, the issues which is of interest to put and the potential consequences for the insurer, its customers and competitors. This guidance does not delve into these possible considerations but regulators should be prompt to address them as they arise.</td>
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</tr>
<tr>
<td>Page/Parag.</td>
<td>Exposed Sections VIII to XVI</td>
<td>Commenter Name</td>
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<td>------------</td>
<td>-------------------------------</td>
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</tr>
<tr>
<td>NEW</td>
<td>2. Thoroughly review all aspects of the model including the source data, assumptions, adjustments, variables, and resulting output.</td>
<td>CAPRIC</td>
</tr>
<tr>
<td>NEW</td>
<td>3. Determine that individual input characteristics to a predictive model and their resulting rating factors are related to the expected loss or expense differences in risk. Each input characteristic should have an intuitive or demonstrable causal relationship to expected loss or expense.</td>
<td>All data</td>
</tr>
<tr>
<td>NEW</td>
<td>a. Merge 2.a into 2.a. In order to determine that inputs are related to loss/expense one needs the associated factors (weight or directly derived from the model).</td>
<td>CAPRIC</td>
</tr>
</tbody>
</table>

For part (b), we feel that regulators should be asking for a histogram of rate changes, with the expectation that there are not a lot of outliers. An explanation of individual changes tracks the overviews. Moreover, this level of detail does not appear to market.

The amount of information required may vary by filing and is up to each state’s discretion.

No change recommended.

There may be a misunderstanding in what this best practice is looking for. We are not looking for a listing of individual policy changes but for changes aggregated by either dollar or percent change categories. We do not believe an overview of burninidence. These projections have to be submitted for approval, and exhibits may already require and should be readily available. And, state often request dollar impact as well as percent change distributions to identify extreme changes or outliers.

It is also important for regulators to explain the impact to policyholders. Therefore, the regulator needs to know which factor changes were most important in the extreme disruptions.

No change recommended.

We agree that aggregated disruption analysis may be all that is needed, not individual policy identification and changes. However, we do not believe it is overreach to understand the cause of extreme disruptions. Therefore, the regulator needs to know which factor changes were most important in the extreme disruptions.

No change recommended.

We are troubled by the use of the word “thoroughly,” particularly with respect to data. Actuaries and data scientists would consider a “thorough” review of the source data to require direct access to the data and include exploratory data analysis beyond the capabilities of most DOIs. Additionally, insurers historically are usually not asked to provide such detailed data for a rate filing.

No recommended change.

Thoroughly review all aspects of the model including the source data, assumptions, adjustments, variables, and resulting output.

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No change recommended.
<table>
<thead>
<tr>
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<tr>
<td>Text from 5-14-19 Exposure White Paper</td>
<td>Ad Hoc Team recommendations to exposure e-comment as of 10-14-2019</td>
<td></td>
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<tr>
<td>(Text in red are action items to be handled in a future draft of the white paper.)</td>
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<table>
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<th>New Item</th>
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<th>Commenter’s Suggestion</th>
<th>Final Ad Hoc Team Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEW</td>
<td>• In item c, we again note the use of the word “intuitive”. In this context, the word “intuitive” has been added, which we assume considers the fact that insurers may have fair and accurate models for which there is no ready intuitive explanation (see related point above).</td>
<td>CASRRC</td>
<td>Revise text to:</td>
<td></td>
</tr>
<tr>
<td>NEW</td>
<td>b. Determine that the data used as input to the predictive model is accurate, including a clear understanding of how inputting values, erroneous values, and deleted values are handled.</td>
<td>All data</td>
<td>No longer recommended. While the data used as input to the predictive model is accurate, including a clear understanding of how inputting values, erroneous values, and deleted values are handled.</td>
<td></td>
</tr>
<tr>
<td>NEW</td>
<td>c. Determine that any adjustments to the data are handled appropriately, including how the data is updated and whether the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.</td>
<td>CASRRC</td>
<td>Revise text to:</td>
<td></td>
</tr>
<tr>
<td>NEW</td>
<td>d. Determine whether the data used as input to the model is compatible with practices allowed in the jurisdiction and do not reflect characteristics prohibited in the state for the purposes of ratemaking.</td>
<td>California Department of Insurance</td>
<td>No longer recommended. While the data used as input to the predictive model is accurate, including a clear understanding of how inputting values, erroneous values, and deleted values are handled.</td>
<td></td>
</tr>
<tr>
<td>NEW</td>
<td>• A clear understanding of how the selected predictive model was built and why the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.</td>
<td>All data</td>
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<td></td>
</tr>
<tr>
<td>NEW</td>
<td>• Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated and whether the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.</td>
<td>All data</td>
<td>No longer recommended. While the data used as input to the predictive model is accurate, including a clear understanding of how inputting values, erroneous values, and deleted values are handled.</td>
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<td>a. Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated and whether the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.</td>
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<td>Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated and whether the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.</td>
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<td>Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated and whether the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.</td>
<td></td>
</tr>
<tr>
<td>NEW</td>
<td>b. Obtain a clear understanding of how the selected predictive model was built and why the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.</td>
<td>CASRRC</td>
<td>Observe whether the data used in relation to the model is compatible with practices allowed in the jurisdiction and do not reflect characteristics prohibited in the state.</td>
<td></td>
</tr>
<tr>
<td>NEW</td>
<td>c. Obtain a clear understanding of how the selected predictive model was built and why the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.</td>
<td>CASRRC</td>
<td>Observe whether the data used in relation to the model is compatible with practices allowed in the jurisdiction and do not reflect characteristics prohibited in the state.</td>
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<tr>
<td>NEW</td>
<td>d. Obtain a clear understanding of how the selected predictive model was built and why the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.</td>
<td>CASRRC</td>
<td>Observe whether the data used in relation to the model is compatible with practices allowed in the jurisdiction and do not reflect characteristics prohibited in the state.</td>
<td></td>
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<tr>
<td>NEW</td>
<td>e. Obtain a clear understanding of how the selected predictive model was built and why the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.</td>
<td>CASRRC</td>
<td>Observe whether the data used in relation to the model is compatible with practices allowed in the jurisdiction and do not reflect characteristics prohibited in the state.</td>
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<tr>
<td>NEW</td>
<td>f. Obtain a clear understanding of how the selected predictive model was built and why the insurer believes this type of model works in a private passenger automobile or homeowner’s insurance risk application.</td>
<td>California Department of Insurance</td>
<td>Observe whether the data used in relation to the model is compatible with practices allowed in the jurisdiction and do not reflect characteristics prohibited in the state.</td>
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</table>

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Sections Written by: 44 of 62

About the Authors - Fall 2019

Casualty Actuarial and Statistical (C) Task Force

Attachment Two B

8-189

12/7/19
<table>
<thead>
<tr>
<th>Rule #</th>
<th>Exposure of Sections VIII to XVI</th>
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<th>Commenter’s Suggestion</th>
<th>Final Ad Hoc Team Recommendation</th>
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<tbody>
<tr>
<td>NEW</td>
<td>Enable innovation in the pricing of insurance through acceptance of predictive models, provided they are actuarially sound and in compliance with state laws.</td>
<td>ASBO</td>
<td>Text: “though” should be “through”</td>
<td>Text: “though” should be “through”</td>
</tr>
<tr>
<td>NEW</td>
<td>Protect the confidentiality of filed predictive models and supporting information, as provided in Section VII of the paper.</td>
<td>ASBO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEW</td>
<td>Review predictive models in a timely manner to enable reasonable speed to market.</td>
<td>ASBO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEW</td>
<td>Information regarding Predictive Analytics</td>
<td>ASBO</td>
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</tbody>
</table>

To assist the regulator in following best practices, the Casualty Actuarial and Statistical Task Force (CASTF) is issuing a white paper titled: Regulatory Review of Predictive Analytics Best Practices. The paper contains a list of information elements, and considerations that should be used during the review of a model, and a rating plan. To further assist the regulator, these information elements were mapped into the above best practices listed above in Section VIII of the paper.

| Ad Hoc | general guidance beyond UGMs | | |
| Ad Hoc | general guidance beyond UGMs | | |

Guidance on these might be useful, but also depend on context as to review different types of predictive models. If the model is not a GLM, some listed items might not apply. For example, not all models are seen as regulatory or actuarial; some other considerations might be important. When transferring guidance to other forms of business and other types of models, unique considerations may arise, depending on the context in which a predictive model is proposed to be deployed. The assumption is, which is proposed to be put, and the potential consequences as for the insurer, its customers and its competitors. This paper does not delve into these possible considerations, but regulations should be prepared to address them as they arise.

| F IV | Refer to Table 1, which lists predictive models (see Section II, B) outlining the best practices. | | |

More elaborate guidelines are also incorporated into a number of state laws. However, insurers should be aware that a rating plan might be a actuarially sound part of the premium that is not determined by the actuarial cost of claims. In some states, the confidentiality of a rate filing, supplemental material to the filing, when filing information might be one public, the insurer to request that filing information be held confidential, and the insur er to request that file public records. It is important in an insurer to be familiar with such details, and understanding the confidentiality of information submitted with their rating plan.

| NEW | | | |

After applying credibility, the indicated rate change should reflect the company’s best estimate of their premium needs given their current or expected book of business. However, insurance companies also have other business considerations including competition, marketing, legal issues, impact of the rate change on retention, etc. A company might wish to defer from that indicated rate change and should justify those decisions, within the context of the law.

| NEW | Capping and Transition Rules | CASROC | | |

Though predictive models can result in significant rate disruption at renewal, capping and transition rules do not change because of the review of predictive models. This is a separate issue to be addressed in a separate issue to be addressed independently of the review of predictive models. Capping and transition rules are at the discretion of the state and vary by state.
### Best Practices for Regulatory Review of Predictive Analytics White Paper

#### Text from 5-14-2019 Exposure

<table>
<thead>
<tr>
<th>New</th>
<th>Expounder Section VIII to XVI</th>
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<tr>
<td></td>
<td>Transition rules for individual policyholders can get quite complex and you need to be aware of your state’s positions on premium capping rules. Any premiums capping and transition rules require weighing the pros and cons of the potential for unfair discrimination (with some customers not paying the same rate as others) vs. rate stability for existing policyholders.</td>
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<tr>
<td>NEW</td>
<td>If premium capping or transition rules are allowed, additional decisions will need to be made.</td>
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<tr>
<td>NEW</td>
<td>All rates should get capped.</td>
<td></td>
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<tr>
<td>NEW</td>
<td>Rate decreases get capped if so, what is the impact if the policyholder asks to be quoted as new business?</td>
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</tr>
<tr>
<td>NEW</td>
<td>Should the insured be told what the final premium will become once rate capping is applied?</td>
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</tr>
<tr>
<td>NEW</td>
<td>How would price change be addressed? (If the policyholder buys a new car or changes liability limits, what is the impact on rate capping?)</td>
<td></td>
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<tr>
<td>NEW</td>
<td>How much time will lapse or how many renewal cycles will occur before the new rates are implemented or different rating plans are merged?</td>
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</tr>
<tr>
<td>NEW</td>
<td>When premiums capping or transition rules have been incorporated, future indicated rate changes and rating factor analyses need to properly reflect the full extent of rate changes. If the overall approved rate changes is 10%, set capping resulted in only 8% being implemented in the first year, the re-estimation to recognize the full 10% should be reflected in the premium level adjustment. Otherwise, the individual rate would be misleading.</td>
<td></td>
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</tr>
<tr>
<td>NEW</td>
<td>Some states encourage a more frequent filing of rate changes that can help to avoid the need for premiums capping and transition rules. Some states might prefer capping of individual rating variables, rather than capping for individual policyholders.</td>
<td></td>
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<tr>
<td>NEW</td>
<td>Installment Plans – (No change is proposed)</td>
<td></td>
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<td>NEW</td>
<td>Policy fees – (No change is proposed)</td>
<td></td>
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<td>NEW</td>
<td>Potential changes to the Ad Hoc Team’s agenda – Page 35</td>
<td></td>
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</tr>
<tr>
<td>NEW</td>
<td>Every filing will be different and will require different regulatory analyses. But the following are some questions the regulator might ask oneself in a certifying review:</td>
<td></td>
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<tr>
<td>NEW</td>
<td>a. Regarding data</td>
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<tr>
<td>NEW</td>
<td>b. Is the data submitted with the filing enough information for a regulatory review?</td>
<td></td>
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<tr>
<td>NEW</td>
<td>c. Is the number of years of experience appropriate?</td>
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<tr>
<td>NEW</td>
<td>d. Did the company sufficiently analyze and control their quality of data?</td>
<td></td>
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<tr>
<td>NEW</td>
<td>2. Regarding the support and justification of rates</td>
<td></td>
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<tr>
<td>NEW</td>
<td>a. Do they propose rate changes written in justification?</td>
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<tr>
<td>NEW</td>
<td>b. Are they based on a judgment or competitive analysis? If so, are the results reasonable and credible? Are there inappropriate market conditions?</td>
<td></td>
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</tr>
<tr>
<td>NEW</td>
<td>c. Are the assumptions (loss development, trend, expense load, profit provision, crediting metrics) used to derive the indication appropriate and how they are supported with data and are deviations from data results sufficiently explored?</td>
<td></td>
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<tr>
<td>NEW</td>
<td>d. Better weighting of data factors (e.g. stabilizing properly justified or data, if appropriate)</td>
<td></td>
<td></td>
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<tr>
<td>NEW</td>
<td>Is there more weight being placed on data in one year solely because it produces a higher indicated rate change?</td>
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</table>
### Best Practices for Regulatory Review of Predictive Analytics White Paper

**Text from 5-14-2019 Exposure**

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<tr>
<td>NEW</td>
<td>• If there are two indications being weighted together and one is for a rate increase and one is for a rate decrease, is the weighting justified?</td>
<td>NEW</td>
<td>[NEW]</td>
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<tr>
<td>NEW</td>
<td>e. Is there satisfactory explanation about why a proposed rate change deviates from the indicated rate change?</td>
<td>NEW</td>
<td>[NEW]</td>
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<tr>
<td>NEW</td>
<td>3. Regarding differences in assumptions from previous filings:</td>
<td>NEW</td>
<td>[NEW]</td>
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<tr>
<td>NEW</td>
<td>a. Have methodologies changed significantly?</td>
<td>NEW</td>
<td>[NEW]</td>
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<tr>
<td>NEW</td>
<td>b. Are assumptions on the weighting of scores or credibility appropriately reflected to appear to be some manipulation to the rate indicator?</td>
<td>NEW</td>
<td>[NEW]</td>
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<tr>
<td>NEW</td>
<td>c. Do classifications comply with state requirements?</td>
<td>NEW</td>
<td>[NEW]</td>
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<tr>
<td>NEW</td>
<td>d. Are proposed rates established in a different way as to produce the same underwriting results?</td>
<td>NEW</td>
<td>[NEW]</td>
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<tr>
<td>NEW</td>
<td>4. Is there unfair discrimination?</td>
<td>NEW</td>
<td>[NEW]</td>
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<tr>
<td>NEW</td>
<td>a. Do classifications comply with state requirements?</td>
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<td>[NEW]</td>
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<td>NEW</td>
<td>b. Are proposed rates established so that different classes will produce the same underwriting results?</td>
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<td>[NEW]</td>
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<tr>
<td>NEW</td>
<td>c. If predictions are used in the rating plan, are there concerns related to input variables that are prohibited or proxies for prohibited variables?</td>
<td>NEW</td>
<td>[NEW]</td>
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<tr>
<td>NEW</td>
<td>d. If predictive models are used in the rating plan, are there concerns related to input proxies for prohibited variables?</td>
<td>NEW</td>
<td>[NEW]</td>
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<tr>
<td>NEW</td>
<td>e. Is there a satisfactory explanation about why a proposed rate change deviates from the indicated rate change?</td>
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<td>[NEW]</td>
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*Note: The above text is a redacted version of the original content.*

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**Ad Hoc Team recommendation to expose comments as of 10-14-2019**

---

**Third-Party Comments on 5-14-2019 Exposure of Complex Model Best Practices White Paper**

(Text in red are action items to be handled in a future draft of the white paper.)

---

**Best Practices for Regulatory Review of Predictive Analytics White Paper**

Ad Hoc Team recommendation to expose comments as of 10-14-2019

(Text in red are action items to be handled in a future draft of the white paper.)

---

**Casualty Actuarial and Statistical (C) Task Force**

If there are additional items of concern, the company can be notified so they will make appropriate modifications in future filings.

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**Other Reading – Page 36**

<table>
<thead>
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<td>Chapter 6: Risk Classification</td>
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<td>Chapter 8: Investment Issues in Property/Liability Insurance</td>
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<tr>
<td>NEW</td>
<td>• Casualty Actuarial Society (CAS) Statements of Principles, especially regarding property and casualty rating</td>
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<tr>
<td>NEW</td>
<td>• Casualty Actuarial Society (CAS) Statements of Principles, especially regarding property and casualty rating</td>
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<td>NEW</td>
<td>• American Institute for Chartered Property Casualty Underwriters “Insurance Operations, Regulations, and Statutory Accounting” Chapter Eight</td>
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<td>NEW</td>
<td>• NAIC’s Casualty Actuarial and Statistical Task Force White Paper “Regulatory Review of Predictive Models”</td>
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<tr>
<td>NEW</td>
<td>• Summary — Page 67</td>
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<tr>
<td>NEW</td>
<td>Rate regulation for property/casualty lines of business requires significant knowledge of loss rating laws, rating standards, statistical modeling, and:</td>
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<tr>
<td>NEW</td>
<td>• Rating laws vary by state, but the rating law are usually grouped into three categories, fee-in or use and file, non-file (open competition), and:</td>
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<td>NEW</td>
<td>• Rely on data typically included in the state regulations require that “rates shall not be inadequate, excessive, or unfairly discriminatory.”</td>
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<tr>
<td>NEW</td>
<td>• A company will likely determine their indicated rate change by starting with historical data:</td>
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<tr>
<td>NEW</td>
<td>• Once an overall rate level is determined, the rate change gets allocated to individual classifications and other rating factors.</td>
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<tr>
<td>NEW</td>
<td>• Individual risk rating allows manual rates to be modified by an individual policyholder’s own experience.</td>
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<tr>
<td>NEW</td>
<td>• Advisory organizations provide the underwriting costs, so companies are able to develop their own expenses and profit provisions with their costs and other expenses.</td>
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<tr>
<td>NEW</td>
<td>• NAIC model law also include special provisions for workers’ compensation business.</td>
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<tr>
<td>NEW</td>
<td>• Best practices for reviewing predictive models outlined in the CASP Whitepaper “Guiding Principles for the Use of Predictive Models.”</td>
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</table>

**Policy text as follows:**

"Best practices for reviewing predictive models are provided in the CASP Whitepaper titled "Guiding Principles for the Use of Predictive Models." Although the white paper focuses on CASP for home and private passenger automobile insurance, some of the concepts may be transferable to other types of models and/or other lines of insurance."
NEW When are rating variables or rating plans too granular? How is granularity handled during the development of the model and during the selection of rate relativities filed in a rating plan supported by a model?

24/7 TBD When are rating variables or rating plans too granular? How is granularity handled during the development of the model and during the selection of rate relativities filed in a rating plan supported by a model?

Revise text as follows:

"During the development of the guidance, topics arose that are not thoroughly addressed in this paper. These topics may need to be addressed during the regulatory review of predictive models. A few of these topics may be discussed elsewhere within NAIC as either technical or policy matters. All of these topics, if addressed, will be part of the proposed state guidance. In many states, due to the data already collected, it may be too granular and may not be as effective in that state. If so, it may be of value to provide guidance around granularity, such as: When are rating variables or rating plans too granular? How is granularity handled during the development of the model or during the selection of rate relativities filed in a rating plan supported by a model?"

This paper acknowledges that different states will apply the guidance within it differently, based on variations in the legal environment pertaining to insurance regulation in those states, as well as the extent of available resources, including staff members with advanced knowledge and/or statistical expertise, the workloads of those staff members, and their training needs.

No additional changes are proposed to the Product Filing Review Handbook.

IX. PROPOSED STATE GUIDANCE

TBD – placeholder to include best practices for review of predictive models and analytics filed by insurers to justify rates.

This paper acknowledges that different states will apply the guidance within it differently, based on variations in the legal environment pertaining to insurance regulation in those states, as well as the extent of available resources, including staff members with actuarial and/or statistical expertise, the workloads of those staff members, and their training needs.

This paper acknowledges that different states will apply the guidance within it differently, based on variations in the legal environment pertaining to insurance regulation in those states, as well as the extent of available resources, including staff members with actuarial and/or statistical expertise, the workloads of those staff members, and their training needs. Ultimately, the insurance regulators within each state will decide how best to tailor the guidance within this paper to achieve the most effective and successful implementation, subject to the framework of statutes, regulations, precedents, and processes that comprise the insurance regulatory framework in that state.

X. OTHER CONSIDERATIONS

1. TBD. When are rating variables or rating plans too granular? How is granularity handled during the development of the model and during the selection of rate relativities filed in a rating plan supported by a model?

24/5 TBD: When are rating variables or rating plans too granular? How is granularity handled during the development of the model and during the selection of rate relativities filed in a rating plan supported by a model?

NEW No additional changes are proposed to the Product Filing Review Handbook.

NEW No additional changes are proposed to the Product Filing Review Handbook.
**Ad Hoc Team recommendation to exposure comment as of 10-14-2019**

<table>
<thead>
<tr>
<th>Date</th>
<th>Commenter</th>
<th>Suggestion</th>
<th>Final Ad Hoc Team Recommendation</th>
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<tbody>
<tr>
<td>24/8</td>
<td>TBD</td>
<td>Discuss the scientific mindset of open inquiry and its relevance to the best practice white paper.</td>
<td>We recognize that intuitive assisted aviators between predictor variables and the predicted variable are conceivable; however, ARDP does not require more than a correlation. ARDP 12 suggests that it is insufficient to demonstrate that &quot;the variation in actual or reasonably anticipated experience correlate to the risk characteristic.&quot;</td>
</tr>
<tr>
<td>24/9</td>
<td>TBD</td>
<td>Discuss correlation causally in general in relation to ARDP 12.</td>
<td>This white paper is general in its analysis of the correlation between the risk characteristic and expected outcome in order to use a specific risk characteristic while omitting the leading phrase &quot;while the actuary should select risk characteristics that are related to expected outcomes.&quot;</td>
</tr>
<tr>
<td>36/10</td>
<td>TBD</td>
<td>With following guidance provided in this white paper increase or pressure state regulatory budgets elsewhere?</td>
<td>Take this consideration as the result will be taken up in a state by state basis.</td>
</tr>
</tbody>
</table>

Adopted: 10/14/2019
### Best Practices for Regulatory Review of Predictive Analytics White Paper

**Text from 5-14-2019 Exposure of Complex Model Best Practices White Paper**

<table>
<thead>
<tr>
<th>Page</th>
<th>Exposure Sections VIII to XVI</th>
<th>Commenter Name</th>
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<tbody>
<tr>
<td>3/11</td>
<td>TIBO. Discussion of data mining being in conflict with standard scientific model and increase in “false positives.”</td>
<td></td>
<td></td>
<td>Defer to Task Force 416: Discuss in next iteration. Note: Discussion of data mining being in conflict with standard scientific model and increase in “false positives.” (Much of the following discussion is attributable to Jerrie Kallie, Michigan Department of Insurance, Financial Institutions &amp; Professional Registration.) Throughout this white paper, the regulator asks the modeler to go beyond correlation and document their basic, causal understanding of how variables used in a model or rating plan are related to risk. A correlation is not the final arbiter of validity of findings, but causal understanding can be reviewed across a variety of relationships and can yield additional insights into what are non-causal relationships, and which are most likely to be inducing causal relationships. Though this white paper does not delve deeply into these relationships are identified and documented, the paper does a fine modeler to provide their understanding of these relationships. The future considerations is whether the regulator should think deeply into the causal relationships of variables used in a model or rating plan. The Actuarial Statistical Association (ASA) impressed some degree of alarm at approaches to data mining (Waserman and Zadeh, 2010). In a formal statement of the ASA, the association warned against its so-called “black box” approach to analytics... “... a partial way (it taken itself often only weakly dense or even random) with which not only can such models be built up, but also are literally used (page 201). Last, the ASA warned strongly against an over-reliance on data mining. “Cherry picking promising findings, also known by such terms as data dredging, significance chasing...” (emphasis added) had a serious sense of analytically significant result... and should be rigorously avoided.” (page 201). A potential threat will increase significantly with the adoption of data mining techniques and the increasing availability of very large datasets that can plow everything available even just a single adverse (that data mining will threaten the risk of their model and increase in “false positives”) that has the potential to identify a non-causal results. Knowing which changes to make will be a challenge for data mining practitioners will significantly improve the model. Causality from the basis of the standard model of natural and social science. Evaluating on models should consider the nature of evidence of causal relationships.</td>
</tr>
<tr>
<td>3/12</td>
<td><strong>TIBO. Specify how the insurer will help educate consumers to mitigate their risk.</strong></td>
<td></td>
<td></td>
<td>Add/Rep/Hi/Consider:</td>
</tr>
</tbody>
</table>
Discuss the development of new tools and techniques for monitoring consumer market outcomes resulting from insurers' use of Big Data analytics in property and casualty rating plans.

"While regulators have historically pursued consumer protection by reviewing insurers' forms and rates on the front end, the variety and volume of new data sources and complexity of algorithms require a different front-end approach. Consumer protection in an era of Big Data analytics requires regulators to collate and analyze granular data on actual consumer market outcomes. This is not as easy as it sounds. Complex consumer reviews on the front end are likely no longer possible, but also because actual market outcomes may differ dramatically from historical or projected market outcomes. Stated differently, it is no longer sufficient to rely on a front-end as a point of data source or algorithm to ensure fair consumer treatment and to avoid unfair discrimination. Routine analysis of actual consumer market outcomes is needed. It is also completely feasible today."

NEW

Discuss policyholder disclosure when complex predictive model underlies a rating plan.

Delete this consideration and merge with item on "educate consumers" above.

Delete this consideration as confidentiality is adequately discussed elsewhere in this paper and will be determined by state law.

The following are examples of topics that may be included in the recommendations:

- TBD: Discuss confidentiality as it relates to filings submitted as part of the filing process.

Confidentiality, Proprietary Information, Trade Secrets, Confidential Tiers, and Information Sharing.

NAMIC wishes to continue to reiterate that exposing confidential and proprietary trade secrets, confidential information, and other business practices simply for accumulation of data in a rate filing, when otherwise unnecessary, is problematic for all involved. The data provided for these requirements subjects the regulator to increased Freedom of Information Act requests, subpoenas, and other types of litigation when there has been no demonstrated harm to consumers or triggers for the inquiry. Additionally, some proprietary trade or have contractual terms that prevent disclosure and therefore an interference with contractual relations may occur. Without a demonstrated necessity, exposing this data to additional dissemination appears to be detracting from protection.

While the Task Force has added discussion and information concerning protection of this information, which is appreciated, more should be done in the aggregate insurance consumer context including more discussion on this in the paper. Additionally, while the Task Force has been technical in its further review by NAMIC, there is concern that without that topic addressed, this paper may need further attention in the future and not provide specific action as opposed to the general nature of the discussion.

Delete this consideration as confidentiality is adequately discussed elsewhere in this paper and will be determined by state law.

- TBD: Discuss confidentiality as it relates to state statutes and regulations.

- TBD: Discuss confidentiality as it relates to filings submitted as part of the filing process.

### Text from 5-14-2019 Exposure

<table>
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<tbody>
<tr>
<td>3K/21</td>
<td>TBD: Discuss theme for NAC to update and strengthen information sharing platforms and protocols.</td>
<td>Delete from the comments going forward and move to X. Other Gnd directions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3K/22</td>
<td>TBD: Determine the means available to a consumer to correct or contest individual data input values that may be in error.</td>
<td>Delete this consideration and merge with item on “indicate consumer” above.</td>
<td></td>
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<tr>
<td>3K/23</td>
<td>TBD: Give an insurer’s rating rules more a predictive model and borrowing from insurance (h)and (d) of a risk, discuss question assignment (h) to adjust the risk’s premium without conversation with the insurer.</td>
<td>Delete this consideration and merge with item on “indicate consumer” above.</td>
<td></td>
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<tr>
<td>3K/24</td>
<td>Other TBDs</td>
<td>NAIC et al.</td>
<td>NAIC and others are concerned that the paper’s scope (GLMs used in PPA and HO) is too narrow.</td>
<td>Add new consideration: “The scope of this white paper was narrowed to GLMs as used in personal automobile and homeowners insurance applications. Many commenters expressed concern that the paper’s scope is too narrow. NAIC may want to expand these best practices or create new best practices for other lines of business, other insurance applications (other than personal automobile and homeowners) and other types of models.”</td>
</tr>
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</table>

### New

- New California Department of Insurance
- Add: TBD: Discuss whether the filer, in the development of the model, has used any proxies for variables which may cause regulatory concern, be expressly prohibited by state regulation/statute, or be perceived to be unfairly discriminatory.
- No change recommended.
- Proxies are already addressed in B.3.a.
- Add “proxy” to Glossary.

## VIII. APPENDIX A – BEST PRACTICE DEVELOPMENT

### A. Scope

Best practices development is a tool for reviewing available policy practices that have been effective in addressing particular issues and could be helpful to a current problem. This process relies on the assumptions that top performance is a result of good practices and these practices may be adapted and emulated by others to improve results.

The term “best practice” can be a misleading one due to the slippery nature of the word “best”. When proceeding with policy research of this kind, it may be more helpful to focus the paper on a way of identifying positive or processes that have enjoyed exceptional results and the underlying reasons for their success. This allows for a more realistic and accurate approach for making recommendations that might encompass pieces of many good practices.

### B. Identify Top Performers

Identify outstanding performers in this area to partner with and learn from. In this phase, it is key to review the best practices in a tangible behavior or process designed to solve a problem or achieve a goal. The identifying conduct at the organizational level important. Furthermore, Bardach’s importance of isolating evaluators in order to avoid improperly attributing results to a best practice without taking into account internal validity problems.

### C. Analyze Best Practices

Once successful practices are identified, analysts will begin to observe, gather information and identify the distinct elements that contribute to superior performance. Bardach suggests it is important at this stage to distill the useful elements of the processes down to their most essential ideas. This allows for flexibility since the practice is adopted for new or unique organization or location.

- **Ad Hoc**
Add definitions for composite variable, continuous variable, discrete variable, discrete variable level, and post-model adjustment.

Add "composite variable," "continuous variable," "discrete variable," "discrete variable level," and "post-model adjustment."
Data dredging: Data dredging is also referred to as data fishing, data snooping, data butchery, and come back with significant results, instead of stating a single hypothesis about an underlying effect before the analysis and then conducting a single test for it.

The process of data dredging involves automatically testing huge numbers of hypotheses about a single data set by exhaustively searching—perhaps for combinations of variables that might show a correlation, and perhaps for groups of traits or observations that show differences in their means or in their breakdown by some other variable.

Conventional tests of statistical significance are based on the probability that a particular result would arise if chance alone were at work, and necessarily accept some risk of mistaken conclusions of a certain type (type I error). This level of risk is absolute significance. When millions of tests are performed, some produce falsely significant results of this type. Because of the relatively unknown hypothesis, they cannot be significant at the 5% level. Therefore, to be significant at this level the results must often have enough hypotheses at hand. It is virtually certain that some will be statistically significant but misleading, as in almost every statistical test that is conducted.

It is important to note that data dredging is a common problem in data mining techniques, where researchers can easily be misled by these results. Researchers need to be cautious when using data mining techniques to avoid spurious correlations.

The multiple comparisons hazards are common in data dredging. Subgroups are sometimes explored without adhering to the model to the number of questions at issue, which can lead to misinterpreted results.

### Double Lift Chart

The double lift chart sorts based on the ratio of the two models’ predicted loss costs. Double lift charts directly compare the results of two models.

### Fair Credit Reporting Act

The Fair Credit Reporting Act was intended to protect consumers from the willful and/or negligent inclusion of inaccurate information in their credit reports. To that end, the FCRA regulates the collection, dissemination and use of consumer information, including consumer credit information.

### Generalized Linear Model

The Generalized Linear Model (GLM) is a flexible generalization of ordinary linear regression. It introduces the concept of the link function, which connects the expected value of the response variable to the linear predictor. For quantitative target variables such as those above, the GLM will produce an estimate of the expected value of the outcome. For other applications, the target variable may be the occurrence or non-occurrence of a certain event. Examples include:

- Whether or not a policyholder will renew their policy.
- Whether a submitted claim contains fraud.
- Type of vehicle, age, or marital status for personal auto insurance.

For such variables, a GLM can be applied to estimate the probability that the event will occur. The explanatory variables, or predictors, are denoted $x_1, x_2, \ldots, x_p$, where $p$ is the number of predictors in the model. Potential predictors are typically any policy term or policyholder characteristic that an insurer may wish to include in a correlation. Some examples are:

- Type of vehicle, age, or marital status for personal auto insurance.
- Geographic type, building age, or area of structure for home insurance.
### Best Practices for Regulatory Review of Predictive Analytics White Paper

**Test from 5-14-2019 Exposure**

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**Advice Team recommendation to expose comments as of 10-14-2019**

(Text in red are action items to be handled in a future draft of the white paper.)


- **Text from 5-14-2019 Exposure**
- **Third-Party Comments on 5-14-2019 Exposure of Complex Model Best Practices White Paper**

### Geodemographic Segmentation

- **New**
  - Whether or not a policyholder will renew his/her policy.
  - Whether a submitted claim contains fraud.
  - Type of vehicle, age, or marital status for personal auto insurance.
  - Construction type, building age, or amount of insurance (AOI) for home insurance.

- **Granularity of Data**
  - The granularity of data refers to the size in which data fields are subdivided.
  - For example, postal address can be recorded, with coarse granularity, as a single field:
    - Address: 1234 Main St, Anytown, CA 90210
  - Or, with fine granularity, as multiple fields:
    - Street address: 1234 Main St
    - City: Anytown
    - State: CA
    - Zip code: 90210

- **Insurance Data**
  - Some insurance companies may use databases to determine the probability that the event will occur.
  - The explanatory variables, or predictors, are denoted \( x_1, \ldots, x_p \), where \( p \) is the number of predictors in the model.
  - Potential predictors are typically any policy terms or policyholder characteristics, such as age, gender, or policy type.

- **Insurance Data**
  - Data collected by the insurance company.
  - Internal Event Form - Two predictor variables are used to test if the effect of one of the predictors on the target variable depends on the level of the other. Suppose that predictor variable \( x_1 \) and \( x_2 \) interact. A GLM model could account for the interaction by including interaction terms of the form \( x_1 x_2 \), in the formula for the linear predictor. For instance, rather than defining the linear predictor as \( \eta = \beta_0 + \beta_1 x_1 + \beta_2 x_2 \), the model instead could include terms \( \beta_3 x_1 x_2 \), \( \beta_4 x_1^2 \), or \( \beta_5 x_2^2 \).

- **Interaction Term**
  - The interaction term captures the relationship between two variables. For example, if we have a GLM with an interaction term \( x_1 x_2 \), the model could include terms \( \beta_3 x_1 x_2 \), \( \beta_4 x_1^2 \), or \( \beta_5 x_2^2 \).

- **Linear Predictor**
  - The linear predictor is the linear combination of explanatory variables \( x_1, x_2, \ldots, x_p \) in the model, e.g., \( \eta = \beta_0 + \beta_1 x_1 + \beta_2 x_2 \).

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<tbody>
<tr>
<td>Non-Insurance Data</td>
<td>Link Function - The link function, e.g. logit, specifies the link between random and systematic components. It describes how the expected value of the response relates to the linear predictor of explanatory variables, e.g., in logistic regression or in logistic regression (35).</td>
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<td>Mining data - Mining data occurs when some records contain blanks or &quot;Not Available&quot; or &quot;NA&quot; where variable values should be.</td>
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<td></td>
<td>Offset Variable - Offset variables or factors are model variables with a known or prespecified coefficient. Their relatives are included in the model and the final rating algorithm, but they are generated from other variables outside the actuarial model and not allowed to change in the model when risk factors are included in the model. The offset variables are then calculated for the exposure in the model. This does not get included in the final rating algorithm. (36).</td>
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<tr>
<td></td>
<td>Non-Insurance Data - Non-insurance data is provided by another party that is not the insurer company.</td>
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<td>New</td>
<td>Rating Algorithm - Rating algorithm is the mathematical or computational component of the rating plan used to calculate premiums.</td>
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<td>Rating Characteristic - Rating characteristics are used to rate risk of the insurer to be involved in the insurer's rating plan.</td>
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<td>Rating Algorithm - Rating algorithm is the mathematical or computational component of the rating plan used to calculate premiums.</td>
<td></td>
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<td>Rating Characteristic - Rating characteristic is used to rate risk of the insurer to be involved in the insurer's rating plan.</td>
<td></td>
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<tr>
<td></td>
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<td>Rating Factor - Rating factor is the numerical component included in the rate pages of the rating plan's manual. Rating factors are used together with the rating algorithm to calculate the insured's premiums.</td>
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Ad Hoc Commented Draft 4/2/2019 v1

Third-Party Comments on 5-14-2019 Exposure of Complex Model Best Paper

Text from 5-14-2019 Exposure

Exposed Sections VIII to XVI

Commenter's Suggestion

Final Ad Hoc Team Recommendation

- Home insurance covers damage to the property, contents, and structures, as well as loss of use, liability, and medical coverage. The perils covered in home insurance include fire, windstorms, and other natural disasters.

- Overfitting is the production of an analysis that corresponds too closely or exactly to a particular set of data and may, therefore, fail to fit additional data or predict future observations reliably. (21)

- Principal Component Analysis (PCA) creates new variables from correlated groups of predictors. These new variables exhibit little or no correlation between them, thereby reducing potential problems such as collinearity.

- PCA Approach (Principal Component Analysis) - The PCA method creates multiple new variables from correlated groups of predictors. These new variables exhibit little or no correlation between them, thereby reducing potential problems such as collinearity.

- Overfitting - Overfitting is the production of an analysis that corresponds too closely or exactly to a particular set of data and may, therefore, fail to fit additional data or predict future observations reliably. (21)
### Rating System

**Sub-Model**

- The rating plan describes in detail how to combine the various components in the rules and rate pages to calculate the overall premium charged for any risk that is not specifically pre-printed in the Premium Rule Framework. The rating plan is a tool that includes explicit instructions, such as:
  - **Checklist:** In which rating variables should be considered.
  - How the effect of rating variables is applied to the calculation of premium (e.g., multiplicative, additive, or some unique on a mathematical expresses the evidence of measures or ratios or prem composity; in some cases, the insurance premium or not that can be applied).
  - Ensure that the variables are aligned with the state laws.

If the insurance product contains multiple coverages, then separate rating plans by coverage may apply.

### Scrubbing Data

- **New:** Scrubbing data is the process of removing errors from a dataset that is incorrect, incomplete, improperly formatted, or duplicated.

<table>
<thead>
<tr>
<th>Sample Record</th>
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<tbody>
<tr>
<td><strong>Transformed Data:</strong> <em>Scrubbed data is data reviewed for errors, where “Ag” has been replaced with a value, and where most transformations have been performed. Data that has been “scrubbed” is now in a useable format to begin building the model.</em></td>
</tr>
<tr>
<td><strong>In-Valid Data:</strong> <em>Scrubbing the process of editing, removing, or replacing data in a dataset that does not represent raw data. For example:</em></td>
</tr>
</tbody>
</table>

### Univariate Model

**Definition:** A univariate model is a model that only has one independent variable.

**Examples:**

- **Oracle Model:** A univariate model is a model that provides output into another model.
- **Transformation:** A transformation is a process of changing a variable to a function of a variable. Examples include: 
  - Voluntary Reported Data: *Voluntarily reported data is data directly obtained from a company or consumer. Examples would be utilization data obtained from an insurance or obtained verbally by a company representative.* 
  - Univariate Model: *A univariate model is a model that only has one independent variable.* 

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<table>
<thead>
<tr>
<th>Rating Plan</th>
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<tbody>
<tr>
<td><strong>Rating Plan</strong></td>
<td><strong>Scrubbing Data</strong></td>
</tr>
<tr>
<td><strong>Rating Plan</strong></td>
<td><strong>Univariate Model</strong></td>
</tr>
<tr>
<td><strong>Rating Plan</strong></td>
<td><strong>Scrubbed Data</strong></td>
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**Ad Hoc Team Recommendation**

<p>| Exposure Comments as of 10-14-2019 |
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### Best Practices for Regulatory Review of Predictive Analytics White Paper

**Text from 5-14-2019 Exposure**

**Third-Party Comments on 5-14-2019 Exposure of Complex Model Best Practices White Paper**

**Ad Hoc Team recommendation to exposure comments as of 10-14-2019**

(Text in red are action items to be handled in a future draft of the white paper.)

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**Note:** To use this second definition accounts for the interaction, note that it is equivalent to $x = b_0 + b_1 X_1 + b_2 X_2 + b_3 X_1 X_2$, and to $y = b_0 + b_1 X_1 + b_2 X_2 + b_3 X_1 X_2 + b_4 X_4$. Here $X_1$ and $X_2$ are variables, and $b_0, b_1, b_2, b_3$, and $b_4$ are coefficients. The effect of $X_1$ depends on the level of $X_2$, and vice versa.

**REFERENCE:**

* *Nonlinear Linear Models for Insurance Rating,* CAS Monograph Series, Number 5, by Mark Goldblatt et al., Casualty Actuarial Society, 2016, pp. 52-58. A second at:

* *An Introduction to Statistical Learning* with Applications in R, by Gareth James et al., Springer, 2013, pp. 87-89. A second at:

**Uncapped Rate Disruption**

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<tr>
<th>Percent-Change Range</th>
<th>Number of Cases in Range</th>
<th>Uncapped Rate Disruption</th>
<th>Capped (If Applicable)</th>
<th>Capped Rate Disruption</th>
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<td>95% - 100%</td>
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Ad Hoc Team recommendation to exposure comments as of 10-14-2019


Text from 5-14-2019 Exposure

Third-Party Comments on 5-14-2019 Exposure of Complex Model Best Practices White Paper

Largest Percentage Increase

Corresponding Dollar Increase (for Insured Receiving Largest Percentage Increase)
Text From 5-14-2019 Exposure

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<tr>
<td>20/41</td>
<td>Proposition I: 65-150</td>
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<td>Purpose of the study to address limitations of traditional models and promote transparency in risk scoring.</td>
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<td>20/43</td>
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<td>20/44</td>
<td>WP: Explain the steps taken to ensure the model is explainable and the score is meaningful.</td>
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<td>V: Model should be trusted by the regulator to be fair and to prevent data manipulation.</td>
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**Most Significant Impacts to This Policy**

The most significant impacts to this policy are the increases to the relativities for the age of insured, ZIP Code 89105, COMP Deductible of $1,000, and symbol for 2003 Honda Accord.

**NOTE:**
If capping is proposed to apply for this policy, include the impact of capping at the end, after displaying uncapped impacts by attribute. Add rows as needed. Total percent and dollar impacts should reconcile to the values presented above in this exhibit.

What lengths of policy terms does the insurer offer in this book of business?

Check all options that apply below.

- 12-Month Policies
- 6-Month Policies
- 3-Month Policies
- Other (SPECIFY)

**Uncapped Change**

$306.60

**Current Premium**

$2,555.00

**Uncapped Percent Change**

12.00%

**Proposed Premium**

$2,861.60

**Capped % Change (If Applicable)**

12.00%

**Characteristics of Policy (Fill in Below)**

- **Vehicle:**
  - BI Limits: $200,000 / $600,000
  - PD Limits: $50,000
  - UM/UIM Limits: $200,000 / $600,000
  - MED Limits: $10,000

- **Class (W205):**
  - BI Limits: $200,000 / $600,000
  - PD Limits: $50,000
  - UM/UIM Limits: $200,000 / $600,000
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**Capped Change (If Applicable)**

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**For Auto Insurance:**

At minimum, identify the age and gender of each named insured, limits by coverage, territory, make / model of vehicle(s), prior accident / violation history, and any other key attributes whose treatments are affected by this filing.

**For Casualty Insurance:**

At minimum, identify age and gender of each named insured, amount of insurance, territory, construction type, protection class, any prior loss history, and any other key attributes whose treatments are affected by this filing.

**Corresponding Percentage Increase (for Insured Receiving Largest Dollar Increase)**

Largest Dollar Increase

**Most Significant Impacts to This Policy**

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© 2019 National Association of Insurance Commissioners
The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met via conference call Nov. 20, 2019. The following Working Group members participated: Julie Lederer, Chair (MO); Anna Krylova, Vice Chair (NM); Amy Waldhauer (CT); David Christhilf (DC); Chantel Long (IL); Sandra Darby (ME); Andrew Schallhorn (OK); Kevin Clark (PA); and Miriam Fisk and Bethany Sims (TX). Also participating was: Tomasz Serbinowski (UT).

1. Discussed Statement of Actuarial Opinion Statistics

Ms. Fisk presented statistics on Statements of Actuarial Opinion gathered by a few states (Attachment Three-A). She said five states (Illinois, New York, Ohio, Pennsylvania and Texas) have compiled data since 2006. Recently, Connecticut and Montana began providing data, and Missouri plans to start providing data. Additional states are asked to participate next year or start to collect data until the state has five years of historical data to share. Some state representatives remarked that their state had so few domestic property/casualty (P/C) insurers, the additional data would not affect the results. Therefore, it was questionable whether the time to collect and add in the information would be worthwhile. Ms. Fisk said she would like to have a complete dataset if states can participate.

2. Discussed 2019 Statement of Actuarial Opinion Instructions

Ms. Lederer said the Blanks (E) Working Group issued a correction in October to the version of the P/C Statement of Actuarial Opinion instructions included in the Annual/Quarterly Statement Instructions publication. As is usual practice with a correction, the revisions are provided on the Blanks (E) Working Group’s website. Ms. Lederer said Milliman actuaries spotted the incorrect hardcopy version and were not aware of the corrections on the website. While the changes are not significant, she said she plans to send a memorandum to appointed actuaries to describe the three minor changes and instruct where to find the corrected pages. Kris DeFrain (NAIC) said the electronic version of the Annual/Quarterly Statement Instructions requested through the NAIC publications department and the Working Group’s website posting of the 2019 actuarial opinion instructions are correct.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.
P&C Actuarial Opinion Summary (AOS) Statistics
to be discussed on 11/20/2019 AOWG call

Background
- Data in companies’ Statement of Actuarial Opinion (SAO) Exhibits A and B are filed in both print and data capture format. SAO data can be queried/analyzed/summarized easily.
- Companies file their AOS with their domiciliary state directly. AOS data is not submitted electronically to the NAIC.

AOS Statistics Project
- Several states have voluntarily provided aggregate data from their domestic insurers’ AOSs.
- The information provided by the states is then combined. This allows us to look at overall trends in:
  - Carried reserve position relative to Appointed Actuaries’ estimates
  - Type of actuarial estimates provided by Appointed Actuaries
- The information is typically presented during various presentations at the CLRS and the American Academy of Actuaries’ Seminar on Effective P/C Loss Reserve Opinions

Data collected
- Number of companies where AOS included each type of estimate:
  - Point estimate only
  - Range of estimates only
  - Point estimate and range
- Number of companies where AOS showed carried reserves were:
  - More than 10% below actuary’s estimate
  - Between 5% and 10% below (including 10%)
  - Between 0% and 5% below (including 5%)
  - Equal to actuary’s estimate
  - Between 0% and 5% above (including 5%)
  - Between 5% and 10% above (including 10%)
  - More than 10% above
- Gross and net is collected separately, although some states only provide net
- All data excludes companies with zero carried reserves
- Carried vs. estimate based on point estimate if provided, midpoint of range if no point estimate provided
Who currently participates?
- IL, NY, OH, PA, TX have provided data going back through 2006.
- More recently, CT and MN began providing data, and MO plans to provide data this year.
- The 7 states providing data in 2018 represented approximately 1/3 of the total number of companies with non-zero carried net reserves found in the electronic SAO data.

What is required to begin participating?
- The first year a state participates, we request a total of 5 years of data – the current year plus the previous 4 years. In subsequent years, only the current year would need to be provided.
- The deadline for submitting data is typically the beginning of August, to allow time for the information to be included in slides for the CLRS.
- Contact Miriam Fisk (Miriam.Fisk@tdi.texas.gov). She will send you the spreadsheet template.

Texas AOS data process
In Texas, an intern enters information from each AOS we receive into an internal database. The information captured includes:
- Appointed Actuary’s estimates (gross and net)
- Whether the Appointed Actuary’s estimates include only a point estimate, only a range, or both (gross and net)
- Carried reserves (gross and net)
Once the data is in the database, it’s quick and easy to summarize using queries.

Questions for AOWG

What do other states do with AOS information?

Do states not currently providing data have concerns about participating?
- Confidentiality?
- Time and effort required to compile the data?
- Other?

Other comments/questions/concerns?
Carried Reserves vs. Actuarial Estimate* (Net)

* Midpoint of range if no point estimate provided. Point estimate if provided.
The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met via conference call Oct. 4, Oct. 1, Sept. 20, Sept. 12, Sept. 10 and Sept. 6, 2019. The following Working Group members participated: Julie Lederer, Chair (MO); Anna Krylova, Vice Chair (NM); Susan Andrews, Wanchin Chou and Qing He (CT); David Christhilf (DC); Chantel Long and Judy Mottar (IL); Sandra Darby (ME); Gordon Hay (NE); Tom Botsko (OH); Andrew Schallhorn and Kate Yang (OK); Kevin Clark, James DiSanto and Melissa Greiner (PA); and Miriam Fisk, Walt Richards and Bethany Sims (TX). Also participating was: Kevin Dyke (MI); and Tomasz Serbinowski (UT).

1. **Adopted the 2019 Regulatory Guidance**

Ms. Lederer said the Working Group was given the following 2019 charge: “Based on language for the *Annual Statement Instructions—Property/Casualty* requiring completion of the appointed actuary’s attestation of qualification, provide additional guidance in the 2019 regulatory guidance document.”

Ms. Lederer said the Working Group exposed the first draft of the 2019 Regulatory Guidance in May and received one comment letter (Attachment Four-A). She said the 2019 Statement of Actuarial Opinion instructions were subsequently revised and adopted by the Financial Condition (E) Committee Aug. 29 and by the NAIC membership in September. She said those instructions differ from what was used to initially draft the 2019 Regulatory Guidance.

For the Sept. 6 conference call, Ms. Lederer said she revised the draft 2019 Regulatory Guidance. Based on the submitted comment letter, the word “may” was added to the phrase “what an Appointed Actuary should know and do.” Based on instruction changes, “NAIC” was deleted from the term “NAIC Accepted Actuarial Designation”; references to “grandfathering” were eliminated and replaced with references to the “exam-substitution table”; and a reference to qualification documentation being included in the Actuarial Report was removed.

Ralph Blanchard (Travelers) asked about the discussion of experience in the qualification documentation that may be confidential, including work experience for competitor insurers. Ms. Lederer said it would be expected that actuaries would not violate confidentiality, whether stated or not.

Mr. Blanchard suggested adding “or exam substitution” when referring to the need for basic education. Ms. Lederer agreed. Mr. Blanchard also mentioned that in years past there was no advanced reserving exam. Kris DeFrain (NAIC) said after a certain number of years, the experience an actuary has would be much more important than the exams they passed. She said state insurance regulators might consider adding such a note. Ms. Lederer said she agreed so long as the Working Group would not be adding unintended interpretations.

Kathleen C. Odomirok (American Academy of Actuaries—Academy) asked about submitting qualification documentation prior to the continuing education (CE) being completed for the year. Ms. Lederer said the instructions refer to the definition of a qualified actuary being “met or expected to be met.” She said the documentation could include CE taken and a statement explaining how the actuary plans to complete CE.

For the Sept. 10 and Sept. 12 conference calls, the Working Group discussed the revised draft 2019 Regulatory Guidance, which included changes discussed during the Sept. 6 conference call, plus some additional changes to aid communication. The group clarified the description of the timing around CE requirements.

Ms. Odomirok asked about the timing of the annual submission of qualification documentation and whether it needs to be supplied prior to the opinion being issued. Ms. Lederer said the Working Group cannot add a due date. She said it seems that the appointed actuary can work with the board and/or company management to determine an agreed time for submission.

Ms. DeFrain said that with no mention of a due date in the instructions, there is no exact date upon which the qualification documentation must be submitted. The appointed actuary would need to submit its annual documentation sometime during the year. Ms. Lederer said she would not see the annual time as needing to be on the anniversary of the appointment.
Ms. Greiner suggested that state insurance regulators should consider adding a due date in the 2020 instructions. She said the due date would aid the process for companies whose boards are not active and aid the financial examiners’ searches through board minutes.

Mr. Serbinowski and Mr. Dyke said establishing a date in the future might be preferable, perhaps to say the qualification document should be provided “prior to the issuance of the actuarial report.” Mr. Hay said he believes that the annual qualification document should be provided to the board in time for the board to take any action, if needed. Mr. Dyke said the qualification document is a workpaper, so it should be ready when the workpapers are due at the same time as the Actuarial Report. Ms. Lederer said the 2019 Regulatory Guidance followed the instructions and qualified actuary definition in order.

Ms. Krylova suggested that the guidance should be modified to be less repetitive and more useful for the board. The Academy’s Committee on Property and Liability Financial Reporting offered a rewrite of the guidance for the Sept. 20 conference call. She said: 1) the resume-type biography is normally minimal information, and she believes that there needs to be some discussion about experience and how it is relevant; and 2) the CE log should be included and might be useful for board discussion. Mr. Hay agreed.

Ms. Odomirok said the concern with the detailed log is that the board would not follow the courses, events or content, so she believes high-level descriptions such as “seminars, online courses, or industry conferences” might be sufficient for board use. Ms. Krylova said there should be more of a description. Mr. Hay said that saying, “the CE log is available” is not preferable.

The 2019 Regulatory Guidance was revised during the Oct. 1 conference call to: 1) state that the qualification documentation should provide a brief overview of the CE topics; and 2) revise the examples to be less specific and more applicable to actuarial opinion topics.

During the Oct. 4 conference call, Ms. Krylova made a motion, seconded by Ms. Andrews, to adopt the 2019 Regulatory Guidance, with Section IV.C., CE Logging Procedure, pending. The motion passed unanimously.

The Working Group discussed the Casualty Actuarial Society (CAS)/Society of Actuaries (SOA) Appointed Actuary Continuing Education Project and what should be referenced in the 2019 Regulatory Guidance. Mr. Dyke said the CAS and SOA are producing a new attestation procedure and appointed actuary log prior to year-end 2019. He proposed wording. Ms. Lederer said she had concerns about the 2019 Regulatory Guidance being the first communication about the project. Ms. Odomirok said the U.S. Qualification Standards do not require a specific log form, yet the CAS and SOA would be requiring such in conflict with the standards.

[Editor’s Note: After discussion by the Casualty Actuarial and Statistical (C) Task Force during its Oct. 15 conference call (see NAIC Proceedings – Fall 2019, Casualty Actuarial and Statistical (C) Task Force, Attachment Two) to eliminate the new CE log requirement for 2019 and to begin the CE log part of the project in 2020, the Working Group adopted wording for Section IV.C., CE Logging Procedure, via e-vote.]

The 2019 Regulatory Guidance was finalized and provided to the Academy for inclusion in the practice note (Attachment Four-B).

2. Discussed the 0% Intercompany Pool and a Company’s Persistent Adverse Development

During the Sept. 12 conference call, Ms. Greiner said a company redomiciled to Pennsylvania in a slightly troubled reserve position in that the persistent adverse development reporting requirement was triggered. The appointed actuary opined and provided the required discussion in the Actuarial Opinion Summary. Later, the company was acquired by a larger group with a different appointed actuary. From 2012 to 2016, the actuary continued to opine. After that, the company became a 0% member of an intercompany pool. With a change in appointed actuary, there was no longer any explanation about persistent adverse development. The actuary said for 0% pool companies, the opinion should be a group opinion. The group did not trigger the persistent adverse development.

Ms. Greiner said the lead company is not a Pennsylvania domestic. Mr. Hay asked if the problem was with the lead state system or with the Actuarial Opinion Summary instructions. Ms. Greiner said it is not with the lead state, but rather is a concern because there is no guaranty that the pooling arrangement will not change in the future. Ms. Long said it would be a positive action for the group to absorb the persistent development. Ms. Greiner agreed.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.
I have a suggested edit to the Regulatory Guidance. Where it says:

“The NAIC’s P/C Appointed Actuary Job Analysis Project resulted in documentation of knowledge statements, or what an Appointed Actuary needs to know and do.”

I would change the “needs” to “may need”. The current wording is inaccurate. It contradicts what I’ve been told by several who participated in the process, as well as my own evaluation of the Knowledge Statements. Many of the knowledge statements are only relevant to some P&C opinions and not all.

Ralph
Adopted by the Actuarial Opinion (C) Working Group: October 25, 2019

REGULATORY GUIDANCE on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2019

Prepared by the NAIC Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force

The NAIC Actuarial Opinion (C) Working Group (Working Group) of the Casualty Actuarial and Statistical (C) Task Force believes that the Statement of Actuarial Opinion (Actuarial Opinion), Actuarial Opinion Summary (AOS), and Actuarial Report are valuable tools in serving the regulatory mission of protecting consumers. This Regulatory Guidance document supplements the NAIC Annual Statement Instructions – Property/Casualty (Instructions) in an effort to provide clarity and timely guidance to companies and Appointed Actuaries regarding regulatory expectations on the Actuarial Opinion, AOS, and Actuarial Report.

An Appointed Actuary has a responsibility to know and understand both the Instructions and the expectations of state insurance regulators. One expectation of regulators clearly presented in the Instructions is that the Actuarial Opinion, AOS, and supporting Actuarial Report and workpapers be consistent with relevant Actuarial Standards of Practice (ASOPs).

There are changes to the Instructions for 2019. Pursuant to efforts undertaken by the Task Force and the Executive (EX) Committee, the definition of “Qualified Actuary” is significantly revised and a new requirement called “qualification documentation” was added. These changes are described in this Regulatory Guidance document and additional guidance is offered to assist an Appointed Actuary in creating qualification documentation.

There were also changes to the Instructions for 2018. As a result of these changes, the Instructions now:

- Include a new definition for “Accident & Health (A&H) Long Duration Contracts” in order to draw a distinction between these contracts and the Property and Casualty (P&C) Long Duration Contracts whose unearned premium reserves are reported on Exhibit A, Items 7 and 8,
- Add a reference to SSAP No. 65 in the definition of P&C Long Duration Contracts,
- Include a new disclosure item on Exhibit B for net reserves associated with A&H Long Duration Contracts,
- State that the Actuarial Report should disclose all reserve amounts associated with A&H Long Duration Contracts, and
- State that the Actuarial Report and workpapers summarizing the asset adequacy testing of long-term care contracts must be in compliance with Actuarial Guideline LI – The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) of the Accounting Practices and Procedures Manual.
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I. General comments

A. Reconciliation between documents

If there are any differences between the values reported in the Actuarial Opinion, AOS, Actuarial Report, and Annual Statement, the Working Group expects Appointed Actuaries to include an explanation for these differences in the appropriate document (Actuarial Opinion, AOS, or Actuarial Report). The use of a robust peer review process by the Appointed Actuary should reduce reporting errors and non-reconciling items.

One situation in which a legitimate difference might arise is in the case of non-tabular discounting: The direct and assumed loss reserves on line 3 of the Actuarial Opinion’s Exhibit A come from Schedule P, Part 1, which is gross of non-tabular discounting, while the Actuarial Report and AOS might present the direct and assumed loss reserves on a net of discounting basis.

B. Role of illustrative language in the Instructions

While the Instructions provide some illustrative language, the Working Group encourages Appointed Actuaries to use whatever language they believe is appropriate to clearly convey their opinion and the basis for that opinion. In forming their opinion, Appointed Actuaries should consider company-specific characteristics such as intercompany pooling arrangements; recent mergers or acquisitions; and significant changes in operations, product mix, or reinsurance arrangements.

C. Qualified Actuary definition

With the introduction of an additional educational track for property and casualty (P/C) actuaries, the NAIC needed to consider revisions to the definition of “Qualified Actuary.” Upon receiving advice from a consultant on the NAIC’s definition of a “Qualified Actuary,” the NAIC began a project to re-define a Qualified Actuary using objective criteria. Upon nomination by the Casualty Actuarial Society (CAS), Society of Actuaries (SOA), and the American Academy of Actuaries (Academy), many Appointed Actuaries and other subject matter experts volunteered to assist the NAIC. The NAIC’s P/C Appointed Actuary Job Analysis Project resulted in documentation of knowledge statements, or what an Appointed Actuary may need to know and do. The NAIC’s P/C Educational Standards and Assessment Project resulted in documentation of which elements in each knowledge statement should be included in basic education as a minimum standard, with the remaining elements achievable through experience or continuing education. Using the minimum educational standards, the NAIC and subject matter experts assessed the CAS and SOA syllabi and reading materials. The CAS and SOA have made or agreed to make specific changes to their syllabi and/or reading materials to meet the standards. The revised syllabi and reference materials are required to be in place by Jan. 1, 2021.

As a result of these NAIC projects, the definition of “Qualified Actuary” was crafted to include basic education requirements and professionalism requirements (e.g. application of U.S. Qualification Standards, Code of Conduct, and ABCD). The definition of Qualified Actuary replaces the requirement to be “a member in good standing of the Casualty Actuarial Society” with a requirement to obtain and maintain an “Accepted Actuarial Designation.” An Accepted Actuarial Designation is one that was considered by the NAIC to meet the NAIC’s minimum educational standards for an Appointed Actuary. See the Instructions for the list of Accepted Actuarial Designations. It is important to note that some designations are accepted as meeting the basic education standards only if certain specific exams and/or tracks are successfully completed (with exceptions noted in the exam substitutions table of the Instructions). The NAIC process requires a recurring assessment of the “Qualified Actuary” definition every 5-10 years.

The NAIC does not intend to retroactively change requirements for Appointed Actuaries. If an actuary previously met the 2018 qualified actuary definition but lacks the specific exams and/or tracks under the new definition, the Instructions provide a list of acceptable substitutions.

D. Qualification documentation

The 2019 Instructions require the Appointed Actuary to provide “qualification documentation” to the Board of Directors upon initial appointment and annually thereafter. The documentation provided to the Board must be available to the
regulator upon request and during a financial examination. Guidance on qualification documentation is in Section IV of this document.

E. Replacement of an Appointed Actuary

The Instructions require two letters when the Board replaces an Appointed Actuary: one addressed from the insurer to the domiciliary commissioner, and one addressed from the former Appointed Actuary to the insurer. The insurer must provide both of these letters to the domiciliary commissioner.

The detailed steps are as follows:

1. Within 5 business days, the insurer shall notify its domiciliary insurance department that the former Appointed Actuary has been replaced.
2. Within 10 business days of the notification in step 1, the insurer shall provide the domiciliary commissioner with a letter stating whether in the 24 months preceding the replacement, there were disagreements with the former Appointed Actuary. The Instructions describe the types of disagreements required to be reported in the letter.
3. Within the same 10 business days referred to in step 2, the insurer shall, in writing, request that its former Appointed Actuary provide a letter addressed to the insurer stating whether the former Appointed Actuary agrees with the statements contained in the insurer’s letter referenced in step 2.
4. Within 10 business days of the request from the insurer described in step 3, the former Appointed Actuary shall provide a written response to the insurer.
5. The insurer shall provide the letter described in step 2 and the response from the former Appointed Actuary described in step 4 to the domiciliary commissioner.

Regarding the disagreements referenced in step 2 above, regulators understand that there may be disagreements between the Appointed Actuary and the insurer during the course of the Appointed Actuary’s analysis that are resolved by the time the Appointed Actuary concludes the analysis. For instance, the Appointed Actuary’s analysis may go through several iterations, and an insurer’s comments on the Appointed Actuary’s draft Actuarial Report may prompt the Appointed Actuary to make changes to the report. While regulators are interested in material disagreements regarding differences between the former Appointed Actuary’s final estimates and the insurer’s carried reserves, they do not expect notification on routine discussions that occur during the course of the Appointed Actuary’s work.

F. Reporting to the Board of Directors

The Appointed Actuary is required to report to the insurer’s Board every year, and the Instructions were amended in 2016 to require the Board’s minutes to specify the manner in which the Appointed Actuary presented the required information. This may be done in a form of the Appointed Actuary’s choosing, including, but not limited to, an executive summary or PowerPoint presentation. The Working Group strongly encourages the Appointed Actuary to present his or her analysis in person so that the risks and uncertainties that underlie the exposures and the significance of the Appointed Actuary’s findings can be adequately conveyed and discussed. Regardless of how the Appointed Actuary presents his or her conclusions, the Actuarial Report must be made available to the Board.

Management is limited to reporting single values on lines 1 and 3 of the Liabilities, Surplus, and Other Funds page of the balance sheet. However, actuarial estimates are uncertain by nature, and point estimates do not convey the variability in the projections. Therefore, the Board should be made aware of the Appointed Actuary’s opinion regarding the risk of material adverse deviation, the sources of risk, and what amount of adverse deviation the Appointed Actuary judges to be material.
G. Requirements for pooled companies

Effective with the 2014 Instructions, requirements for companies that participate in intercompany pools are as follows:

For all intercompany pooling members:
- Text of the Actuarial Opinion should include the following:
  - Description of the pool
  - Identification of the lead company
  - A listing of all companies in the pool, their state of domicile, and their respective pooling percentages
- Exhibits A and B should represent the company’s share of the pool and should reconcile to the financial statement for that company

For intercompany pooling members with a 0% share of the pooled reserves:
- Text of the Actuarial Opinion should be similar to that of the lead company
- Exhibits A and B should reflect the 0% company’s values
  - Response to Exhibit B, Item 5 (materiality standard) should be $0
  - Response to Exhibit B, Item 6 (risk of material adverse deviation) should be “not applicable”
- Exhibits A and B of the lead company should be filed with the 0% company’s Actuarial Opinion
- Information in the AOS should be that of the lead company

Note the distinction between pooling with a 100% lead company with no retrocession and ceding 100% via a quota share reinsurance agreement. The regulator must approve these affiliate agreements as either an intercompany pooling arrangement or a quota share reinsurance agreement. The proper financial reporting is dependent on the approved filings, regardless of how company management regards its operating platform.

For intercompany pooling members with a greater than 0% share of the pooled reserves, regulators encourage the Appointed Actuary to display values in the AOS on a pooled (or consolidated) basis in addition to the statutory entity basis. This can be accomplished by displaying two tables of information.

H. Explanation of adverse development

1. Comments on unusual Insurance Regulatory Information System (IRIS) ratios in the Actuarial Opinion

   The Appointed Actuary is required to provide comments in the Actuarial Opinion on factors that led to unusual values for IRIS ratios 11, 12, or 13. The Working Group considers it insufficient to attribute unusual reserve development to “reserve strengthening” or “adverse development” and expects the Appointed Actuary to provide insight into the company-specific factors which caused the unusual value. Detailed documentation should be included in the Actuarial Report to support statements provided in the Actuarial Opinion.

2. Comments on persistent adverse development in the AOS

   The Appointed Actuary is required to comment on persistent adverse development in the AOS. Comments can reflect common questions that regulators have, such as:
   - Is development concentrated in one or two exposure segments, or is it broad across all segments?
   - How does development in the carried reserve compare to the change in the Appointed Actuary’s estimate?
   - Is development related to specific and identifiable situations that are unique to the company?
   - Does the development or the reasons for development differ depending on the individual calendar or accident years?
I. Revisions

When a material error in the Actuarial Opinion or AOS is discovered by the Appointed Actuary, the company, the regulator, or any other party, regulators expect to receive a revised Actuarial Opinion or AOS.

Regardless of the reason for the change or refiling, the company should submit the revised Actuarial Opinion in hard copy to its domiciliary state and electronically to the NAIC. The company should submit the revised AOS in hard copy to the domiciliary state but should not submit the document to the NAIC.

A revised Actuarial Opinion or AOS should clearly state that it is an amended document, contain or accompany an explanation for the revision, and include the date of revision.

II. Comments on Actuarial Opinion and Actuarial Report

A. Review date

The illustrative language for the Scope paragraph includes “… and reviewed information provided to me through XXX date.” This is intended to capture the ASOP No. 36 requirement to disclose the date through which material information known to the Appointed Actuary is included in forming the reserve opinion (the review date), if it differs from the date the Actuarial Opinion is signed. When the Appointed Actuary is silent regarding the review date, this can indicate either that the review date is the same as the date the Actuarial Opinion is signed or that the Appointed Actuary overlooked this disclosure requirement. When the Appointed Actuary’s review date is the same as the date the Actuarial Opinion is signed, regulators suggest the Appointed Actuary clarify this in the Actuarial Opinion by including a phrase such as “… and reviewed information provided to me through the date of this opinion.”

B. Making use of another’s work

If the Appointed Actuary makes use of the work of another not within the Appointed Actuary’s control for a material portion of the reserves, the Instructions say that the Appointed Actuary must provide the following information in the Actuarial Opinion:

- The person’s name;
- The person’s affiliation;
- The person’s credential(s), if the person is an actuary; and
- A description of the type of analysis performed, if the person is not an actuary.

Furthermore, Section 4.2.f of ASOP No. 36 says that the actuary should disclose whether he or she reviewed the other’s underlying analysis and, if so, the extent of the review. Though this is not mentioned in the ASOP, the Working Group encourages the Appointed Actuary to consider discussing his or her conclusions from the review.

Section 3.7.2 of ASOP No. 36 describes items the actuary should consider when determining whether it is reasonable to make use of the work of another. One of these items is the amount of the reserves covered by the other’s analyses or opinions in comparison to the total reserves subject to the actuary’s opinion. The Working Group encourages the Appointed Actuary to disclose these items in the Actuarial Opinion by providing the dollar amount of the reserves covered by the other’s analyses or opinions and the percentage of the total reserves subject to the Appointed Actuary’s opinion that these other reserves represent.

C. Points A and B of the Opinion paragraph when opinion type is other than reasonable

Regulators encourage Appointed Actuaries to think about their responses to point A (meet the requirements of the insurance laws of the state) and point B (computed in accordance with accepted actuarial standards and principles) of the Opinion paragraph when they issue an Actuarial Opinion of a type other than “Reasonable.”
D. Conclusions on a net versus a direct and assumed basis

Unless the Appointed Actuary states otherwise, regulators will assume that the Appointed Actuary’s conclusion on the type of opinion rendered, provided in points C and D of the Opinion paragraph, applies to both the net and the direct and assumed reserves. If the Appointed Actuary reaches different conclusions on the net versus the direct and assumed reserves, the Appointed Actuary should include narrative comments to describe the differences and clearly convey a complete opinion. The response to Exhibit B, Item 4 should reflect the Appointed Actuary’s opinion on the net reserves.

Similarly, the materiality standard in Exhibit B, Item 5 and the RMAD conclusion in Exhibit B, Item 6 should pertain to the net reserves. If the Appointed Actuary reaches a different conclusion on the risk of material adverse deviation in the net versus the direct and assumed reserves, the Appointed Actuary should include a Relevant Comments paragraph to address the differences. Regulators understand that a net versus a direct and assumed RMAD will have different meanings and, potentially, different materiality standards.

E. Unearned premium for P&C Long Duration Contracts

Exhibit A, Items 7 and 8 require disclosure of the unearned premium reserve for P&C Long Duration Contracts. The Instructions require the Appointed Actuary to include a point D in the Opinion paragraph regarding the reasonableness of the unearned premium reserve when these reserves are material.

The Working Group expects that the Appointed Actuary will include documentation in the Actuarial Report to support a conclusion on reasonableness whenever point D is included in the Actuarial Opinion. This documentation may include the three tests of SSAP No. 65 or other methods deemed appropriate by the Appointed Actuary to support his or her conclusion.

Regulators see many opinions where dollar amounts are included in Exhibit A, Items 7 and 8; some opinions include a Relevant Comments paragraph discussing these amounts and some do not. Regulators would prefer at a minimum that Appointed Actuaries include some discussion in Relevant Comments on these amounts including an explicit statement as to whether these amounts are material or immaterial.

F. Other premium reserve items

With regard to “Other Premium Reserve Items” in Exhibit A, Item 9, the Appointed Actuary should include an explanatory paragraph about these premium reserves in Relevant Comments and state whether the amounts are material or immaterial. If the amounts are material, and the Appointed Actuary states the amounts are reasonable in an Opinion paragraph, regulators would expect the actuarial documentation to support this conclusion in the Actuarial Report.

Typical items regulators see listed as “Other Premium Reserve Items” are Medical Professional Liability Death, Disability & Retirement (DD&R) unearned premium reserves (UPR) and Other Liability Claims DD&R UPR. Depending on the nature of these exposures, these items may be also listed on Exhibit B, Line 12.2 as claims made extended UPR.

G. The importance of Relevant Comments paragraphs

The Working Group considers the Relevant Comments paragraphs to be the most valuable information in the Actuarial Opinion. Relevant Comments help the regulator interpret the Actuarial Opinion and understand the Appointed Actuary’s reasoning and judgment. In addition to the required Relevant Comments, the Appointed Actuary should consider providing information on other material items such as reinsurance with affiliates, mergers or acquisitions, other premium reserves, and catastrophe risk.

H. Risk of Material Adverse Deviation

The Relevant Comments paragraphs on the Risk of Material Adverse Deviation (RMAD) are particularly useful to regulators. The first two RMAD comments below respond to questions that Appointed Actuaries have posed to regulators. The second two stem from regulators’ reviews of Actuarial Opinions.
1. No company-specific risk factors – The Appointed Actuary is asked to discuss company-specific risk factors regardless of the RMAD conclusion. If the Appointed Actuary does not believe that there are any company-specific risk factors, the Appointed Actuary should state that.

2. Mitigating factors – Regulators generally expect Appointed Actuaries to comment on significant company-specific risk factors that exist prior to the company’s application of controls or use of mitigation techniques. The company’s risk management behaviors may, however, affect the Appointed Actuary’s RMAD conclusion.

3. Consideration of carried reserves, materiality standard, and reserve range when making RMAD conclusion – When deciding whether RMAD exists, the Appointed Actuary should consider the materiality standard in relation to the range of reasonable estimates and the carried reserves. For example, RMAD should likely exist when the sum of the materiality standard plus the carried reserves is within the range of reasonable estimates. Regardless, the Appointed Actuary should support the conclusion of whether RMAD exists.

4. Materiality standards for intercompany pool members – With the exception of intercompany pooling members that retain a 0% share, each statutory entity is required to have a separate Actuarial Opinion with its own materiality standard. Where there are no unusual circumstances to consider, it may be acceptable to determine a standard for the entire pool and assign each member its proportionate share of the total. It is not appropriate to use the entire amount of the materiality threshold for the pool as the standard for each individual pool member.

I. Regulators’ use of the Actuarial Report

Regulators should be able to rely on the Actuarial Report as an alternative to developing their own independent estimates. A well-prepared and well-documented Actuarial Report that complies with ASOP No. 41 can provide a foundation for efficient reserve evaluation during a statutory financial examination. This expedites the examination process and may provide cost savings to the company.

1. Schedule P reconciliation

The Working Group acknowledges that myriad circumstances (such as mergers, acquisitions, changes in claim systems, and the use of underwriting year data in the analysis) may make it difficult for the Appointed Actuary to reconcile the analysis data to Schedule P. The Working Group encourages Appointed Actuaries to disclose reconciliation issues in the Actuarial Report. If the data cannot be reconciled, the Appointed Actuary should document the reasons.

The Working Group believes that:

- A summary reconciliation that combines all years and all lines is an insufficient demonstration of data integrity. A reconciliation should include enough detail to reflect the segmentation of exposures used in the reserve analysis, the accident years of loss activity and the methods used by the Appointed Actuary.
- The Appointed Actuary should map the data groupings used in the analysis to Schedule P lines of business and should provide detailed reconciliations of the data at the finest level of segmentation that is possible and practical. The Working Group recognizes that the Appointed Actuary chooses the data segmentation for the analysis and that there is often not a direct correspondence between analysis segments and Schedule P lines of business.
- The Appointed Actuary should reconcile all data material to the analysis, including claim counts and earned premium if appropriate.

The Working Group draws a distinction between two types of data checks:

- The Schedule P reconciliation performed by the Appointed Actuary. The purpose of this exercise is to show the user of the Actuarial Report that the data significant to the Appointed Actuary’s analysis ties to the data in Schedule P.
- Annual testing performed by independent CPAs to verify the completeness and accuracy of the data in Schedule P or the analysis data provided by the company to the Appointed Actuary.

One key difference is that independent CPAs generally apply auditing procedures to loss and loss adjustment expense activity that occurred in the current calendar year (for example, tests of payments on claims for all accident years that
were paid during the current calendar year). Projection methodologies used by Appointed Actuaries, on the other hand, often use cumulative loss and loss adjustment expense data, which may render insufficient a testing of activity during the current calendar year alone.

Along similar lines, regulators encourage Appointed Actuaries to consider whether a reconciliation of incremental payments during the most recent calendar year for all accident/report years combined provides sufficient assurance of the integrity of the data used in the analysis, given that development factors are generally applied to cumulative paid losses by accident/report year.

2. Change in estimates

The Working Group expects the Appointed Actuary to discuss any significant change in the Appointed Actuary’s total estimates from the prior Actuarial Report. However, an explanation should also be included for any significant fluctuations within accident years or segments. When preparing the change-in-estimates exhibits, the Appointed Actuary should choose a level of granularity that provides meaningful comparisons between the prior and current year’s results.

3. Narrative

The narrative section of the Actuarial Report should clearly convey the significance of the Appointed Actuary’s findings and conclusions, the uncertainty in the estimates, and any differences between the Appointed Actuary’s estimates and the carried reserves.

4. Support for assumptions

Appointed Actuaries should support their assumptions. The use of phrases like “actuarial judgment,” either in the narrative comments or in exhibit footnotes, is not sufficient. A descriptive rationale is needed.

The selection of expected loss ratios could often benefit from expanded documentation. When making their selection, Appointed Actuaries should consider incorporating rate changes, frequency and severity trends, and other adjustments needed to on-level the historical information. Historical loss ratio indications have little value if items such as rate actions, tort reform, schedule rating adjustments, or program revisions have materially affected premium adequacy.

5. Support for roll forward analyses

The Working Group recognizes that the majority of the analysis supporting an Actuarial Opinion may be done with data received prior to year-end and “rolled forward” to year-end. By reviewing the Actuarial Report, the regulator should be able to clearly identify why the Appointed Actuary made changes in the ultimate loss selections and how those changes were incorporated into the final estimates. A summary of final selections without supporting documentation is not sufficient.

J. Exhibits A and B

1. “Data capture format”

The term “data capture format” in Exhibits A and B of the Instructions refers to an electronic submission of the data in a format usable for computer queries. This process allows for the population of an NAIC database that contains qualitative information and financial data. Appointed Actuaries should assist the company in accurately completing the electronic submission.

2. Scope of Exhibit B, Item 12

Exhibit B, Item 12 requests information on extended loss and unearned premium reserves for all property/casualty lines of business, not just medical professional liability. The Schedule P Interrogatories referenced in the parenthetical only address reserves associated with yet-to-be-issued extended reporting endorsements offered in the case of death, disability, or retirement of an individual insured under a medical professional liability claims-made policy.
3. Exhibit B, Item 13

The Working Group added disclosure item Exhibit B, Item 13 in 2018. This item requests information on reserves associated with “A&H Long Duration Contracts,” defined in the Instructions as “A&H contracts in which the contract term is greater than or equal to 13 months and contract reserves are required.”

This disclosure item was added for several reasons:

- **A desire by regulators to gain a greater understanding of property and casualty insurers’ exposure to A&H Long Duration Contracts.**
  - This guidance does not specify how P&C insurers should report the liabilities associated with A&H Long Duration Contracts on the annual statement. Through work performed on financial examinations, regulators have found that P&C insurers may include the liabilities in various line items of the Liabilities, Surplus and Other Funds page. SSAP No. 54R provides accounting guidance for insurers.
  - Regardless of where the amounts are reported on the annual statement, the materiality of the amounts, and whether the insurer is subject to AG 51, the Appointed Actuary should disclose the amounts associated with A&H Long Duration Contracts on Exhibit B, Item 13. The Appointed Actuary should provide commentary in a Relevant Comments paragraph in accordance with paragraph 6.C of the Instructions. The Appointed Actuary should also disclose all reserve amounts associated with A&H Long Duration Contracts in the Actuarial Report.

- **The adoption of AG 51 in 2017.** On August 9, 2017, the NAIC’s Executive (EX) Committee and Plenary adopted AG 51 requiring stand-alone asset adequacy analysis of long-term care (LTC) business. The text of AG 51 is included in the March 2019 edition of the NAIC’s Accounting Practices and Procedures Manual. The effective date of AG 51 was December 31, 2017, and it applies to companies with over 10,000 inforce lives covered by LTC insurance contracts as of the valuation date. The Instructions state that the Actuarial Report and workpapers summarizing the asset adequacy testing of LTC business must be in compliance with AG 51 requirements.

- **Recent adverse reserve development in LTC business.** Regulators expect Appointed Actuaries to disclose company-specific risk factors in the Actuarial Opinion. Given the recent adverse experience for LTC business, Appointed Actuaries should consider whether exposure to A&H Long Duration Contracts poses a risk factor for the company.

The Appointed Actuary is not asked to opine on the reasonableness of the reserves associated with A&H Long Duration Contracts except to the extent that the reserves are included within the amounts reported on Exhibit A of the Actuarial Opinion. For this reason, the Working Group intentionally excluded Items 13.3 and 13.4 from this sentence in paragraph 4 of the Instructions: “The Appointed Actuary should state that the items in the SCOPE, on which he or she is expressing an opinion, reflect Disclosure items 8 through 13.2 in Exhibit B.” Exhibit B, Item 13.1 asks the Appointed Actuary to disclose the reserves for A&H Long Duration Contracts that the company carries on the Losses line of the Liabilities, Surplus and Other Funds page. The Appointed Actuary is not asked to opine on the reasonableness of the reserves disclosed on Exhibit B, Item 13.1 in isolation, but these reserves are a subset of the amount included on Exhibit A, Item 1, and Exhibit A lists amounts with respect to which the Appointed Actuary is expressing an opinion. The same is true for Exhibit B, Item 13.2, whose reserves are a subset of the amount included on Exhibit A, Item 2.

A&H Long Duration Contracts are distinct from P&C Long Duration Contracts. There were no changes to the opinion requirements in 2018 regarding P&C Long Duration Contracts, but the Working Group added a reference to SSAP No. 65 in the definition of “P&C Long Duration Contracts” to clarify the difference between “A&H Long Duration Contracts” and “P&C Long Duration Contracts.” The newly-added mention of SSAP No. 65 in the Instructions is not intended to change the Appointed Actuary’s treatment of P&C Long Duration Contracts in the Actuarial Opinion or the underlying analysis, but insurers and Appointed Actuaries may refer to SSAP No. 65, paragraphs 21 through 33 for a description of the three tests, a description of the types of P&C contracts to which the tests apply, guidance on the minimum required reserves, and instructions on the Actuarial Opinion and Actuarial Report.
III. Comments on AOS

A. Confidentiality

The AOS is a confidential document and should be clearly labeled and identified prominently as such. The AOS is not submitted to the NAIC. The Working Group advises the Appointed Actuary to provide the AOS to company personnel separately from the Actuarial Opinion and to avoid attaching the related Actuarial Opinion to the AOS.

B. Different requirements by state

Not all states have enacted the NAIC Property and Casualty Actuarial Opinion Model Law (#745), which requires the AOS to be filed. Nevertheless, the Working Group recommends that the Appointed Actuary prepare the AOS regardless of the domiciliary state’s requirements, so that the AOS will be ready for submission should a foreign state – having the appropriate confidentiality safeguards – request it.

Most states provide the Annual Statement contact person with a checklist that addresses filing requirements. The Working Group advises the Appointed Actuary to work with the company to determine the requirements for its domiciliary state.

C. Format

The purpose of the AOS is to show a comparison between the company’s carried reserves and the Appointed Actuary’s estimates. Because the AOS is a synopsis of the conclusions drawn in the Actuarial Report, the content of the AOS should reflect the analysis performed by the Appointed Actuary. Therefore, all of the Appointed Actuary’s calculated estimates, including actuarial central estimates and ranges, are to be presented in the AOS consistent with estimates presented in the Actuarial Report.

The American Academy of Actuaries’ Committee on Property and Liability Financial Reporting provides illustrative examples in its annual practice note “Statements of Actuarial Opinion on Property and Casualty Loss Reserves” that show how the Appointed Actuary might choose to display the required information. These examples present the numerical data in an easy-to-read table format.

IV. Guidance on qualification documentation

The Instructions have been modified for 2019 to require the Appointed Actuary to document qualifications in what is called “qualification documentation.” The qualification documentation needs to be provided to the Board of Directors at initial appointment and annually thereafter.

The following provides guidance Appointed Actuaries may find useful in drafting qualification documentation. Appointed Actuaries should use professional judgment when preparing the documentation and need not use the sample wording or format provided below. As a general principle, Appointed Actuaries should provide enough detail within the documentation to demonstrate that they satisfy each component of the ‘Qualified Actuary’ definition.

A. Brief biographical information

- The Appointed Actuary may provide resume-type information.
- Information may include the following:
  - professional actuarial designation(s) and year(s) first attained
  - insurance or actuarial coursework or degrees;
  - actuarial employment history: company names, position title, years of employment, and relevant information regarding the type of work (e.g., reserving, ratemaking, ERM)
B. “Qualified Actuary” definition

The Appointed Actuary should provide a description of how the definition of “Qualified Actuary” in the Instructions is met or expected to be met (in the case of continuing education) for that year. The Appointed Actuary should provide information similar to the following. Items (i) through (iii) below correspond with items (i) through (iii) in the Qualified Actuary definition.

(i) “I meet the basic education, experience and continuing education requirements of the Specific Qualification Standards for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement, as set forth in the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States (U.S. Qualification Standards), promulgated by the American Academy of Actuaries (Academy). The following describes how I meet these requirements:

a. Basic education:"

[Option 1] “met through relevant examinations administered by the Casualty Actuarial Society;” or

[Option 2] “met through alternative basic education.” The Appointed Actuary should further review documentation necessary per section 3.1.2 of the U.S. Qualification Standards.

b. “Experience requirements: met through relevant experience as described below.”

• To describe the Appointed Actuary’s responsible experience relevant to the subject of the Actuarial Opinion, information may include specific actuarial experiences relevant to the company’s structure (e.g., insurer, reinsurer, RRG), lines of business, or special circumstances.

• Experiences may include education (through organized activities or readings) about specific types of company structures, lines of business, or special circumstances.

c. “Continuing education: met (or expected to be met) through a combination of [industry conferences; seminars (both in-person and webinar); online courses; committee work; self-study; etc.], on topics including ______ (provide a brief overview of the CE topics. For example, ‘trends in workers’ compensation’ or ‘standards of actuarial practice on reserving.’). A detailed log of my continuing education credit hours is available upon request.”

• Section 3.3 of the Specific Qualification Standards for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement requires the Appointed Actuary to earn 15 hours of CE on topics mentioned in Section 3.1.1.2. The Appointed Actuary should consider providing expanded detail on the completion (or planned completion) of these hours in the CE documentation.

(ii) “I have obtained and maintain an Accepted Actuarial Designation.” One of the following statements may be made, depending on the Appointed Actuary’s exam track:

• “I am a Fellow of the CAS (FCAS) and my basic education includes credit for Exam 6 – Regulation and Financial Reporting (United States).”

• “I am an Associate of the CAS (ACAS) and my basic education includes credit for Exam 6 – Regulation and Financial Reporting United States) and Exam 7 – Estimation of Policy Liabilities, Insurance Company Valuation, and Enterprise Risk Management.”

• “I am a Fellow of the SOA (FSA) and my basic education includes completion of the general insurance track, including the following optional exams: the United States’ version of the Financial and Regulatory Environment Exam and the Advanced Topics in General Insurance Exam.”
Alternatively, if the actuary was evaluated by the Academy's Casualty Practice Council and determined to be a Qualified Actuary, the Appointed Actuary may note such and identify any restrictions or limitations, including those for lines of business and business activities.

(iii) “I am a member of [professional actuarial association] that requires adherence to the same Code of Professional Conduct promulgated by the Academy, requires adherence to the U.S. Qualification Standards, and participates in the Actuarial Board for Counseling and Discipline when its members are practicing in the U.S.”

C. CE logging procedure

One of the Casualty Actuarial and Statistical (C) Task Force’s 2019 charges is to work with the CAS and SOA to identify: 1) whether the P/C Appointed Actuaries' logs of continuing education (CE) should contain any particular categorization to assist regulatory review; 2) what types of learning P/C Appointed Actuaries are using to meet CE requirements for ‘Specific Qualification Standards’ today; and 3) whether more specificity should be added to the P/C Appointed Actuaries' CE requirements to ensure CE is aligned with the educational needs for a P/C Appointed Actuary.

The Task Force has adopted a project plan that includes 2020 requirements for 1) categorization of continuing education (CE) in the Appointed Actuaries’ CE log and 2) CE log audits by the CAS/SOA of a percentage of Appointed Actuaries. Appointed Actuaries will need to use a specific logging format for their CE logs. While audited Appointed Actuaries will submit their individual logs, the CAS and SOA will only share aggregated information with the NAIC. The CAS and SOA will distribute information on 2020 CE logging and submission instructions, CE categories, and categorization rules.
November 21, 2019

Kris DeFrain, FCAS, MAAA, CPCU
Director of Research and Actuarial Services
National Association of Insurance Commissioners (NAIC) Central Office

Via Email

Re: CASTF Regulatory Review of Predictive Models White Paper

Dear Kris,

As the American Academy of Actuaries’ senior property/casualty fellow, I appreciate this opportunity to comment further on the Casualty Actuarial and Statistical Task Force (CASTF) draft white paper discussing best practices for the Regulatory Review of Predictive Models (RRPM). My comments herein relate to the discussion draft released on October 15, 2019.

Throughout the RRPM paper, the philosophical benefits of predictive analytics and big data are well documented. Additionally, the paper describes well the challenges inherent in reviewing the models and regulating rates resulting from these models. The American Academy of Actuaries remains committed to effective actuarial practice in this area. It was our great pleasure to once again host a day-long session on predictive modeling at the NAIC Insurance Summit this past June. I will also point out anew that in 2018, the Academy produced a monograph, *Big Data and the Role of the Actuary*, which includes extensive sections on regulatory and professionalism considerations. My comments here will be brief, and it is my hope that they will be helpful to you and the CASTF members.

First, I will focus on a technical point. In Section VI, we see that the wording has been modified to emphasize the concept that input characteristics and rating factors are related to the expected loss or expense differences in risk. I strongly agree with this shift from the earlier version. However, I note that in A.4.b and B.3.d, the wording of “rational relationship” and “rational explanation” are less precise. I was not certain if this was intentional or an oversight. The current Section VI wording would seem to lead to better actuarial practice.

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1 The American Academy of Actuaries is a 19,500+ member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
My second point is more philosophical than technical. It is one that I have raised before, and I suspect that you have received similar feedback from others. In short, the new requirements of the RRPM process have the potential to become unwieldy. Rate filers and regulatory reviewers will have to perform considerably more detailed work as a result. I certainly note throughout the document that you reference the fact that the RRPM structure is meant as guidance to regulators and is not binding. I also note considerable conciliatory language throughout. Knowing many of the CASTF members personally, I have no doubt that this is genuine.

Finally, I note that you have somewhat scaled back the list of potential request items and in some cases reduced the Level of Importance. All of this notwithstanding, one can hope that the near-term learning curve that will result will be brief and that delays will not be onerous.

In closing, I wish to reiterate that the American Academy of Actuaries remains committed to working with CASTF on this matter.

If you have any questions about these comments, contact me (gibson@actuary.org) or Marc Rosenberg, senior casualty policy analyst, at 202-785-7865 or rosenberg@actuary.org.

Sincerely,

Richard Gibson, MAAA, FCAS
Senior Casualty Fellow
American Academy of Actuaries
November 22, 2019

Kris DeFrain, FCAS, MAAA, CPCU
Director, Research and Actuarial Services
National Association of Insurance Commissioners (NAIC)
NAIC Central Office
1100 Walnut Street, Suite 1500 Kansas City, MO
64106-2197

Sent via e-mail at kdefrain@naic.org


The American Property Casualty Insurance Association (APCIA)\(^1\) appreciates the opportunity to provide comment on the NAIC Casualty Actuarial and Statistical Task Force (CASTF) exposure draft, dated October 15, 2019, regarding the *Regulatory Review of Predictive Models*.

The APCIA remains committed to working collaboratively with the Task Force in support of innovation and the effort to leverage the advancements in technology and data analytics to effectively respond to the changing risks and needs of our insurance consumers. The APCIA believes that development of best practices regarding the regulatory review of predictive models can foster beneficial upfront dialogue between the filing company and regulator that supports an efficient and effective review appropriately focused on ensuring compliance with applicable regulatory rating standards. However, the APCIA cautions against developing best practices that could create new standards or establish information elements that extend the statutory scope of the rate review process.

The following outlines our priority items of interest in the October 15, version of the white paper:

1. **Section VI. Guidance for Regulatory Review of Predictive Models (Best Practices)**
   a. **Best Practices #1:** Remove the newly added language "or other analysis". These Best Practices relate to the review of a predictive model used to inform how an insured’s premium is determined. It is unnecessary to broaden the scope beyond predictive models to include "other analysis".
   b. **Best Practices #3:** The regulator should "Consider whether the model is an update to or resolves a model submitted within a previously approved filing or, is completely new to the rating plan." This can help the reviewer save time by using information from the previous review of the

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\(^1\) Representing nearly 60 percent of the U.S. property casualty insurance market, the American Property Casualty Insurance Association (APCIA) promotes and protects the viability of private competition for the benefit of consumers and insurers. APCIA represents the broadest cross-section of home, auto, and business insurers of any national trade association. APCIA members represent all sizes, structures, and regions, protecting families, communities, and businesses in the U.S. and across the globe.
predictive model.

c. Opening paragraph and Best Practices #3: Remove "and improves." "Improve" applies subjectivity and may result in different interpretations from different stakeholders (regulators, consumers, agents, insurers). The Best Practices should be agnostic to how the new or resolved predictive model impacts the rating plan. After the predictive model is reviewed, then the state’s DOI may determine if the predictive model "improved" the rating plan relative to their regulatory responsibilities.

d. Best Practices 4a: revise "actuarially sound" to "consistent with actuarial standards of practice, other applicable professional standards." Otherwise, we suggest that CASTF define the term "actuarially sound" in the glossary. As stressed in previous APCIA feedback, reference to applicable actuarial standards and principles should give the regulator greater comfort and knowledge of the general professional practices that guide the elements of the actuary’s filed rating plan, including the relevant aspects and use of any predictive model.

2. Section VII - Comments on specific Information Elements

a. C.1.c - Revise this information element to include a list of the relevant characteristics/variables from the associated predictive model. A predictive model may only impact one part of the rating plan, for example solving for expenses as opposed to indemnity costs. It will be extremely burdensome and unnecessarily exhaustive to both the company producing the filing and the DOI reviewing the filing to discuss all variables used in any capacity to produce a rating plan. A relevant list of variables will aid in reviewing the filed predictive model for prohibited variables and appropriate modeling procedures, which is consistent with the goals of these Best Practices. A review of the information element as stated is a review of the entire rating plan, consistent with the responsibilities of a DOI filing reviewer, but beyond the scope of this White Paper.

b. B.4.b, B.4.c, B.4.d - P-values, Statistical Significance, and all listed statistics should not be required. For example, P-values are not always used to develop a model. The APCIA suggests rewording these information elements to align with the Best Practice #2a, specifically determining how the resulting rating factors (or coefficients) are related to the differences in risk. The insurer can then provide a narrative and results for their process of following this Best Practice. Otherwise, this is an exercise where an insurer will provide p-values that are not used in developing a model. A reviewer at the DOI will question high p-values, but the modelers will not have an adequate response since p-values were not reviewed. The information elements as written are unduly prescribing how to develop a predictive model.

3. Section X Other Considerations

a. Discuss Correlation vs. Causality. This discussion is establishing a newly defined standard in reviewing a predictive model. However, the discussion of correlation vs. causality is not limited to the variables/characteristics used in a predictive model. Consistency should be applied to all variables/characteristics used in any capacity in a rating plan. The review of a predictive model should have similar Best Practices with those for reviewing a rating plan when the requested information (causation) is not unique to a predictive model. Rational explanations for the predictiveness of a variable are subjective and each regulator, actuary, data scientist, etc. has his or her own opinion. It is understood that regulators have the authority to impose standards of a rating plan to ensure that state laws are followed, e.g. avoiding unfair discrimination and specifically unaccepted variables. However, the APCIA encourages each DOI that may
implement or revise this subjective standard to determine and communicate their position relative to the specific statutes and regulations of their respective state. Clear communication on how companies should discuss causation vs. correlation and how a DOI will evaluate the discussion will provide companies with the understanding of how to build a rating plan for that state.

b. C.2.a. The APCIA reiterates our objection to guidance that suggests all characteristics and rating variables can be isolated and related to the risk of insurance loss in a manner that is logical and intuitive to any regulator or consumer regardless of their background or expertise. We agree that an insurer should be able to show that there is statistically significant correlation between a predictive variable and loss. However, an intuitive explanation is not proof of causation. An intuitive explanation may be illusory. Instead, the focus should be on identifying variables that are unfairly discriminatory. So long as a variable is not shown to be unfairly discriminatory, as that standard is currently and in past applied, its use should be permitted without requirement of an intuitive explanation. Insurers could be required to attest to the fact its variables are not unfairly discriminatory. A regulator could then object to use of a variable that the regulator can demonstrate as unfairly discriminatory.

The APCIA believes that for this white paper to meet its purpose of providing effective and practical regulatory guidance to improve the quality of predictive model reviews across states and aid speed to market and the competitiveness of the state marketplace, measures should be taken prior to adoption to demonstrate its efficacy for regulators and the industry. To that end, the APCIA strongly suggests “field testing” the Best Practices in Section VI using the Information Elements for Regulatory Review in Section VII. This idea of field testing was raised by a regulator member of the Task Force during its October 15, conference call.

Why is Field Testing needed? The CASTF White Paper drafting group stated, "We believe that there is a misunderstanding between the terms "best practices" and "information elements" that have been identified in this paper. Many comments appear to interpret "information elements" to mean "best practices" and as such have concerns. We believe the concerns raised in this and other similar comments is with the "information elements" that regulators may find helpful when applying the "best practices." However, the White Paper does not clarify which Best Practices are supported by each information element. Therefore, DOI’s are required to understand all information elements to determine which to use when implementing these Best Practices in reviewing a predictive model filing. The White Paper would benefit from field testing that could provide more practical guidance in applying these valuable Best Practices.

What does it achieve? The CASTF members can review true examples from companies in providing information elements to satisfy the Best Practices. The examples can be discussed by those with knowledge of predictive modeling to educate and give guidance on adequate responses provided by a company or responses that require additional regulator questions.

Why does it need to occur before the final adoption of the White Paper? Field testing may identify needed revisions to the White Paper before it is finalized and implemented as information elements may provide too much or too little information to evaluate the Best Practices. If the CASTF does not leverage field testing, these practical learnings will occur individually in each state as the Best Practices are applied. Clarity and consistency of implementation across many states will aid
regulators because it increases the ability to discuss findings with each other or leverage potential
NAIC assistance in reviewing predictive models. Clarity in how states will implement these Best
Practices will aid companies in preparing documentation of a predictive model. The documentation
often occurs during or immediately after solving the model. Companies are better able to provide
filing requirements if known ahead of time because model documentation may be months before
the model is implemented in a state’s rating plan and provided to the DOI in a filing.

Thank you again for the opportunity to comment. We look forward to working with the Task Force to
achieve a solution that benefits regulators, insurers and ultimately our consumers.

****

Respectfully Submitted,

[Signature]

David Kodama, Jr.
Assistant Vice President, Research & Policy Analysis
California Comments

Draft: 10/15/2019
As adopted by the Casualty Actuarial and Statistical (C) Task Force on XX/XX/XX

EXPOSURE NOTE: The drafting group considered comments submitted based on the 5/14/19 draft of the bulk of the paper and comments submitted on the 7/24/19 draft of Sections VIII “Proposed Changes to the Product Filing Review Handbook” and IX “Proposed State Guidance” (exposed 8/3/19). Please submit comments to Kris DeFrain (kdefrain@naic.org) on this 10/14/19 draft by Nov. ___, 2019.

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I. INTRODUCTION

Insurers’ use of predictive analytics along with big data has significant potential benefits to both consumers and insurers. Predictive analytics can reveal insights into the relationship between consumer behavior and the cost of insurance, lower the cost of insurance for many, and provide incentives for consumers to better control and mitigate loss. However, predictive analytic techniques are evolving rapidly and leaving many regulators without the necessary tools to effectively review insurers’ use of predictive models in insurance applications.

When a rate plan is truly innovative, the insurer must anticipate or imagine the reviewers’ interests because reviewers will respond with unanticipated questions and have unique educational needs. Insurers can learn from the questions, teach the reviewers, and so forth. When that back-and-forth learning is memorialized and retained, filing requirements and insurer presentations can be routinely organized to meet or exceed reviewers’ needs and expectations. Hopefully, this paper helps bring more consistency and to the art of reviewing predictive models within a rate filing.

The Casualty Actuarial and Statistical (C) Task Force (CASTF) has been charged with identifying best practices to serve as a guide to state insurance departments in their review of predictive models1 underlying rating plans. There were two charges given to CASTF by the Property and Casualty Insurance (C) Committee at the request of the Big Data (EX) Working Group:

A. Draft and propose changes to the Product Filing Review Handbook to include best practices for review of predictive models and analytics filed by insurers to justify rates.
B. Draft and propose state guidance (e.g., information, data) for rate filings that are based on complex predictive models.

This paper will identify best practices when reviewing predictive models and analytics filed by insurers with regulators to justify rates and provide state guidance for review of rate filings based on predictive models. Upon adoption of this paper by the Executive (EX) Committee and Plenary, the Task Force will evaluate how to incorporate these best practices into the Product Filing Review Handbook and will recommend such changes to the Speed to Market (EX) Working Group.

II. WHAT IS A “BEST PRACTICE?”

A best practice is a form of program evaluation in public policy. At its most basic level, a practice is a “tangible and visible behavior… [based on] an idea about how the actions… will solve a problem or achieve a goal”2. Best practices are used to maintain quality as an alternative to mandatory legislated standards and can be based on self-assessment or benchmarking.3 Therefore, a best practice represents an effective method of problem solving. The "problem" regulators want to solve is probably better posed as seeking an answer to this question: How can regulators determine that predictive models, as used in rate filings, are compliant with state laws and regulations?

Key Regulatory Principles

In this paper, best practices are based on the following principles that promote a comprehensive and coordinated review of predictive models across states:

1. State insurance regulators will maintain their current rate regulatory authority.
2. State insurance regulators will be able to share information to aid companies in getting insurance products to market more quickly.
3. State insurance regulators will share expertise and discuss technical issues regarding predictive models.
4. State insurance regulators will maintain confidentiality, where appropriate, regarding predictive models.

In this paper, best practices are presented in the form of guidance to regulators who review predictive models and to insurance companies filing rating plans that incorporate predictive models. Guidance will identify specific information

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1 In this paper, references to “model” or “predictive model” are the same as “complex predictive model” unless qualified.
useful to a regulator in the review of a predictive model, comment on what might be important about that information and, where appropriate, provide insight as to when the information might identify an issue the regulator needs to be aware of or explore further.

III. DO REGULATORS NEED BEST PRACTICES TO REVIEW PREDICTIVE MODELS?

The term “predictive model” refers to a set of models that use statistics to predict outcomes. When applied to insurance, the model is chosen to estimate the probability or expected value of an outcome given a set amount of input data; for example, models can predict the frequency of loss, the severity of loss, or the pure premium. The generalized linear model (GLM) is a commonly used predictive model in insurance applications, particularly in building an insurance product’s rating plan.

Depending on definitional boundaries, predictive modeling can sometimes overlap with the field of machine learning. In this modeling space, predictive modeling is often referred to as predictive analytics.

Before GLMs became vogue, rating plans were built using univariate methods. Univariate methods were considered intuitive and easy to demonstrate the relationship to costs (loss and/or expense). Today, many insurers consider univariate methods too simplistic since they do not take into account the interaction (or dependencies) of the selected input variables.

According to many in the insurance industry, GLMs introduce significant improvements over univariate-based rating plans by automatically adjusting for correlations among input variables. Today, the majority of predictive models used in private passenger/persianal automobile and homeowner/home rating plans are GLMs. However, GLM results are not always intuitive, and the relationship to costs may be difficult to explain. This is a primary reason regulators can benefit from best practices.

A GLM consists of three elements:

- A target variable, $Y$, which is a random variable that is independent and follows a probability distribution from the exponential family, defined by or more generally, a selected variance function and dispersion parameter.
- A linear predictor $\eta = X^T \beta$.
- A link function $g$ such that $E(Y) = \mu = g^{-1}(\eta)$.

As can be seen in the description of the three GLM components above, it may take more than a casual introduction to statistics to comprehend the construction of a GLM. As stated earlier, a downside to GLMs is that it is more challenging to interpret the GLM output than with univariate models.

If the underlying data is not credible, then no model will improve that credibility, and segmentation methods could make credibility worse. GLM software provides point estimates and allows the modeler to consider standard errors and confidence intervals. GLM output is typically assumed to be 100% credible no matter the size of the underlying data set. GLMs effectively assume that the underlying datasets are 100% credible no matter their size. If some segments have little data, the resulting uncertainty would not be reflected in the GLM parameter estimates themselves (although it might be reflected in the standard errors, confidence intervals, etc.). Even though the process of selecting relativities often includes adjusting the raw GLM output, the resultant selections are not typically credibility-weighted with any complement of credibility. Nevertheless, selected relativities based on GLM model output may differ from GLM point estimates.

Because of this presumption in credibility, which may or may not be valid in practice, the modeler and the regulator reviewing the model would need to engage in thoughtful consideration when incorporating GLM output into a rating plan.

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4 A more thorough exploration of different predictive models will be found in many statistics’ books, including Geisser, Seymour (September 2016). Predictive Inference: An Introduction. New York: Chapman & Hall.

5 The generalized linear model (GLM) is a flexible family of models that are unified under a single method. Types of GLM include logistic regression, Poisson regression, gamma regression and multinomial regression.

6 More information on model elements can be found in most statistics’ books.

7 Sometimes insurers do review complements of credibility and further weight the GLM output with those complements. While this may not be a standard practice today, new techniques could result in this becoming more standard in the future.

8 GLMs provide confidence intervals, credibility methods do not. There are techniques such as penalized regression that blend credibility with a GLM and improve a model’s ability to generalize.
to ensure that model predictiveness is not compromised by any lack of actual credibility. Another consideration is the availability of big data, both internal and external, that may result in the selection of predictor variables that have spurious correlation with the target variable. Therefore, to mitigate the risk that model credibility or predictiveness is lacking, a complete filing for a rating plan that incorporates GLM output should include validation evidence for the rating plan, not just the statistical model.

To further complicate regulatory review of models in the future, modeling methods are evolving rapidly and not limited just to GLMs. As computing power grows exponentially, it is opening up the modeling world to more sophisticated forms of data acquisition and data analysis. Insurance actuaries and data scientists seek increased predictiveness by using even more complex predictive modeling methods. Examples of these are predictive models utilizing random forests, decision trees, neural networks, or combinations of available modeling methods (often referred to as ensembles). These evolving techniques will make the regulators’ understanding and oversight of filed rating plans incorporating predictive models even more challenging.

In addition to the growing complexity of predictive models, many state insurance departments do not have in-house actuarial support or have limited resources to contract out for support when reviewing rate filings that include use of predictive models. The Big Data (EX) Working Group identified the need to provide states with guidance and assistance when reviewing predictive models underlying filed rating plans.9 The Working Group circulated a proposal addressing aid to state insurance regulators in the review of predictive models as used in personal insurance rate filings. This proposal was circulated to all of the Working Group members and interested parties on December 19, 2017, for a public comment period ending January 12, 2018.10 The Big Data Working Group effort resulted in the new CASTF charges (see the Introduction section) with identifying best practices that provide guidance to states in the review of predictive models.

So, to get to the question asked by the title of this section: Do regulators need best practices to review predictive models? It might be better to ask this question another way: Are best practices in the review of predictive models of value to regulators and insurance companies? The answer is “yes” to both questions. Regulatory best practices need to be developed that do not unfairly or inordinately create barriers for insurers and ultimately consumers while providing a baseline of analysis for regulators to review the referenced filings. Best practices will aid regulatory reviewers by raising their level of model understanding. With regard to scorecard models and the model algorithm, there is often not sufficient support for relative weight, parameter values, or scores of each variable. Best practices can potentially aid in this problem.

However, best practices are not intended to create standards for filings that include predictive models. Rather, best practices will assist the states in identifying the model elements they should be looking for in a filing that will aid the regulator in understanding why the company believes that the filed predictive model improves the company’s rating plan, making that rating plan fairer to all consumers in the marketplace. To make this work, both regulators and industry need to recognize that:

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9 Minutes of the Big Data (EX) Working Group, March 9, 2018: https://secure.naic.org/secure/minutes/2018_spring/ex_it_ifpdf59
10 All comments received by the end of January were posted to the NAIC website March 12 for review.
Best practices merely provide guidance to regulators in their essential and authoritative role over the rating plans in their state.

All states may have a need to review predictive models whether that occurs with approval of rating plans or in a market conduct exam. Best practices help the regulator identify elements of a model that may influence the regulatory review as to whether modeled rates are appropriately justified. Each regulator needs to decide if the insurer’s proposed rates are compliant with state laws and regulations and whether to act on that information.

Best practices will lead to improved quality in predictive model reviews across states, aiding speed to market and competitiveness of the state marketplace.

Best practices provide a framework for states to share knowledge and resources to facilitate the technical review of predictive models.

Best practices aid training of new regulators and/or regulators new to reviewing predictive models. (This is especially useful for those regulators who do not actively participate in NAIC discussions related to the subject of predictive models.)

Each regulator adopting best practices will be better able to identify the resources needed to assist their state in the review of predictive models.

Lastly, from this point on in this paper, best practices will be referred to as “guidance.” This reference is in line with the intent of this paper to support individual state autonomy in the review of predictive models.

IV. SCOPE

The focus of this paper will be on GLMs used to create private passenger personal automobile and home insurance rating plans.

The legal and regulatory constraints (including state variations) are likely to be more evolved, and challenging, for personal automobile and home insurance. Through review of these personal lines, the knowledge needed to review predictive models, and guidance in this paper regarding GLMs for personal automobile and home insurance may be transferrable when the review involves GLMs applied to other lines of business. Modeling depends on context, so the GLM reviewer has to be alert for data challenges and business applications that differ from the more familiar personal lines. For example, compared to personal lines, modeling for rates in commercial lines is more likely to encounter low volumes of historical data, dependence on advisory loss costs, unique large accounts with some large deductibles and package products that build create policies from numerous line-of-business and coverage building blocks. Commercial lines commonly use individual risk modifications following experience, judgment, and/or expense considerations. A regulator may never see how models impact commercial excess and surplus lines filings. The legal and regulatory constraints (including state variations) are likely to be more evolved, and challenging, in personal lines. A GLM rate model for personal lines in 2019 is either an update or a late-adopter's defensive tactic. adopting GLM for commercial lines has a shorter history. Also, the legal and regulatory constraints (including state variations) are likely to be more prevalent, and challenging in personal lines, which is the basis of this paper’s guidance. A GLM rate model for personal lines in 2019 is either an update or a late-adopter's defensive tactic. adopting a GLM for commercial lines rating plans has a shorter history and thus is less familiar to many regulators.

Guidance offered here might be useful (with deeper adaptations) when starting to review different types of predictive models. If the model is not a GLM, some listed items might not apply. Not all predictive models generate p-values or F tests. Depending on the model type, other considerations might be important. When transferring guidance to other lines of business and other types of model, unique considerations may arise depending on the context in which a predictive model is proposed to be deployed, the uses to which it is proposed to be put, and the potential consequences for the insurer, its customers and its competitors. This paper does not delve into these possible considerations but regulators should be prepared to address them as they arise.

V. CONFIDENTIALITY

Regulatory reviewers are required to protect confidential information in accordance with applicable State law. However, insurers should be aware that a rate filing might become part of the public record. Each state determines the confidentiality of a rate filing, supplemental material to the filing, when filing information might become public, the procedure to request
that filing information be held confidentially, and the procedure by which a public records request is made. It is incumbent
on an insurer to be familiar with each state’s laws regarding the confidentiality of information submitted with their rate
filing.

Though state authority, regulations and rules governing confidentiality always apply, this reliance should be revisited if
the NAIC or another third party becomes involved in the review process on behalf of the states.

VI. GUIDANCE FOR REGULATORY REVIEW OF PREDICTIVE MODELS (BEST PRACTICES)

Best practices will help the regulator understand if a predictive model is cost based, if the predictive model is compliant
with state law, and how the model improves, the company’s rating plan. Best practices can, also, make the regulator's
review more consistent across states and more efficient, and assist companies in getting their products to market faster.

With this in mind, the regulator’s review of predictive models should:

1. Ensure that the selected rating factors, developed based on the model or other analysis, produce rates that are
   not excessive, inadequate, or unfairly discriminatory.
   a. Review the overall rate level impact of the proposed revisions proposed based on the predictive model
      output in comparison to rate level indications provided by the filer.
   b. Review the premium disruption for individual policyholders and how the disruptions can be explained to
      individual consumers.
   c. Review the individual input characteristics to and output factors from the predictive model (and its sub-
      models), as well as, associated selected relativities to ensure they are not unfairly discriminatory.

2. Thoroughly review all aspects of obtaining a clear understanding of the data used to build and validate the model,
   and thoroughly review all other aspects of the model, including the source data, assumptions, adjustments,
   variables, submodels used as input, and resulting output.
   a. Determine that individual input characteristics to a predictive model and their resulting rating factors are
      related to the expected loss or expense differences in risk. Each input characteristic should have an intuitive
      or demonstrable actual relationship to expected loss or expense.
   b. Determine that the data used as input to the predictive model is accurate, including a clear understanding
      how missing values, erroneous values and outliers are handled.
   c. Determine that any adjustments to the raw data are handled appropriately, including but not limited to,
      trending, development, capping, removal of catastrophes.
   d. Determine that rating factors from a predictive model are related to expected loss or expense differences in
      risk. Each rating factor should have a demonstrable actual relationship to expected loss or expense.
   e. Obtain a clear understanding of how each risk characteristic, used as input to the model, is updated
      and whether the model is periodically rerun, so model output reflects changes to non-static risk
      characteristics.
   f. Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated
      and whether the model is periodically rerun, so model output reflects changes to non-static risk
      characteristics.
   g. Determine whether internal and external data used in relation to the model is compatible with practices
      allowed in the jurisdiction and do not reflect prohibited characteristics.
   h. Obtain a clear understanding of how the selected predictive model was built.

3. Evaluate how the model interacts with and improves the rating plan.
   a. Obtain a clear understanding of the characteristics that are input to a predictive model (and its sub-models),
      their relationship to each other and their relationship to non-modeled characteristics/variables used to
      calculate a risk’s premium.
   b. Obtain a clear understanding of how the selected predictive model was built and why the insurer believes
      this type of model works in a private passenger automobile or homeowner’s insurance risk application.
   c. Obtain a clear understanding of how model output interacts with non-modeled characteristics/variables
      used to calculate a risk’s premium.
d. Obtain a clear understanding of how the predictive model was integrated into the insurer’s state rating plan and how it improves that plan.

e. For predictive model refreshes, determine whether sufficient validation was performed to ensure the model is still a good fit.

4. Enable competition and innovation to promote the growth, financial stability, and efficiency of the insurance marketplace.

   a. Enable innovation in the pricing of insurance through acceptance of predictive models, provided they are actuarially sound and in compliance with state laws.
   
   b. Protect the confidentiality of filed predictive models and supporting information in accordance with state law.
   
   c. Review predictive models in a timely manner to enable reasonable speed to market.

VII. PREDICTIVE MODELS – INFORMATION FOR REGULATORY REVIEW

This section of the paper identifies the information a regulator may need to review a predictive model used by an insurer to support a filed P/C-personal automobile or home insurance rating plan. The list is lengthy but not exhaustive. It is not intended to limit the authority of a regulator to request additional information in support of the model or filed rating plan. Nor is every item on the list intended to be a requirement for every filing. However, the items listed should help guide a regulator to obtain sufficient information to determine if the rating plan meets state specific filing and legal requirements.

Documentation of the design and operational details of the model is required to ensure business continuity and transparency of models used. Granularity of documentation takes into account the level of management or key function at which it is intended to be used. Documentation should be sufficiently detailed and complete to enable a third party to form a sound judgment on the suitability of the model for the intended purpose. The theory, assumptions, methodologies, software and empirical bases should be explained, as well as the data used in developing and implementing the model. Relevant testing and ongoing performance testing need to be documented. Key model limitations and overrides need to be pointed out so that stakeholders understand the circumstances under which the model does not work effectively. End-user documentation should be provided and key reports using the model results described. Major changes to the model need to be shared in a timely manner and documented, and IT controls should be in place, such as a record of versions, change control and access to model.¹¹

Many information elements listed below are probably confidential, proprietary or trade secret and should be treated as such according to state law. Regulators should be aware of their state laws on confidentiality when requesting data from insurers that may be proprietors or trade secret. For example, some proprietary models may have contractual terms (with the insurer) that prevent disclosure to the public. Without clear necessity, exposing this data to additional dissemination may hinder the model’s protection.¹²

Though the list seems long, the insurer should already have internal documentation on the model for more than half of the information listed. The remaining items on the list require either minimal analysis (approximately 25%) or deeper analysis to generate the information for a regulator (approximately 25%).

The “Importance to Regulator’s Review” ranking of information a regulator may need to review is based on the following level criteria:

Level 1 - This information is necessary to begin the review of a predictive model. These data elements pertain to basic information about the type and structure of the model, the data and variables used, the assumptions made, and the goodness of fit. Ideally, this information would be included in the filing documentation with the initial submission of a filing made based on a predictive model.

¹¹ Michele Bourdeau, The Modeling Platform ISSUE 4 • DECEMBER 2016 Model Risk Management: An Overview, Page 6; Published by the Modeling Section of the Society of Actuaries.

¹² There are some models that are made public by the vendor and would not result in a hindrance of the model’s protection.
Draft: 10/15/2019
As adopted by the Casualty Actuarial and Statistical (C) Task Force on XX/XX/XX

Level 2 - This information is necessary to continue the review of all but the most basic models; such as those based only on the filer’s internal data and only including variables that are in the filed rating plan. These data elements provide more detailed information about the model and address questions arising from review of the information in Level 1. Insurers concerned with speed to market may also want to include this information in the filing documentation.

Level 3 - This information is necessary to continue the review of a model where concerns have been raised and not resolved based on review of the information in Levels 1 and 2. These data elements address even more detailed aspects of the model including (to be listed after we assign levels). This information does not necessarily need to be included with the initial submission, unless specifically requested in a particular jurisdiction, as it is typically requested only if the reviewer has concerns that the model may not comply with state laws.

Level 4 - This information is necessary to continue the review of a model where concerns have been raised and not resolved based on the information in Levels 1, 2, and 3. This most granular level of detail is addressing the basic building blocks of the model and does not necessarily need to be included by the filer with the initial submission, unless specifically requested in a particular jurisdiction. It is typically requested only if the reviewer has serious concerns that the model may produce rates or rating factors that are excessive, inadequate, or unfairly discriminatory.

A. Selecting Model Input

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<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Importance to the Regulator’s Review</th>
<th>Comments</th>
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<tbody>
<tr>
<td>A.1.a</td>
<td>Review the details of all data sources for both insurance and non-insurance data used as input to the model (only need sources for filed input characteristics included in the filed model). For each source, obtain a list all data elements used as input to the model that came from that source.</td>
<td>1</td>
<td>Request details of all data sources, whether internal to the company or from external sources. For insurance experience (policy or claim), determine whether data are aggregated by calendar, accident, fiscal or policy year and when it was last evaluated. For each data source, get a list all data elements used as input to the model that came from that source. For insurance data, get a list all companies whose data is included in the datasets. Request details of any non-insurance data used (customer-provided or other), including who owns this data, on how consumers can verify their data and corrections, whether the data was collected by use of a questionnaire/checklist, whether data was voluntarily reported by the applicant, and whether any of the data is subject to the Fair Credit Reporting Act. If the data is from an outside source, find out what steps were taken to verify the data was accurate. Note that reviewing source details should not make a difference when the model is new or refreshed; refreshed models would report the prior version list with the incremental changes due to the refresh.</td>
</tr>
<tr>
<td>A.1.b</td>
<td>Reconcile raw-aggregated insurance data underlying the model with available external insurance reports.</td>
<td>24</td>
<td>Accuracy of insurance data should be reviewed as well. Aggregated data is straight from the insurer's data banks without modification (e.g., not scrubbed or transformed). The dataset would not be adjusted for...</td>
</tr>
</tbody>
</table>
The company should provide some form of reasonability check that the data makes sense when checked against other audited sources.

The company should explain how the data used to build the model makes sense for a specific state. The regulator should inquire which states were included in the data underlying the model build, testing and validation. The company should provide an explanation where the data came from geographically and that it is a good representation for a state, i.e., the distribution by state should not introduce a geographic bias. For example, there could be a bias by peril or wind-resistant building codes. Evaluate whether the data is relevant to the loss potential for which it is being used. For example, verify that hurricane data is only used where hurricanes can occur.

If the data is from a third-party source, the company should provide information on the source. Depending on the nature of the data, data should be documented and an overview of who owns it and the topic of consumer verification should be addressed.

Check if the same variables/datasets were used in both the model, a submodel or as stand-alone rating characteristics. If so, verify there was no double-counting or redundancy.

If the sub-model was previously approved, that may change the extent of the sub-model’s review. If approved, verify when and that it was the same model currently under review. However, previous approval does not necessarily confer a guarantee of ongoing approval, for example when statutes and regulations have changed or if a model's indications have been undermined by subsequent empirical experience. However, knowing whether a model has been previously approved can help focus the regulator’s efforts and determine whether or not the prior decision needs to be revisited.
**A.2.bc**

Determine if sub-model output was used as input to the GLM; obtain the vendor name, and the name and version of the sub-model.

To accelerate the review of the filing, the regulator needs to know the name of 3rd party vendor and contact information for a representative from the vendor, whether model or sub-model. The company should provide the name of the third-party vendor and a contact in the event the regulator has questions. The “contact” can be an intermediary at the insurer, e.g., a filing specialist, who can place the regulator in direct contact with a Subject Matter Expert (SME) at the vendor.”

Examples of such sub-models include credit/financial scoring algorithms and household composite score models. Sub-models can be evaluated separately and in the same manner as the primary model under evaluation. A sub-model contact for additional information should be provided. SMEs on sub-model may need to be brought into the conversation with regulators (whether in-house or 3rd-party sub-models are used).

**A.2.cd**

If using catastrophe model output, identify the vendor and the model settings/assumptions used when the model was run.

For example, it is important to know hurricane model settings for storm surge, demand surge, long/short-term views.

To accelerate the review of the filing, get contact information for the SME that ran the model and an SME from the vendor. The “SME” can be an intermediary at the insurer, e.g., a filing specialist, who can place the regulator in direct contact with the appropriate SMEs at the insurer or model vendor.

**A.2.de**

If using catastrophe model output (a sub-model) as input to the GLM under review, verify whether loss associated with the modeled output was removed from the loss experience datasets.

If a weather-based sub-model is input to the GLM under review, loss data used to develop the model should not include loss experience associated with the weather-based sub-model. Doing so could cause distortions in the modeled results by double counting such losses when determining relativities or loss loads in the filed rating plan. For example, redundant losses in the data may occur when non-hurricane wind losses are included in the data while also using a severe convective storm model in the actuarial indication. Such redundancy may also occur with the inclusion of fluvial or pluvial flood losses when using a flood model, inclusion of freeze losses when using a winter storm model or including demand surge caused by any catastrophic event.

Note that, the rating plan or indications underlying the rating plan, may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted. For example, should large BI losses, in the case of personal automobile insurance, be capped or excluded, or should large non-catastrophe wind/hail claims in...
### A.2.2
If using output of any scoring algorithms, obtain a list of the variables used to determine the score and provide the source of the data used to calculate the score.

| 1 | Any sub-model should be reviewed in the same manner as the primary model that uses the sub-model’s output as input. |

### 3. Adjustments to Data

#### A.3.a
Determine if premium, exposure, loss or expense data were adjusted (e.g., developed, trended, adjusted for catastrophe experience or capped) and, if so, how? Do the adjustments vary for different segments of the data and, if so, identify the segments and how was the data adjusted?

| 2 | The rating plan or indications underlying the rating plan may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted. For example, should large bodily injury (BI) liability losses in the case of personal automobile insurance be excluded, or should large non-catastrophe wind/hail claims in home insurance be excluded from the model's training, test and validation data? Look for anomalies in the data that should be addressed. For example, is there an extreme loss event in the data? If other processes were used to load rates for specific loss events, how is the impact of those losses considered? Examples of losses that can contribute to anomalies in the data are large losses or flood, hurricane or severe convective storm losses. |

#### A.3.b
Identify adjustments that were made to raw aggregated data, e.g., transformations, binning and/or categorizations. If any, identify the name of the characteristic/variable and obtain a description of the adjustment.

| 1 | This is most relevant for variables that have been "scrubbed" or adjusted. Though most regulators may never ask for aggregated data and do not plan to rebuild any models, a regulator may ask for this aggregated data or subsets of it. It would be useful to the regulator if the percentage of exposures and premium for missing information from the model data by category were provided. This data can be displayed in either graphical or tabular formats. |

#### A.3.c
Ask for aggregated data (one data set of pre-adjusted/scrubbed data and one data set of post-adjusted/scrubbed data) that allows the regulator to focus on the univariate distributions and compare raw data to adjusted/binned/transformed/etc. data.

| 2 | This is most relevant for variables that have been "scrubbed" or adjusted. Though most regulators may never ask for aggregated data and do not plan to rebuild any models, a regulator may ask for this aggregated data or subsets of it. It would be useful to the regulator if the percentage of exposures and premium for missing information from the model data by category were provided. This data can be displayed in either graphical or tabular formats. |

#### A.3.d
Determine how missing data was handled.

| 1 | This is most relevant for variables that have been "scrubbed" or adjusted. The regulator should be aware of assumptions the modeler made in handling missing data. |
null or "not available" values in the data. If adjustments or re-coding of values were made, they should be explained. It may be useful to the regulator if the percentage of exposures and premium for missing information from the model data were provided. This data can be displayed in either graphical or tabular formats.

<table>
<thead>
<tr>
<th>A.3.e</th>
<th>If duplicate records exist, determine how they were handled.</th>
<th>1</th>
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<tbody>
<tr>
<td>A.3.f</td>
<td>Determine if there were any material outliers identified and subsequently adjusted during the scrubbing process. Get a list (with description) of the outliers and determine what adjustments were made to these outliers.</td>
<td>22</td>
</tr>
</tbody>
</table>

Look for a discussion of how outliers were handled. If necessary, the regulator may want to investigate further by getting a list (with description) of the outliers and determine what adjustments were made to each outlier. To understand the filer's response, the regulator should ask for the filer's materiality standard.

4. Data Organization

<table>
<thead>
<tr>
<th>A.4.a</th>
<th>Obtain documentation on the methods used to compile and organize data, including procedures to merge data from different sources or filter data based on particular characteristics and a description of any preliminary analyses, data checks, and logical tests performed on the data and the results of those tests.</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.4.b</td>
<td>Obtain documentation on the insurer’s process for reviewing the appropriateness, reasonableness, consistency and comprehensiveness of the data, including a discussion of the rational relationship the data has to the predicted variable.</td>
<td>2</td>
</tr>
<tr>
<td>A.4.c</td>
<td>Identify material findings the company had during their data review and obtain an explanation of any potential material limitations, defects, bias or unresolved concerns found or believed to exist in the data. If issues or limitations in the data influenced modeling analysis and/or results, obtain a description of those concerns and an explanation how modeling analysis was adjusted and/or results were impacted.</td>
<td>1</td>
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A response of "none" or "n/a" may be an appropriate response.
### B. Building the Model

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<tbody>
<tr>
<td>B.1.a</td>
<td>Identify the type of model underlying the rate filing (e.g. Generalized Linear Model – GLM, decision tree, Bayesian Generalized Linear Model, Gradient-Boosting Machine, neural network, etc.). Understand the model's role in the rating system and provide the reasons why that type of model is an appropriate choice for that role.</td>
<td>1</td>
<td>It is important to understand if the model in question is a GLM, and therefore these best practices are applicable or, if it is some other model type, in which case other reasonable review approaches may be considered. There should be an explanation of why the model (using the variables included in it) is appropriate for the line of business. If by-peril or by-coverage modeling is used, the explanation should be by-peril/coverage. Note, if the model is not a GLM, the guidance and information elements in this white paper may not apply in their entirety.</td>
</tr>
<tr>
<td>B.1.b</td>
<td>Identify the software used for model development. Obtain the name of the software vendor/developer, software product and a software version reference used in model development.</td>
<td>2</td>
<td>Changes in software from one model version to the next may explain if such changes, over time, contribute to changes in the modeled results. The company should provide the name of the third-party vendor and a contact in the event the regulator has questions. The “contact” can be an intermediary at the insurer who can place the regulator in direct contact with appropriate SMEs. Open-source software/programs used in model development should be identified by name and version the same as if from a vendor. If version is not known, simply state such, e.g., “R is the software source.”</td>
</tr>
<tr>
<td>B.1.c</td>
<td>Obtain a description how the available data was divided between model training, test and validation datasets. The description should include an explanation why the selected approach was deemed most appropriate, and whether the company made any further subdivisions of available data and reasons for the subdivisions (e.g., a portion separated from training data to support testing of components during model building). Determine if the validation data was accessed before model training was completed and, if so, obtain an explanation how and why that came to occur.</td>
<td>1</td>
<td>It would be unexpected if validation data were used for any purpose other than validation.</td>
</tr>
<tr>
<td>B.1.d</td>
<td>Obtain a brief description of the development process, from initial concept to final model and filed rating plan (in less than three pages of narrative).</td>
<td>1</td>
<td>The narrative should have the same scope as the filing.</td>
</tr>
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<td>Draft: 10/15/2019</td>
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<tr>
<td>As adopted by the Casualty Actuarial and Statistical (C) Task Force on XX/XX/XX</td>
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| B.1.e | Obtain a narrative on whether loss ratio, pure premium or frequency/severity analyses were performed and, if separate frequency/severity modeling was performed, how pure premiums were determined. | 1 |  

| B.1.f | Identify the model’s target variable. | 1 |  

| B.1.g | Obtain a detailed description of the variable selection process. | 1 |  

| B.1.h | In conjunction with variable selection, obtain a narrative on how the Company determine the granularity of the rating variables during model development. | 1 |  

| B.1.i | Determine if model input data was segmented in any way. For example, was modeling performed on a by-coverage, by-peril, or by-form basis? If so, obtain a description of data segmentation and the reasons for data segmentation. | 1 |  

| B.1.j | If adjustments to the model were made based on credibility considerations, obtain an explanation of the credibility considerations and how the adjustments were applied. | 2 |  

| 2. Medium-Level Narrative for Building the Model |  

| B.2.a | At crucial points in model development, if selections were made among alternatives regarding model assumptions or techniques, obtain a narrative on the judgment used to make those selections. | 2 |  

| B.2.b | If post-model adjustments were made to the data and the model was rerun, obtain an explanation on the details and the rationale for those adjustments. | 2 |  

A clear description of the target variable is key to understanding the purpose of the model. It may also prove useful to obtain a sample calculation of the target variable in Excel format, starting with the “raw” data for a policy, or a small sample of policies, depending on the complexity of the target variable calculation.

The narrative regarding the variable selection process may address matters such as the criteria upon which variables were selected or omitted, identification of the number of preliminary variables considered in developing the model versus the number of variables that remained, and any statutory or regulatory limitations that were taken into account when making the decisions regarding variable selection.

This discussion should include discussion of how credibility was considered in the process of determining the level of granularity of the variables selected.

Adjustments may be needed given models do not explicitly consider the credibility of the input data or the model’s resulting output; models take input data at face value and assume 100% credibility when producing modeled output.

Evaluate the addition or removal of variables and the model fitting. It is not necessary for the company to discuss each iteration of adding and subtracting variables, but the regulator should gain a general understanding how these adjustments were done, including any statistical improvement measures relied upon.
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<tr>
<td><strong>B.2.c</strong></td>
<td>Obtain a description of univariate balancing and the testing that was performed during the model-building process, including an explanation of the thought processes involved and a discussion of why interaction terms were included (or not included).</td>
</tr>
<tr>
<td><strong>Further elaboration from B.2.b.</strong></td>
<td>There should be a description of testing that was performed during the model-building process. Examples of tests that may have been performed include univariate testing and review of a correlation matrix.</td>
</tr>
<tr>
<td><strong>B.2.d</strong></td>
<td>Obtain a description of the 2-way balancing and testing that was performed during the model-building process, including an explanation of the thought processes of including (or not including) interaction terms.</td>
</tr>
<tr>
<td><strong>Further elaboration from B.2.a and B.2.b.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>B.2.e</strong></td>
<td>For the GLM, identify the link function used. Identify which distribution was used for the model (e.g., Poisson, Gaussian, log-normal, Tweedie). Obtain an explanation why the link function and distribution were chosen. Obtain the formulas for the distribution and link functions, including specific numerical parameters of the distribution. Obtain a discussion of applicable convergence criterion.</td>
</tr>
<tr>
<td><strong>B.2.f</strong></td>
<td>Obtain a narrative on the formula relationship between the data and the model outputs, with a definition of each model input and output. The narrative should include all coefficients necessary to evaluate the predicted pure premium, relativity or other value, for any real or hypothetical set of inputs.</td>
</tr>
<tr>
<td><strong>B.2.g</strong></td>
<td>If there were data situations in which GLM weights were used, obtain an explanation of how and why they were used.</td>
</tr>
<tr>
<td><strong>3. Predictor Variables</strong></td>
<td></td>
</tr>
<tr>
<td><strong>B.3.a</strong></td>
<td>Obtain a complete data dictionary, including the names, types, definitions and uses of each predictor variable, offset variable, control variable, proxy variable, geographic variable, geodemographic variable and all other variables in the model used on their own or as an interaction with other variables (including sub-models and external models).</td>
</tr>
<tr>
<td><strong>B.3.b</strong></td>
<td>Obtain a list of predictor variables considered but not used in the final model, and the rationale for their removal.</td>
</tr>
<tr>
<td><strong>B.4.l and B.4.m will show the mathematical functions involved and could be used to reproduce some model predictions.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>B.4.1 and B.4.m will show the mathematical functions involved and could be used to reproduce some model predictions.</strong></td>
<td></td>
</tr>
<tr>
<td>Draft: 10/15/2019</td>
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<tr>
<td>As adopted by the Casualty Actuarial and Statistical (C) Task Force on XX/XX/XX</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.3.c</td>
<td>Obtain a correlation matrix for all predictor variables included in the model and sub-model(s).</td>
</tr>
<tr>
<td></td>
<td>While GLMs accommodate collinearity, the correlation matrix provides more information about the magnitude of correlation between variables. The company should indicate what statistic was used (e.g., Pearson, Cramer's V). The reviewer should understand what statistic was used to produce the matrix; but should not specify the statistic.</td>
</tr>
<tr>
<td>B.3.d</td>
<td>Obtain an intuitive rational explanation for why an increase in each predictor variable should increase or decrease frequency, severity, loss costs, expenses, or any element or characteristic being predicted.</td>
</tr>
<tr>
<td></td>
<td>The explanation should go beyond demonstrating correlation. Considering possible causation is relevant, but proving causation is neither practical nor expected. If no intuitive rational explanation can be provided, greater scrutiny may be appropriate. For example, the regulator should look for unfamiliar predictor variables and, if found, the regulator should seek to understand the rational connection that variable has to increasing or decreasing the target variable.</td>
</tr>
<tr>
<td>B.3.e</td>
<td>If the modeler made use of one or more dimensionality reduction techniques, such as a Principal Component Analysis (PCA), obtain a narrative about that process, an explanation why that technique was chosen, and a description of the step-by-step process used to transform observations (usually correlated) into a set of linearly uncorrelated variables. In each instance, obtain a list of the pre-transformation and post-transformation variable names, and an explanation how the results of the dimensionality reduction technique was used within the model.</td>
</tr>
</tbody>
</table>

4. Adjusting Data, Model Validation and Goodness-of-Fit Measures

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.4.a</td>
<td>Obtain a description of the methods used to assess the statistical significance/goodness of the fit of the model to validation data, such as lift charts and statistical tests. Compare the model's projected results to historical actual results and verify that modeled results are reasonably similar to actual results from validation data.</td>
</tr>
<tr>
<td></td>
<td>For models that are built using multi-state data, validation data for some segments of risk is likely to have low credibility in individual states. Nevertheless, some regulators require model validation on State-only data, especially when analysis using state-only data contradicts the countrywide results. State-only data might be more applicable but could also be impacted by low credibility for some segments of risk. Look for geographic stability measures, e.g., across states or territories within state.</td>
</tr>
<tr>
<td>B.4.b</td>
<td>Obtain a description of any adjustments that were made in the data with respect to scaling for discrete variables or binning the data.</td>
</tr>
<tr>
<td></td>
<td>A3.c addresses pre-modeling adjustments to data. In the mid-level narrative context, B2.a addresses judgments of any kind made during modeling. Only choices made at &quot;crucial points in model development&quot; need be discussed.</td>
</tr>
<tr>
<td>B.4.c</td>
<td>Obtain a description of any transformations made for continuous variables.</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

| A.3.f | addresses pre-modeling transformations to data. In the mid-level narrative context, B.2.a addresses transformations of any kind made during modeling. Only choices made at “crucial points in model development” need to be discussed. |

To build a unique model with acceptable goodness-of-fit to the training data, important steps have been taken. Such steps may have been numerous, and at least some of the judgments involved may be difficult to describe and explain. Nevertheless, neither the model filer nor the reviewer can assume these steps are immaterial, generally understood, or implied by the model’s generic form. The model filer should anticipate regulatory concerns in its initial submission by identifying and explaining the model fitting steps it considers most important. If a reviewer has regulatory concerns not resolved by the initial submission, appropriate follow-up inquiries are likely to depend on the particular circumstances.

| B.4.db | For each discrete variable (discrete or continuous) level, review the appropriate parameter values, confidence intervals, chi-square tests, p-values and any other relevant and material tests. Determine if model development data, validation data, test data or other data was used for these tests. |

| Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model. For example, the threshold might be lower when many candidate variables were evaluated for inclusion in the model. |

Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed.
Identify the threshold for statistical significance and explain why it was selected. Obtain a reasonable and appropriately supported explanation for keeping the variable for each discrete variable level where the p-values were not less than the chosen threshold.

Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model. For example, the threshold might be lower when many candidate variables were evaluated for inclusion in the model.

Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AoI curve might be more than what is needed.

For overall discrete variables, review type 3 chi-square tests, p-values, F tests and any other relevant and material test. Determine if model development data, validation data, test data or other data was used for these tests.

Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model, e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.

Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AoI curve might be more than what is needed.

Obtain evidence that the model fits the training data well, for individual variables, for any relevant combinations of variables and for, the overall model.

For a GLM, such evidence may be available using chi-square tests, p-values, F tests and/or other means. The steps taken during modeling to achieve goodness-of-fit are likely to be numerous and laborious to describe, but they contribute much of what is generalized about GLM. We should not assume we know what they did and ask “how?” Instead, we should ask what they did and be prepared to ask follow up questions.
B.4.hf

For continuous variables, provide confidence intervals, chi-square tests, p-values and any other relevant and material test. Determine if model development data, validation data, test data or other data was used for these tests.

2

Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model, e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.

Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed.

B.4.ig

Obtain a description how the model was tested for stability over time.

2

Evaluate the build/test/validation datasets for potential time-sensitive model distortions (e.g., a winter storm in year 3 of 5 can distort the model in both the testing and validation datasets).

Obsolescence over time is a model risk (e.g., old data for a variable or a variable itself may no longer be relevant). If a model being introduced now is based on losses from years ago, the reviewer should be interested in knowing whether that model would be predictive in the proposed context. Validation using recent data from the proposed context might be requested. Obsolescence is a risk even for a new model based on recent and relevant loss data. The reviewer may want to inquire as to the following: What steps, if any, were taken during modeling to prevent or delay obsolescence? What controls will exist to measure the rate of obsolescence? What is the plan and timeline for updating and ultimately replacing the model?

The reviewer should also consider that as newer technologies enter the market (e.g., personal automobile) their impact may change claim activity over time (e.g., lower frequency of loss). So, it is not necessarily a bad thing that the results are not stable over time.

B.4.jh

Obtain a narrative on how potential concerns with overfitting were addressed.

2
### B.4.k
Obtain support demonstrating that the GLM assumptions are appropriate.

Visual review of plots of actual errors is usually sufficient.

The reviewer should look for a conceptual narrative covering these topics: How does this particular GLM work? Why did the rate filer do what it did? Why employ this design instead of alternatives? Why choose this particular distribution function and this particular link function? A company response may be at a fairly high level and reference industry practices.

If the reviewer determines that the model makes no assumptions that are considered to be unreasonable, the importance of this item may be reduced.

### B.4.l
Obtain 5-10 sample records with corresponding output from the model for those records.

5. “Old Model” Versus “New Model”

### B.5.a
Obtain an explanation why this model is an improvement to the current rating plan.

If it replaces a previous model, find out why it is better than the one it is replacing; determine how the company reached that conclusion and identify metrics relied on in reaching that conclusion. Look for an explanation of any changes in calculations, assumptions, parameters, and data used to build this model from the previous model.

Regulators should expect to see improvement in the new class plan’s predictive ability or other sufficient reason for the change.

### B.5.b
Determine if two Gini coefficients were compared and obtain a narrative on the conclusion drawn from this comparison.

One example of a comparison might be sufficient.

This is relevant when one model is being updated or replaced. Regulators should expect to see improvement in the new class plan’s predictive ability. This information element requests a comparison of Gini coefficient from the prior model to the Gini coefficient of proposed model. It is expected that there should be improvement in the Gini coefficient. A higher Gini coefficient indicates greater differentiation produced by the model and how well the model fits that data. This comparison is not applicable to initial model introduction. Reviewer can look to CAS monograph for information on Gini coefficients.

### B.5.c
Determine if double lift charts were analyzed and obtain a narrative on the conclusion was drawn from this analysis.

One example of a comparison might be sufficient.

Note that “not applicable” is an acceptable response.

### B.5.d
If replacing an existing model, obtain a list of any predictor variables used in the old model that are not used in the new model. Obtain an explanation why these variables were dropped from the new model.

Obtain a list of all new predictor variables in the new model that were not in the prior old model.

Useful to differentiate between old and new variables so the regulator can prioritize more time on factors variables not yet reviewed.
### 6. Modeler Software

| B.6.a | Request access to SMEs (e.g., modelers) who led the project, compiled the data, built the model, and/or performed peer review. | 3 | The filing should contain a contact that can put the regulator in touch with appropriate SMEs and key contributors to the model development to discuss the model. |

### C. The Filed Rating Plan

<table>
<thead>
<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Importance to Regulator's Review</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. General Impact of Model on Rating Algorithm</td>
<td>In the actuarial memorandum or explanatory memorandum, for each model and sub-model (including external models), look for a narrative that explains each model and its role (how it was used) in the rating system.</td>
<td>1</td>
<td>The “role of the model” relates to how the model integrates into the rating plan as a whole and where the effects of the model are manifested within the various components of the rating plan. This is not intended as an overarching statement of the model’s goal, but rather a description of how specifically the model is used. This item is particularly important, if the role of the model cannot be immediately discerned by the reviewer from a quick review of the rate and/or rule pages. (Importance is dependent on state requirements and ease of identification by the first layer of review and escalation to the appropriate review staff.)</td>
</tr>
<tr>
<td>C.1.a</td>
<td>Obtain an explanation of how the model was used to adjust the rating algorithm.</td>
<td>1</td>
<td>Models are often used to produce factor-based indications, which are then used as the basis for the selected changes to the rating plan. It is the changes to the rating plan that create impacts. Consider asking for an explanation of how the model was used to adjust the rating algorithm.</td>
</tr>
<tr>
<td>C.1.b</td>
<td>Obtain a complete list of characteristics/variables used in the proposed rating plan, including those used as input to the model (including sub-models and composite variables) and all other characteristics/variables (not input to the model) used to calculate a premium. For each characteristic/variable, determine if it is only input to the model, whether it is only a separate univariate rating characteristic, or whether it is both input to the model and a separate univariate rating characteristic. The list should include transparent descriptions (in plain language) of each listed characteristic/variable.</td>
<td>1</td>
<td>Examples of variables used as inputs to the model and used as separate univariate rating characteristics might be criteria used to determine a rating tier or household composite characteristic.</td>
</tr>
</tbody>
</table>

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| C.2.a | Obtain a narrative regarding how the characteristics/rating variables, included in the filed rating plan, logically and intuitively relate to the risk of insurance loss (or expense) for the type of insurance product being priced. | 2 | The narrative should include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense). The narrative should include a logical and intuitive relationship to cost, and model results should be consistent with the expected direction of the relationship. This explanation would not be needed if the connection between variables and risk of loss (or expense) has already been illustrated. |
| C.3.a | Compare relativities indicated by the model to both current relativities and the insurer's selected relativities for each risk characteristic/variable in the rating plan. | 1 | “Significant difference” may vary based on the risk characteristic/variable and context. However, the movement of a selected relativity should be in the direction of the indicated relativity; if not, an explanation is necessary as to why the movement is logical. |
| C.3.b | Obtain documentation and support for all calculations, judgments, or adjustments that connect the model's indicated values to the selected values. | 1 | The documentation should include explanations for the necessity of any such adjustments and explain each significant difference between the model's indicated values and the selected values. This applies even to models that produce scores, tiers, or ranges of values for which indications can be derived. This information is especially important if differences between model indicated values and selected values are material and/or impact one consumer population more than another. |
| C.3.c | For each characteristic/variable used as both input to the model (including sub-models and composite variables) and as a separate univariate rating characteristic, obtain a narrative how each characteristic/variable was tempered or adjusted to account for possible overlap or redundancy in what the characteristic/variable measures. | 2 | Modeling loss ratio with these characteristics/variables as control variables would account for possible overlap. The insurer should address this possibility or other considerations, e.g., tier placement models often use risk characteristics/variables that are also used elsewhere in the rating plan. One way to do this would be to model the loss ratios resulting from a process that already uses univariate rating variables. Then the model/composite variables would be attempting to explain the residuals. |

3. Comparison of Model Outputs to Current and Selected Rating Factors

| C.3.a | Compare relativities indicated by the model to both current relativities and the insurer's selected relativities for each risk characteristic/variable in the rating plan. | 1 | “Significant difference” may vary based on the risk characteristic/variable and context. However, the movement of a selected relativity should be in the direction of the indicated relativity; if not, an explanation is necessary as to why the movement is logical. |
| C.3.b | Obtain documentation and support for all calculations, judgments, or adjustments that connect the model's indicated values to the selected values. | 1 | The documentation should include explanations for the necessity of any such adjustments and explain each significant difference between the model's indicated values and the selected values. This applies even to models that produce scores, tiers, or ranges of values for which indications can be derived. This information is especially important if differences between model indicated values and selected values are material and/or impact one consumer population more than another. |
| C.3.c | For each characteristic/variable used as both input to the model (including sub-models and composite variables) and as a separate univariate rating characteristic, obtain a narrative how each characteristic/variable was tempered or adjusted to account for possible overlap or redundancy in what the characteristic/variable measures. | 2 | Modeling loss ratio with these characteristics/variables as control variables would account for possible overlap. The insurer should address this possibility or other considerations, e.g., tier placement models often use risk characteristics/variables that are also used elsewhere in the rating plan. One way to do this would be to model the loss ratios resulting from a process that already uses univariate rating variables. Then the model/composite variables would be attempting to explain the residuals. |

4. Responses to Data, Credibility and Granularity Issues
C.4.a  Determine what, if any, consideration was given to the credibility of the output data.  2  At what level of granularity is credibility applied. If modeling was by-coverage, by-form or by-peril, explain how these were handled when there was not enough credible data by coverage, form or peril to model.

C.4.b  If the rating plan is less granular than the model, obtain an explanation why.  2  This is applicable if the insurer had to combine modeled output in order to reduce the granularity of the rating plan.

C.4.c  If the rating plan is more granular than the model, obtain an explanation why.  2  A more granular rating plan implies that the insurer had to extrapolate certain rating treatments, especially at the tails of a distribution of attributes, in a manner not specified by the model indications.

5. Definitions of Rating Variables

C.5.a  Obtain a narrative on adjustments made to raw data/model output, e.g., transformations, binning and/or categorizations. If adjustments were made, obtain the name of the characteristic/variable and a description of the adjustment.  2  If rating tiers or other intermediate rating categories are created from model output, the rate and/or rule pages should present these rating tiers or categories. The company should provide an explanation how model output was translated into these rating tiers or intermediate rating categories.

C.5.b  Obtain a complete list and description of any rating tiers or other intermediate rating categories that translate the model outputs into some other structure that is then presented within the rate and/or rule pages.  1  .

6. Supporting Data

C.6.a  Obtain aggregated state-specific, book-of-business-specific univariate historical experience data, separately for each year included in the model, consisting of loss ratio or pure premium relativities and the data underlying those calculations: at minimum, earned exposures, earned premiums, incurred losses, loss ratios and loss ratio relativities for each category of model output(s) proposed to be used within the rating plan. For each data element, obtain an explanation whether it is raw or adjusted and, if the latter, obtain a detailed explanation for the adjustments.  2 4  For example, were losses developed/undeveloped, trended/un趋势ed, capped/uncapped, etc? Univariate indications should not necessarily be used to override more sophisticated multivariate indications. However, they do provide additional context and may serve as a useful reference.
## C.6.b
Obtain an explanation of any material (especially directional) differences between model indications and state-specific univariate indications.

Multivariate indications may be reasonable as refinements to univariate indications, but possibly not for bringing about significant reversals of those indications. For instance, if the univariate indicated relativity for an attribute is 1.5 and the multivariate indicated relativity is 1.25, this is potentially a plausible application of the multivariate techniques. If, however, the univariate indicated relativity is 0.7 and the multivariate indicated relativity is 1.25, a regulator may question whether the attribute in question is negatively correlated with other determinants of risk. Credibility of state data should be considered when state indications differ from modeled results based on a broader data set. However, the relevance of the broader data set to the risks being priced should also be considered. Borderline reversals are not of as much concern.

### 7. Consumer Impacts

<table>
<thead>
<tr>
<th>C.7.a</th>
<th>Obtain a listing of the top five rating variables that contribute the most to large swings in premium, both as increases and decreases.</th>
<th>These rating variables may represent changes to rating factors relativities, be newly introduced to the rating plan, or have been removed from the rating plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.7.b</td>
<td>Determine if the insurer performed sensitivity testing to identify significant changes in premium due to small or incremental change in a single risk characteristic. If such testing was performed, obtain a narrative that discusses the testing and provides the results of that testing.</td>
<td>One way to see sensitivity is to analyze a graph of each risk characteristic’s variable’s possible relativities. Look for significant variation between adjacent relativities and evaluate if such variation is reasonable and credible.</td>
</tr>
<tr>
<td>C.7.c</td>
<td>For the proposed filing, obtain the impacts on expiring policies and describe the process used by management, if any, to mitigate those impacts.</td>
<td>Some mitigation efforts may substantially weaken the connection between premium and expected loss and expense, and hence may be viewed as unfairly discriminatory by some states.</td>
</tr>
</tbody>
</table>
### C.7.d

Obtain a rate disruption/dislocation analysis, demonstrating the distribution of percentage and/or dollar impacts on renewal business (created by rerating the current book of business), and sufficient information to explain the disruptions to individual consumers.

2

The analysis should include the largest dollar and percentage impacts arising from the filing, including the impacts arising specifically from the adoption of the model or changes to the model as they translate into the proposed rating plan.

While the default request would typically be for the distribution/dislocation of impacts at the overall filing level, the regulator may need to delve into the more granular variable-specific effects of rate changes if there is concern about particular variables having extreme or disproportionate impacts, or significant impacts that have otherwise yet to be substantiated.

See Appendix C for an example of a disruption analysis.

### C.7.e

Obtain exposure distributions for the model's output variables and show the effects of rate changes at granular and summary levels, including the overall impact on the book of business.

3

See Appendix C for an example of an exposure distribution.

### C.7.f

Identify policy characteristics, used as input to a model or sub-model, that remain "static" over a policy's lifetime versus those that will be updated periodically. Obtain a narrative on how the company handles policy characteristics that are listed as "static," yet change over time.

3

Some examples of "static" policy characteristics are prior carrier tenure, prior carrier type, prior liability limits, claim history over past X years, or lapse of coverage. These are specific policy characteristics usually set at the time new business is written, used to create an insurance score or to place the business in a rating/underwriting tier, and often fixed for the life of the policy. The reviewer should be aware, and possibly concerned, how the company treats an insured over time when the insured’s risk profile based on "static" variables changes over time but the rate charged, based on a new business insurance score or tier assignment, no longer reflect the insured’s true and current risk profile.

A few examples of "non-static" policy characteristics are age of driver, driving record and credit information (FCRA related). These are updated automatically by the company on a periodic basis, usually at renewal, with or without the policyholder explicitly informing the company.
### 8. Accurate Translation of Model into a Rating Plan

| C.7.g | Obtain a means to calculate the rate charged a consumer. | 3 | The filed rating plan should contain enough information for a regulator to be able to validate policy premium. However, for a complex model or rating plan, a score or premium calculator via Excel or similar means would be ideal, but this could be elicited on a case-by-case basis. Ability to calculate the rate charged could allow the regulator to perform sensitivity testing when there are small changes to a risk characteristic/variable. Note that this information may be proprietary. |
| C.7.h | In the filed rating plan, be aware of any non-insurance data used as input to the model (customer-provided or other). In order to respond to consumer inquiries, it may be necessary to inquire as to how consumers can verify their data and correct errors. | | If the data is from a third-party source, the company should provide information on the source. Depending on the nature of the data, data should be documented and an overview of who owns it and the topic of consumer verification should be addressed, including how consumers can verify their data and correct errors. |

| C.8.a | Obtain sufficient information to understand how the model outputs are used within the rating system and to verify that the rating plan’s manual, in fact, reflects the model output and any adjustments made to the model output. | 1 | The regulator can review the rating plan's manual to see that modeled output is properly reflected in the manual's rules, rates, factors, etc. |
VIII. PROPOSED CHANGES TO THE PRODUCT FILING REVIEW HANDBOOK

TBD — placeholder to include best practices for review of predictive models and analytics filed by insurers to justify rates.

The Task Force was charged to propose modifications to the 2016 Product Filing Review Handbook to reflect best practices for the regulatory review of predictive analytics. The following are the titled sections in Chapter Three “The Basics of Property and Casualty Rate Regulation.” Proposed changes are shown as tracked changes.


CHAPTER THREE

The Basics of Property and Casualty Rate Regulation

No changes are proposed to the following sections at the beginning of Chapter Three: Introduction; Rating Laws; Rate Standards; Rate Justification and Supporting Data; Number of Years of Historical Data; Segregation of Data; Data Adjustments; Premium Adjustments; Losses and LAE (perhaps just DCC) Adjustments; Catastrophe or Large Loss Provisions; Loss Adjustment Expenses; Data Quality; Rate Justification: Overall Rate Level; Contingency Provision; Credibility; Calculation of Overall Rate Level Need: Methods (Pure Premium and Loss Ratio Methods); Rate Justification: Rating Factors; Calculation of Deductible Rating Factors; Calculation of Increased Limit Factors; and Credibility for Rating Factors.

Data Adjustments

Because the insurance contracts will be written to cover future accident periods, the past data needs to be adjusted to reflect the anticipated future premiums and costs. These adjustments will provide a profit/loss picture if no rate change occurs. Calculations can then be made to determine the overall rate need (or indication). …

Interaction between Rating Variables (Multivariate Analysis)

If each rating variable is evaluated separately, statistically significant interactions between rating variables may not be identified and, thus, may not be included in the rating plan. If the pricing of rating variables is evaluated separately, for each rating variable, there is potential to miss the interaction between rating variables. Care should be taken to have a multivariate analysis when practical. In some instances, a multivariate analysis is not possible. But, with computing power growing exponentially, insurers believe they have found many ways to improve their operations and competitiveness through use of complex predictive models in all areas of their insurance business.

Approval of Classification Systems

With rate changes, companies sometimes propose revisions to their classification system. Because the changes to classification plans can be significant and have large impacts on the consumers’ rates, regulators should focus on these changes.

Some items of proposed classification can sometimes be deemed to be against public policy, such as the use of education or occupation. You should be aware of your state’s laws and regulations regarding which rating factors are allowed, and you should require definitions of all data elements that can affect the charged premium. Finding rating or underwriting characteristics that may violate public policy is becoming more difficult for regulators with the increasing and innovative ways insurers use predictive models.

Rating Tiers

Some states allow an insurer to have multiple rate levels, or rating tiers, within a single company. These rating tiers are another way of classifying risks for rating purposes. Typically, there are requirements for rating tiers: the underwriting rules for each tier should be mutually exclusive, clear, and objective; there should be a distinction between the expected losses or expenses for each tier; and the placement process should be auditable. Tiers within a company are mainly seen in personal lines products.
One particular concern with rating tiers would be the analyses of whether a plan produces unfair discrimination. Questions arise around the time-sensitive aspects of the underwriting criteria and any related re-evaluation of the tiers upon renewal. For example, consider two tiers where the insured is placed in the "high" tier because of a lapse of insurance in the prior 12 months. The question is: What happens upon renewal after there has no longer been a lapse of insurance for 12 months? Does the insured get slotted in the "low" tier as he would if he was new business? Some statutes limit the amount of time that violations, loss history, or insurance scores can be used, and some statutes might only allow credit history to be used for rating at the policyholder’s request. Regulators should consider the acceptability of differences in rates between existing and new policyholders when they have the same current risk profile.

Insurers also can create different rating levels by having separate companies within a group. While regulators should examine rating tiers within an insurer to a high degree of regulatory scrutiny, there tends to be less scrutiny with differences in rates that exist between affiliated companies. Workers’ compensation insurers are more likely to obtain rating tiers using separate companies.

Rate Justification: New Products – (No change is proposed.)

Predictive Modeling

The ability of computers to process massive amounts of data has led to the expansion of the use of predictive modeling in insurance ratemaking. Predictive models have enabled insurers to build rating, marketing, underwriting and claim models with significant segmentation-predictive power and are increasingly being applied in such areas as claims modeling and used in helping insurers to price risks more effectively.

Key new rating variables that are being incorporated into insurers’ predictive models include homeowners’ home rates by peril, homeowners’ home rating by building characteristics, vehicle history, usage-based auto insurance, and credit characteristics.

Data quality within and communication about models are of key importance with predictive modeling. Depending on definitional boundaries, predictive modeling can sometimes overlap with the field of machine learning. In the modeling space, predictive modeling is often referred to as predictive analytics.

Insurers’ use of predictive analytics along with big data has significant potential benefits to both consumers and insurers. Predictive analytics can reveal insights into the relationship between consumer behavior and the cost of insurance, lower the cost of insurance for many, and provide incentives for consumers to better control and mitigate loss. However, predictive analytic techniques are evolving rapidly and leaving many regulators without the necessary tools to effectively review insurers’ use of predictive models in insurance applications. To aid the regulator in the review of predictive models, best practices have been developed for generalized linear models or "GLMs". GLMs are commonly used in personal automobile and home insurance applications.

The term “predictive model” refers to a set of models that use statistics to predict outcomes. When applied to insurance, the model is chosen to estimate the probability or expected value of an outcome given a set amount of input data; for example, models can predict the frequency of loss, the severity of loss, or the pure premium.

To further complicate regulatory review of models in the future, modeling technology and methods are evolving rapidly. GLMs are relatively transparent and their output and consequences are much clearer than many other complex models. But as computing power grows exponentially, it is opening up the modeling world to more sophisticated forms of data acquisition and data analysis. Insurance actuaries and data scientists seek increased predictiveness by using even more complex predictive modeling methods. Examples of these are predictive models utilizing logistic regression, k-nearest neighbor classification, random forests, decision trees, neural networks, or combinations of available modeling methods (often referred to as ensembles). These evolving techniques will make the regulators’ understanding and oversight of filed rating plans even more challenging.

A. Generalized Linear Models

The generalized linear model (GLM) is a commonly used predictive model in insurance applications, particularly in building an insurance product’s rating plan. Because of this and the fact most Property and Casualty regulators are most concerned...
about personal lines. NAIC has developed a white paper for guidance in reviewing GLMs for personal automobile and home insurance.

Before GLMs became vogue, rating plans were built using univariate methods. Univariate methods were considered easy to understand and easy to demonstrate the relationship to costs (loss and/or expense). However, many consider univariate methods too simplistic since they do not take into account the interaction (or dependencies) of the selected input variables. GLMs introduce significant improvements over univariate-based rating plans by automatically adjusting for correlations among input variables. Today, the majority of predictive models used in personal automobile and home insurance rating plans are GLMs. But, GLM results are not always easy to understand and the relationship to costs may be difficult to explain.

A GLM consists of three elements:

- A target variable, which is a random variable that is independent and follows a probability distribution from the exponential family, defined by a selected variance function and dispersion parameter.
- An input variable, which is a function such that \( E(Y) = \mu = g^{-1}(p) \).

As can be seen in the description of the three GLM components above, it may take more than a casual introduction to statistics to comprehend the construction of a GLM. As stated earlier, a downside to GLMs is that it is more challenging to interpret the GLMs output than with univariate models.

B. Credibility of GLM Output

If the underlying data is not credible no model will improve that credibility, and segmentation methods could make credibility worse. GLM software provides point estimates and allows the modeler to consider standard errors and confidence intervals. GLMs effectively assume that the underlying datasets are 100% credible no matter their size. If some segments have little data, the resulting uncertainty would not be reflected in the GLM parameter estimates themselves (although it might be reflected in the standard errors, confidence intervals, etc.). Even though the process of selecting relativities often includes adjusting the raw GLM output, the resultant selections are not typically credibility-weighted with any complement of credibility. [New footnote: “This is not always true. Sometimes insurers do review complements of credibility and further weight the GLM output with those complements. While this may not be a standard practice today, new techniques could result in this becoming more standard in the future.”] GLMs provide confidence intervals; credibility methods do not. There are techniques such as penalized regression that blend credibility with a GLM and improve a model’s ability to generalize. Nevertheless, selected relativities based on GLM model output may differ from GLM point estimates.

Because of this presumption in credibility, which may or may not be valid in practice, the modeler and the regulator reviewing the model would need to engage in thoughtful consideration when incorporating GLM output into a rating plan to ensure that model predictiveness is not compromised by any lack of actual credibility. Therefore, to mitigate the risk that model credibility or predictiveness is lacking, a complete filing for a rating plan that incorporates GLM output should include validation evidence for the rating plan, not just the statistical model.

C. What is a “Best Practice”?

A best practice is a form of program evaluation in public policy. At its most basic level, a practice is a “tangible and visible behavior... [based on] an idea about how the actions... will solve a problem or achieve a goal.” Best practices can maintain quality as an alternative to mandatory legislated standards and can be based on self-assessment or benchmarking. Therefore, a best practice represents an effective method of problem solving. The “problem” regulators want to solve is probably better posed as seeking an answer to this question: How can regulators determine that predictive models, as used in rate filings, are compliant with state laws and regulations? However, best practices are not intended to create standards for filings that include predictive models.

[Commented [WL7]: The lack of credibility WOULD be reflected in inappropriate/poor parameter estimates but could only be DETECTED in the standard errors and confidence intervals.]

12 Refer to NAIC’s white paper titled Regulatory Review of Predictive Models, found at the NAIC website.


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Best practices are based on the following principles that promote a comprehensive and coordinated review of predictive models across states:

- State insurance regulators will maintain their current rate regulatory authority.
- State insurance regulators will be able to share information to aid companies in getting insurance products to market more quickly.
- State insurance regulators will share expertise and discuss technical issues regarding predictive models.
- State insurance regulators will maintain confidentiality, where appropriate, regarding predictive models.

D. Regulatory Review of Predictive Models

The legal and regulatory constraints (including state variations) are likely to be more evolved, and challenging, for personal automobile and home insurance. Through review of these personal lines, the knowledge needed to review predictive models and guidance regarding GLMs may be transferable when the review involves GLMs applied to other lines of business. Modeling depends on context, so the GLM reviewer has to be alert for data challenges and business applications that differ from the more familiar personal lines. For example, compared to personal lines, modeling rates in commercial lines is more likely to encounter low volumes of historical data, dependence on advisory loss costs, unique large accounts with large deductibles, and package products that create policies from numerous line-of-business and coverage building blocks. Commercial lines commonly use individual risk modifications following experience, judgment, and/or expense considerations. A regulator may never see how models impact commercial excess and surplus lines filings.

Guidance offered here and in the NAIC's white paper might be useful (with deeper adaptations) when starting to review different types of predictive models. If the model is not a GLM, however, some of the GLM guidance might not apply. For example, not all predictive models generate p-values or F tests. Depending on the model type under review, other considerations might be important that were not as important in the review of a GLM. Also, when transferring GLM guidance to other lines of business, unique considerations may arise depending on the context in which a predictive model is proposed to be deployed, the uses to which it is proposed to be put, and the potential consequences for the insurer, its customers and its competitors. This guidance does not delve into these possible considerations, but regulators should be prepared to address them as they arise.

Best practices will help the regulator understand if a predictive model is cost based, if the predictive model is compliant with state law, and how the model improves the company’s rating plan. Best practices can also increase the consistency among the regulatory review processes used across states and improve the efficiency of each regulator’s review thereby assisting companies in getting their products to market faster. With this in mind, the regulator's review of predictive models should:

1. Ensure that the selected rating factors based on the model or other analysis produce rates that are not excessive, inadequate, or unfairly discriminatory.
   a. Review the overall rate level impact of the proposed revisions to rate level indications provided by the filer.
   b. Review the premium discount for individual policyholders and how the discounts can be explained to individual consumers.
   c. Review the individual input characteristics to and output factors from the predictive model (and its sub-models), as well as, associated selected relativities to ensure they are not unfairly discriminatory.

2. Obtain a clear understanding of how the data used to build and validate the model, and thoroughly review all other aspects of the model, including assumptions, adjustments, variables, submodels used as input, and resulting output.
   a. Determine that individual input characteristics to a predictive model and their resulting rating factors are related to the expected loss or expense differences in risk.
   b. Determine that the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values and outliers are handled.
   c. Determine that any adjustments to the raw data are handled appropriately, including but not limited to, trending, development, capping, removal of catastrophes.
   d. Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated and whether the model is periodically rerun, so model output reflects changes to non-static risk characteristics.
   e. Obtain a clear understanding of how the selected predictive model was built.
   f. Determine whether internal and external data used in relation to the model is compatible with practices allowed in the jurisdiction and do not reflect characteristics prohibited in the state.

3. Evaluate how the model interacts with and improves the rating plan.
As adopted by the Casualty Actuarial and Statistical (C) Task Force on XX/XX/XX

a. Obtain a clear understanding of the characteristics that are input to a predictive model (and its sub-models), their relationship to each other and their relationship to non-modeled characteristics/variables used to calculate a risk’s premium.
b. Obtain a clear understanding why the insurer believes this type of model works in an insurance risk application.
c. Obtain a clear understanding of how model output interacts with non-modeled characteristics/variables used to calculate a risk’s premium.
d. Obtain a clear understanding of how the predictive model was integrated into the insurer’s state rating plan and how it improves that plan.
e. For predictive model refreshes, determine whether sufficient validation was performed to ensure the model is still a good fit.

4. Enable competition and innovation to promote the growth, financial stability, and efficiency of the insurance marketplace.
   a. Enable innovation in the pricing of insurance through acceptance of predictive models, provided they are actuarially sound and in compliance with state law.
   b. Protect the confidentiality of filed predictive models and supporting information in accordance with state law.
   c. Review predictive models in a timely manner to enable reasonable speed to market.

E. Information Needed to Follow Best Practices

To assist the regulator in following each best practice, the Casualty Actuarial and Statistical Task Force created a white paper titled "Regulatory Review of Predictive Models." The paper contains a list of information elements and considerations that should be useful during the review of a model underlying a rating plan. To further assist the regulator, the information elements were mapped into the best practices listed above in Section XV of the paper.

Note that, in the white paper, CASTF focused on the GLM since it is a commonly used predictive model in insurance applications, particularly in building an insurance product’s rating plan. Combined with the fact most property and casualty regulators are very concerned about personal lines, the white paper is focused on the review of GLMs for personal auto mobile and home insurance rate making applications.

Guidance offered here might be useful (with deeper adaptations) when starting to review different types of predictive models. If the model is not a GLM, some listed items might not apply. For example, not all predictive models generate p-values or F-tests. Depending on the model type, other considerations might be important. When transferring guidance to other lines of business and other types of model, unique considerations may arise depending on the context in which a predictive model is proposed to be employed, the uses to which it is proposed to be put, and the potential consequences for the insurer, its customers and its competitors. This paper does not delve into these possible considerations, but regulators should be prepared to address them as they arise.

F. Confidentiality

Regulatory reviewers are required to protect confidential information in accordance with applicable State law. However, insurers should be aware that a rate filing might become part of the public record. Each state determines the confidentiality of a rate filing, supplemental material to the filing, when filing information might become public; the procedure to request that filing information be held confidentially, and the procedure by which a public records request is made. It is incumbent on an insurer to be familiar with each state’s laws regarding the confidentiality of information submitted with their rate filing.

Advisory Organizations – (No change is proposed.)

Workers’ Compensation Special Rules – (No change is proposed.)

Premium Selection Decisions

- Indicated Rate Change vs. Selected Rate Change

After applying credibility, the indicated rate change should reflect the company’s best estimate of their premium needs given their current or expected book of business. However, insurance companies also have other business considerations including competition, marketing, legal concerns, impact of the rate change on retention, etc. A company might wish to deviate from their indicated rate change and should justify those decisions, within the constraints of the law.
Capping and Transition Rules

With advances in technology, it is possible for companies to introduce capping of rates on individual policies with an aim toward gradually increasing policyholders’ rates, rather than making large modifications all at one time. Similarly, premiums are often proposed to be modified when an insurer acquires another company’s book of business or decides to move from or to an advisory organization’s plan. These types of proposed capping are sometimes called “renewal premium capping,” “rate capping,” “a rate stability program,” or “transition rules.”

Transition rules for individual policyholders can get quite complex and you need to be aware of your state’s positions on premium capping rules. Any premium capping and transition rules require weighing the pros and cons of the potential for unfair discrimination (with some customers not paying the rate commensurate with the risks they have) vs. rate stability for existing policyholders.

If premium capping or transition rules are allowed, additional decisions will need to be made:
- Which rates should get capped?
- Do rate decreases get capped? If so, what is the impact if the policyholder asks to be quoted as new business?
- Do all rate increases get capped or only above a certain percentage?
- How much time will lapse or how many renewal cycles will occur before the new rates are in place or different rating plans are merged?
- Should the insured be told what the final premium will be once no more capping is applied?
- How would exposure change be addressed? If the policyholder buys a new car or changes their liability limits, what is the impact on their rate capping?
- How many rate-capping rules can be implemented at any given time?

When premium capping or transition rules have been incorporated, future indicated rate changes and rating factor analyses need to properly reflect the fully approved rate changes. If the overall approved rate change was +10%, yet capping resulted in only 8% being implemented in the first year, the remaining amount to recognize the full 10% should be reflected in the premium on-level adjustment. Otherwise, the indicated rate would be redundant.

Some states encourage more frequent filing of rate changes that can help to avoid the need of premium capping and transition rules. Some states might prefer capping of individual rating variables, rather than capping for individual policyholders.

Installment Plans – (No change is proposed.)

Policy Fees – (No change is proposed.)

Potential Questions to Ask Oneself as a Regulator

Every filing will be different and will result in different regulatory analyses. But the following are some questions the regulator might ask oneself in a rate filing review:

1. Regarding data:
   a. Is the data submitted with the filing enough information for a regulatory review?
   b. Is the number of years of experience appropriate?
   c. Did the company sufficiently analyze and control their quality of data?

2. Regarding the support and justification of rates:
   a. Did they propose rate changes without justification?
   b. Are proposals based on judgment or competitive analysis? If so, are the results reasonable and acceptable? Are there inappropriate marketing practices?
   c. Are the assumptions (loss development, trend, expense load, profit provision, credibility etc.) used to develop the rate indication appropriate? Are they supported with data and are deviations from data results sufficiently explained?
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d. Is the weighting of data by year (or credibility) properly justified or does it appear random?
   • Is there more weight being placed on data in one year solely because it produces a higher indicated rate change?
   • If there are two indications being weighted together and one is for a rate increase and one is a rate decrease, is the weighting justified?

e. Is there satisfactory explanation about why a proposed rate change deviates from the indicated rate change?

3. Regarding differences in assumptions from previous filings:
   a. Have methodologies changed significantly?
   b. Are assumptions for the weighting of years or credibility significantly different? Or does there appear to be some manipulation to the rate indication?

4. Is there unfair discrimination?
   a. Do classifications comply with state requirements?
   b. Are proposed rates established so that different classes will produce the same underwriting results?
   c. If predictive models are used in the rating plan, are there concerns related to input variables that are prohibited or proxies for prohibited variables?

5. What do you need to communicate?
   a. Can you explain why you are taking a specific action on the filing?
   b. What do you need to tell the Consumer Services Department?
      • Can you explain the impact of the rate change on current business? How big is the company and how much of the market is impacted?
      • What are the biggest changes in the filing (and the ones on which consumer calls might be expected)?
      • What is the maximum rate change impact on any one policyholder?

Questions to Ask a Company

If you remain unsatisfied that the company has satisfactorily justified the rate change, then consider asking additional questions of the company. Questions should be asked of the company when they have not satisfied statutory or regulatory requirements in the state or when any current justification is inadequate and could have an impact on the rate change approval or the amount of the approval.

If there are additional items of concern, the company can be notified so they will make appropriate modifications in future filings.

The CASTF white paper, Regulatory Review of Predictive Models, documents questions that a regulator may want to ask when reviewing a model. These questions are listed in the Predictive Model – Information for Regulatory Review section of the white paper. Note that although the white paper focuses on GLMs for personal automobile and home insurance, some of the concepts may be transferable to other types of models and other lines of business.

Additional Ratemaking Information
The Casualty Actuarial Society (CAS) and the Society of Actuaries (SOA) have extensive examination syllabi that contain a significant amount of ratemaking information, on both the basic topics covered in this chapter and on advanced ratemaking topics. The CAS and SOA websites contain links to many of the papers included in the syllabus. Recommended reading is the Foundations of Casualty Actuarial Science, which contains chapters on ratemaking, risk classification, and individual risk rating.

Other Reading

Some additional background reading is recommended:

  - Chapter 1: Introduction
  - Chapter 3: Ratemaking
  - Chapter 6: Risk Classification
  - Chapter 9: Investment Issues in Property-Liability Insurance
  - Chapter 10: Only the section on Regulating an Insurance Company, pp. 777–787
- Casualty Actuarial Society (CAS) Statements of Principles, especially regarding property and casualty ratemaking.
- Association of Insurance Compliance Professionals: “Ratemaking—What the State Filer Needs to Know.”
- Review of filings and approval of insurance company rates.

Summary

Rate regulation for property/casualty lines of business requires significant knowledge of state rating laws, rating standards, actuarial science, statistical modeling and many data concepts.

- Rating laws vary by state, but the rating laws are usually grouped into prior approval, file and use or use and file (competitive), no file (open competition), and flex rating.
- Rate standards typically included in the state rating laws require that “Rates shall not be inadequate, excessive, or unfairly discriminatory.”
- A company will likely determine their indicated rate change by starting with historical years of underwriting data (earned premiums, incurred loss and loss adjustment expenses, general expenses) and adjusting that data to reflect the anticipated ultimate level of costs for the future time period covered by the policies. Numerous adjustments are made to the data. Common premium adjustments are on-level premium, audit, and trend. Common loss adjustments are trend, loss development, Catastrophe/large loss provisions, and an adjusting and other (A&O) loss adjustment expense provision. A profit/contingency provision is also calculated to determine the indicated rate change.
- Once an overall rate level is determined, the rate change gets allocated to the classifications and other rating factors.
- Individual risk rating allows manual rates to be modified by an individual policyholder’s own experience.
- Advisory organizations provide the underlying loss costs for companies to be able to add their own expenses and profit provisions (with loss cost multipliers) to calculate their insurance rates.
- Casualty Actuarial Society’s Statement of Principles Regarding Property and Casualty Insurance Ratemaking provides guidance and guidelines for the numerous actuarial decisions and standards employed during the development of rates.
- NAIC model laws also include special provisions for workers’ compensation business, penalties for not complying with laws, and competitive market analysis to determine whether rates should be subject to prior approval provisions.
- Best practices for reviewing predictive models are provided in the CASTF white paper titled Regulatory Review of Predictive Models. Although the white paper focuses on GLMs for personal automobile and home insurance, some of the concepts may be transferrable to other types of models and other lines of insurance.

While this chapter provides an overview of the rate determination/actuarial process and regulatory review, state statutory or administrative rule may require the examiner to adopt different standards or guidelines than the ones described.
IX. PROPOSED STATE GUIDANCE

TBD - placeholder for guidance for rate filings that are based on predictive model

This paper acknowledges that different states will apply the guidance within it differently, based on variations in the legal environment pertaining to insurance regulation in those states, as well as the extent of available resources, including staff members with actuarial and/or statistical expertise, the workloads of those staff members, and the time that can be reasonably allocated to reviews of predictive models. States with prior approval authority over personal lines rate filings often already require answers in connection with many of the information elements expressed in this paper. However, states – including those with and without price approval authority – may also use the guidance in this paper to choose which model elements to focus on in their reviews and/or to train new reviewers, as well as to gain an enhanced understanding of how predictive models are developed, supported, and deployed in their markets. Ultimately, the insurance regulators within each state will decide how best to tailor the guidance within this paper to achieve the most effective and successful implementation, subject to the framework of statutes, regulations, precedents, and processes that comprise the insurance regulatory framework in that state.

X. OTHER CONSIDERATIONS

During the development of this guidance, topics arose that are not addressed in this paper. These topics may need addressing during the regulator’s review of a predictive model. A few of these topics may be discussed elsewhere within the NAIC as either technical or policy matters. All of these topics should probably be addressed and be handled by each state on a case-by-case basis. A sampling of topics for consideration in this section includes: Below is a listing of topics that CASTF thought might be important for future discussion and consideration but are beyond the scope of this paper, as well as CASTF’s current charges.

- TBD: Discuss when are rating variables or rating plans become too granular? How is granularity handled during the development of the model and during the selection of rate relativities file in a rating plan supported by a model?
  - The granularity of data refers to the size in which data fields are sub-divided. For example, data could be at the state level or could be subdivided into county or further into zip code or even census tracks. Insurers have been instituting data warehouse initiatives that greatly improved the granularity and accessibility of data that could be analyzed for ratemaking purposes. So, despite the fact that sophisticated statistical techniques existed much earlier than these data warehouses, it was the circumstances of enhanced computing power and better data that enabled their usage in classification ratemaking. Perhaps the most important trigger in the widespread adoption of multivariate methods was competitive pressure. When one or more companies implement improved classification ratemaking, they gain a competitive advantage and put the rest of the industry in a position of adverse selection and decreased profitability. [footnote: Basic Ratemaking, Fifth Edition, May 2016; Geoff Werner, FCAS, MAAA and Claudine Modlin, FCAS, MAAA]
  - The science of classification requires balancing two objectives: grouping risks into a sufficient number of levels to ensure the risks within each group are homogeneous while being careful not to create too many granularly defined groups that may lead to instability in the estimated costs. [footnote: Basic Ratemaking, Fifth Edition, May 2016; Geoff Werner, FCAS, MAAA and Claudine Modlin, FCAS, MAAA]
  - Concern has been expressed that when fields are sub-divided too finely, model results may be less reliable. It is commonly assumed that having a larger volume of data is preferable. However, even with a larger volume of data, if the model is overly granular the more data you have, the better. But, the more granular the data, it may be the harder to see the forest for the trees. More granular data used as input to predictive models may make it easier to measure short-term effects, but it can also make it harder to measure long-term effects, due to a relatively greater noise in the data. However, more granular data may make anomalies in the data more apparent and make it easier to scrub the data.
  - Therefore, it may be of value to provide guidance around granularity, such as: When are rating variables or rating plans too granular? How is granularity handled during the development of the model or during the selection of rate relativities?

No additional changes are proposed to the Product Filing Review Handbook.

Commented [WL13]: Prior approval should not be hyphenated.

Commented [WL14]: Personal lines should not be hyphenated.

Commented [WL15]: "is" or "are" may be appropriate here, depending on the reference: "Below is a listing..." or "Below is a listing of topics that CASTF thought might be important..." but they [the topics] ARE beyond the scope..."

Commented [WL16]: No hyphen needed in "sub-divided"

Commented [WL17]: What is meant by short-term versus long-term effects. Perhaps an example of each here?

Commented [WL18]: This paragraph appears to be confusing granularity of the data and granularity of the model. The data can be very granular – always good – provides more flexibility. But that doesn’t mean the model should be as granular as the data. We suggest a rewrite of this paragraph to clearly separate the granularity of data (which is good), and the granularity of the model (which can be good or bad, for the reasons cited here).
Discuss the regulator’s scientific mindset of unbiased and open inquiry and its relevance to the best practice white paper.

- **TBD:** Discuss correlation vs causality in general and in relation to Actuarial Standard of Practice (ASOP) 12.
  - There were many criticisms during each exposure of this white paper that this paper goes beyond the requirement of Actuarial Standard of Practice #12 and establishes a new standard for the company's actuaries. This topic may need to be explored further by states collectively (through NAIC) or on a case-by-case state basis. What a state does with the results of a discussion of rational or logical connections between particular attributes and the risk of insurance loss is subject to the framework of statutes, regulations, precedents, and processes that comprise the insurance regulatory framework in that state.

The very act of discussion of the rational, logical, or plausible relationships of individual risk attributes to the risk of insurance loss — and all related implications, such as perception by consumers, legislatures, and media; philosophical considerations of fairness; interactions with public policy as determined by the relevant policymaking bodies; and relevance to the evolution of the insurance industry, consumer products, and overall impacts on the incentives and opportunities available to consumers — is crucial to engage in and continue to do so for as long as new predictive models are being developed, new variables are being introduced, and consumer premiums as well as insurer underwriting decisions are being affected. In other words, the discussion needs to continue indefinitely in a variety of venues and evolve along with the industry and the broader society. We, as insurance professionals, cannot insulate ourselves from participation in the conceptual discourse.

- **TBD:** Discuss correlation vs causality in general and in relation to Actuarial Standard of Practice (ASOP) 12.
  - This white paper, in general, establishes that a rating/modeled variable should not only be correlated to expected costs but that there should be a rational explanation as to why the correlation exists. While it is difficult to prove causation, and such a proof is not a standard against which rate filings are evaluated in any jurisdiction, there is an immense difference of both degree and kind between proving causation and discussing a rational or logical connection between a particular variable and the risk of insurance loss. It is a non sequitur to assert that the lack of requirement for the former (proof) confers immunity upon insurers in regard to the latter (discussion and expression of plausibility).

Discussion of the Actuarial Standards of Practice has been consciously excluded from this paper for a number of reasons. Firstly, the Actuarial Standards of Practice (ASOPs) are principles that are not mandatory and should not be considered in a position to be the torchbearers for the scientific approach to unbiased view, by maintaining the commitment to open but rigorous, systematic, and principled inquiry and exploration. Such answers cannot be "synthesized" without considering the context of a given jurisdiction’s and marketplace, and the specific nature of insurers’ proposals. Therefore, to preempt any arguments by some interested parties that the paper may prescribe specific solutions or restrictions — it clearly does not.

- **TBD:** Discuss correlation vs causality in general and in relation to Actuarial Standard of Practice (ASOP) 12.
  - This white paper does not prescribe any specific answers regarding which treatments are to be considered logical or rational. Such answers cannot be synthesized without considering the context of a given jurisdiction’s, marketplace, and the specific nature of insurers’ proposals. Therefore, to preempt any arguments by some interested parties that the paper may prescribe specific solutions or restrictions — it clearly does not.

Initially, we understood this language to refer to “scientific mindset” as meaning the regulator would be the developer of the scientific model. Upon reading this section more closely, we understand that the “scientific approach” is intended to mean the rigorous and unbiased exploration of the models developed by the insurance industry.

Can we revise the paragraph to be a little more clear as to what is meant by “scientific mindset?”

Commented [WL19]: This header is a bit cerebral for the tone of the rest of this section. Can we “layperson-ize” it?

Commented [WL20]: Commitment to open but rigorous inquiry should be no greater or lesser on predictive models than any other item under regulatory review.

Commented [WL21]: Initially, we understood this language to refer to “scientific mindset” as meaning the regulator would be the developer of the scientific model. Upon reading this section more closely, we understand that the “scientific approach” is intended to mean the rigorous and unbiased exploration of the models developed by the insurance industry.

Commented [WL22]: Not all regulators are actuaries. Isn’t this a best practices white paper for regulators, whether they be actuaries or not?

Commented [WL23]: Do the ASOPs also apply to actuarial analysts, or more generally, anyone pursuing an actuarial designation and working in an actuarial capacity?

Commented [WL24]: Keep with same format of other bullets.
Throughout this white paper, the regulator asks the modeler to go beyond correlation and document their basic, causal understanding of how variables used in a model or rating plan are related to risk. A correlation alone is not the final arbiter of the validity of findings, but causal understanding can be employed to assess which correlations may be entirely due to chance, what are non-causal relationships, and which are most likely to be enduring causal relationships. Though this white paper does not delve deeply into these relationships can be identified and documented, the paper does ask the modeler to provide their understanding of causal relationships. The future consideration is whether the regulator should take a deeper dive into the causal relationships of variables used in a model or rating plan.

The American Statistical Association (ASA) expressed some degree of alarm at approaches similar to data mining (Wasserstein and Lazer, 2016). In a formal statement of the ASA, the association warned against a purely “cookbook” approach to statistics... a pea-pot near .05 taken by itself offers only weak evidence of the null hypothesis” (page 129). Lastly, the ASA warned strongly against an over reliance on data mining: “Cherry-picking promising findings, also known by such terms as data dredging, significance chasing... and “p-hacking,” leads to a spurious excess of statistically significant results...and should be vigorously avoided” (page 131).

Another problem that will increase significantly with the increased adoption of data mining techniques and the increasing growth of very large data sets that dwarf anything available even just a decade ago is that data mining will dramatically increase the rate of “false positives” - the technique Data mining will inevitably churn up numerous associations between variables that are simply random, non-meaningful correlations resulting purely from chance. The apparent disregard of causality that seems common among practitioners of data mining techniques will significantly magnify the problem. Causality forms the basis of the standard model of all natural and social sciences. Evaluations of models should consider the nature of observed relationships within the context of prior substantive knowledge.

Because of these issues regarding data mining and false positives stated in the prior paragraphs, throughout this white paper, the regulator asks the modeler to go beyond correlation and document their basic, causal understanding of how variables used in a model or rating plan are related to risk. A correlation alone is not the final arbiter of the validity of findings, but causal understanding can be employed to assess which correlations may be entirely due to chance, what are non-causal relationships, and which are most likely to be enduring causal relationships. Though this white paper does not delve deeply into these relationships can be identified and documented, the paper does ask the modeler to provide their understanding of causal relationships. The future consideration is whether the regulator should take a deeper dive into the causal relationships of variables used in a model or rating plan.

The white paper identified the following best practices:

- C.2.a Provide an explanation how the characteristics/rating variables, included in the filed rating plan, logically and intuitively relate to the risk of insurance loss (or expense) for the type of insurance product being priced. Include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense).
- C.2.b Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers, and information elements that may assist the regulator's and consumer's understanding of the premium being charged.
- C.2.c Identify sources to be used at “point of sale” to place individual risks within the matrix of rating system classifications. How can a consumer verify their own “point-of-sale” data and correct any errors?
- C.2.d Explain how the insurer will help educate consumers to mitigate their risk. Discuss the multitude of Regulators are often responding to consumer inquiries to which regulators respond regarding how a policy premium is calculated and why the premium, or the change in premium, is so high.

The main challenge to consumers is lack of transparency: trying to understand the data and analytics being used to determine their eligibility for products and the price they are being charged. It may not be clear to the consumer how they are being underwritten or what behaviors they can modify or steps they can take to get a better rate. A potential issue with pricing based on predictive analytics is that it can lead to more granular
Discuss revision to model laws regarding advisory organizations.

- Organizations not licensed or supervised as advisory organizations are engaging in precisely the same type of activities as licensed advisory organizations—collecting data from insurers, analyzing the data and combining it with other data and information, and producing collective pricing and claim settlement recommendations in the form of algorithms. The vendors of algorithms are providing the same type of guidance as the archetype of advisory organizations, the Insurance Services Office, by producing loss cost classifications. How can a consumer verify their own “point-of-sale” data and correct any errors?

Commented [WL28]: if we have addressed these topics in the white paper, why are they reiterated in this section of “other considerations” not addressed in the white paper?

If this section is kept, the bullets should be rephrased to be action verbs in the bullet list. We’ve tried to do the latter here.

- TBD: Discuss guidelines for insurers’ handling of consumer-generated data in insurance transactions.
  - Does a consumer have the right to know what data is being used to determine the consumer’s premium, where that data came from, and how the consumer can address errors in the data? To what extent is the insurer accountable for the quality of the data used to calculate a consumer’s premium, whether that data is internal or external to the insurer’s operations? To what extent should the insurer inform the consumer (transparency) and when should the insurer inform the consumer how their premium is calculated? If the consumer is properly informed, the consumer may make physical and behavioral changes to lower their risk, and subsequently their premium. “This issue deals with consumers’ ownership and control of the data they create through interactions with the insurer or devices provided by or monitored by the insurer as well as the permissible uses of those data by insurers.” [Center for Economic Justice, comments to the NAIC Accelerated Underwriting (A) Working Group, September 29, 2019]

- Discuss the development of new tools and techniques for monitoring consumer market outcomes resulting from insurers’ use of Big Data analytics in property and casualty rating plans.
  - Given an insurer’s rating plan relies on a predictive model and knowing all characteristics of a risk, a regulator should be able to audit/calculate the risk’s premium without consultation with the insurer. Does a consumer have the right to know when each risk characteristic (used as input to the model or is in the rating plan) is updated or if the risk characteristic is static.

- TBD: Determine the extent to which the model causes premium disruption for individual policyholders, and how the insurer will explain the disruption to individual consumers that inquire about it.
- TBD: Discuss cost to filing company and state to have expertise and resources adequate to document and review all knowledge elements identified in this white paper.

Given an insurer’s rating plan relies on a predictive model and knowing all characteristics of a risk, a regulator should be able to audit/calculate the risk’s premium without consultation with the insurer.

- As a future consideration, NAIC or a state may want to explore, with insurers, how to improve communications with the consumer on these topics:
  - TBD: Identify sources to be used at “point of sale” to place individual risks within the matrix of rating system classifications. How can a consumer verify their own “point-of-sale” data and correct any errors?
  - TBD: Discuss cost to filing company and state to have expertise and resources adequate to document and review all knowledge elements identified in this white paper.
  - Other TBDs

Commented [WL28]: if we have addressed these topics in the white paper, why are they reiterated in this section of "other considerations" not addressed in the white paper?

If this section is kept, the bullets should be rephrased to be action verbs in the bullet list. We’ve tried to do the latter here.
recommendations. To ensure that data brokers and vendors of algorithms who are engaged in advisory organization activities are properly licensed and supervised, advisory organization model laws could be revised. [Center for Economic Justice, comments to the NAIC Accelerated Underwriting (A) Working Group, September 29, 2019]

- TBD: Discuss the need for NAIC to update and strengthen information-sharing platforms and protocols.
- TBD: Discuss paper topics beyond GLMs and personal automobile and home insurance applications.
- TBD: The scope of this white paper was narrowed to GLMs as used in personal automobile and home insurance rating applications. Many commenters expressed concern that the paper’s scope is too narrow. NAIC may want to expand these best practices or create new best practices for other lines of business, other insurance applications (other than personal automobile and home filings), and other types of models.

XI. RECOMMENDATIONS GOING FORWARD

The following are examples of topics that may be included in the recommendations:

- TBD: Discuss confidentiality as it relates to filings submitted via SERFF.
- TBD: Discuss confidentiality as it relates to state statutes and regulations.
- TBD: Discuss policyholder disclosure when complex predictive model underlies a rating plan.
- TBD: Discuss the need for NAIC to update and strengthen information-sharing platforms and protocols.
- TBD: Determine the means available to a consumer to correct or contest individual data input values that may be in error.
- TBD: Given an insurer’s rating plan relies on a predictive model and knowing all characteristics of a risk, discuss a regulator’s ability/need to audit/calculate the risk’s premium without consultation with the insurer.
- Other TBDs.
APPENDIX A – BEST PRACTICE DEVELOPMENT

Best-practices development is a method for reviewing public policy processes that have been effective in addressing particular issues and could be applied to a current problem. This process relies on the assumptions that top performance is a result of good practices and these practices may be adapted and emulated by others to improve results16.

The term “best practice” can be a misleading one due to the slippery nature of the word “best”. When proceeding with policy research of this kind, it may be more helpful to frame the project as a way of identifying practices or processes that have worked exceptionally well and the underlying reasons for their success. This allows for a mix-and-match approach for making recommendations that might encompass pieces of many good practices17.

Researchers have found that successful best-practice analysis projects share five common phases:

A. **Scope**

The focus of an effective analysis is narrow, precise and clearly articulated to stakeholders. A project with a broader focus becomes unwieldy and impractical. Furthermore, Bardach urges the importance of realistic expectations in order to avoid improperly attributing results to a best practice without taking into account internal validity problems.

B. **Identify Top Performers**

Identify outstanding performers in this area to partner with and learn from. In this phase, it is key to recall that a best practice is a tangible behavior or process designed to solve a problem or achieve a goal (i.e. reviewing predictive models contributes to insurance rates that are not unfairly discriminatory). Therefore, top performers are those who are particularly effective at solving a specific problem or regularly achieve desired results in the area of focus.

C. **Analyze Best Practices**

Once successful practices are identified, analysts will begin to observe, gather information and identify the distinctive elements that contribute to their superior performance. Bardach suggests it is important at this stage to distill the successful elements of the process down to their most essential idea. This allows for flexibility once the practice is adapted for a new organization or location.

D. **Adapt**

Analyze and adapt the core elements of the practice for application in a new environment. This may require changing some aspects to account for organizational or environmental differences while retaining the foundational concept or idea. This is also the time to identify potential vulnerabilities of the new practice and build in safeguards to minimize risk.

E. **Implementation and evaluation**

The final step is to implement the new process and carefully monitor the results. It may be necessary to make adjustments, so it is likely prudent to allow time and resources for this. Once implementation is complete, continued evaluation is important to ensure the practice remains effective.

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APPENDIX B - GLOSSARY OF TERMS

Adjusting Data - Adjusting data refers to any changes made to the raw data. For example, capping losses, on-leveling, binning, transformation of the data, etc. This term includes scrubbing of the data.

Aggregated Data - Aggregated data is from the insurer's data banks without modification (e.g., not scrubbed or transformed). Aggregated datasets are those compiled prior to data selection and model building.

Composite Characteristic - A composite characteristic is a combination of two or more individual risk characteristics. Composite characteristics are used to create composite variables.

Composite Score - A composite score is a number arrived at by combining multiple variables by means of a sequence of mathematical steps. For example, a credit-based insurance scoring model.

Composite Variable - A composite variable is a variable created by combining two or more individual risk characteristics of the insured into a single variable.

Continuous Variable - A continuous variable is a numeric variable that represents a measurement on a continuous scale. Examples include age, amount of insurance (in dollars), and population density.

Control Variable - Control variables are variables whose relativities are not used in the final rating algorithm but are included when building the model. They are included in the model so that other correlated variables do not pick up their signal. For example, state and year are frequently included in countrywide models as control variables so that the different experiences and distributions between states and across time do not influence the rating factors used in the final rating algorithm.

Correlation Matrix - A correlation matrix is a table showing correlation coefficients between sets of variables. Each random variable (X) in the table is correlated with each of the other random variables in the table. Knowing the correlation coefficients of the correlation matrix, one can determine which pairs of variables have the highest correlations. Below is a sample correlation matrix showing correlation coefficients for combinations of 5 variables B1:B5. The table shows that variables B2 and B4 have the highest correlation coefficient (0.96) in this example. The diagonal of the table is always set to ones, because the correlation coefficient between a variable and itself is always 1. You could fill in the upper-right triangle, but there would be a mirror image of the lower-left triangle (because correlation between B1 and B2 is the same as between B2 and B1). In other words, a correlation matrix is also a symmetric matrix.  

<table>
<thead>
<tr>
<th></th>
<th>B1</th>
<th>B2</th>
<th>B3</th>
<th>B4</th>
<th>B5</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1</td>
<td>1</td>
<td>0.53</td>
<td>0.73</td>
<td>0.87</td>
<td>0.43</td>
</tr>
<tr>
<td>B2</td>
<td>0.53</td>
<td>1</td>
<td>0.44</td>
<td>0.96</td>
<td>0.71</td>
</tr>
<tr>
<td>B3</td>
<td>0.73</td>
<td>0.44</td>
<td>1</td>
<td>0.41</td>
<td>0.72</td>
</tr>
<tr>
<td>B4</td>
<td>0.87</td>
<td>0.96</td>
<td>0.41</td>
<td>1</td>
<td>0.56</td>
</tr>
<tr>
<td>B5</td>
<td>0.43</td>
<td>0.71</td>
<td>0.72</td>
<td>0.56</td>
<td>1</td>
</tr>
</tbody>
</table>

Commented [WL29]: "Aggregation" implies that data is summarized or compiled in some way, whether or not it comes straight from the insurer’s data banks, whether or not it has been modified. Perhaps the author confused between aggregation and raw? Raw data is defined below.

Commented [WL30]: Is there another way to say this? Seems unclear.
The process of data dredging involves automatically testing huge numbers of hypotheses about a single data set by exhaustive search—perhaps for combinations of significant results before the analysis and then conducting a single test for it. Data dredging is also referred to as data fishing, data snooping, data butchery, and p-hacking. It is the misuse of data analysis to find patterns in data that can be presented as statistically significant when, in fact, there is no real underlying effect. This is done by performing many statistical tests on the data and only paying attention to those that come back with significant results. The analysis is performed without stating a single hypothesis about an underlying effect before the analysis and then conducting a single test for it.

Data dredging is done by performing many statistical tests on the data and only focusing on those that come back with statistically significant results. This is in conflict with hypothesis testing, which entails performing at most a handful of tests to determine the validity of the hypothesis about an underlying effect, instead of stating a single hypothesis about an underlying effect before the analysis and then conducting a single test for it.

Data dredging involves automatically testing huge numbers of hypotheses about a single data set by exhaustive search—perhaps for combinations of significant results before the analysis and then conducting a single test for it. Data dredging is also referred to as data fishing, data snooping, data butchery, and p-hacking. It is the misuse of data analysis to find patterns in data that can be presented as statistically significant when, in fact, there is no real underlying effect. This is done by performing many statistical tests on the data and only paying attention to those that come back with significant results. The analysis is performed without stating a single hypothesis about an underlying effect before the analysis and then conducting a single test for it.

Conventional tests of statistical significance are based on the probability that a particular result would arise if chance alone were at work, and necessarily accept some risk of mistaken conclusions of a certain type (mistaken rejections of the null hypothesis). This level of risk is called the significance. When large numbers of tests are performed, some false results of this type, hence 5% of randomly chosen hypotheses turn out to be significant at the 5% level, 1% turn out to be significant at the 1% significance level, and so on, by chance alone. When enough hypotheses are tested, it is virtually certain that some will be statistically significant but misleading, since almost every data set with any degree of randomness is likely to contain (for example) some spurious correlations. If they are not cautious, researchers using data mining techniques can be easily misled by these results.

The multiple comparisons hazard is common in data dredging. Moreover, subgroups are sometimes explored without alerting the reader to the number of questions at issue, which can lead to misinformed conclusions.

A data source is the original repository of the information used to build the model. For example, information from internal insurance databases, an application, vendor, credit bureaus, government websites, a sub-model, verbal information provided to agents, external sources, consumer information databases, etc.

A discrete variable is a variable that can only take on a countable number of values or categories. Examples include number of claims, marital status, and gender.

Double lift charts are similar to simple quantile plots, but rather than sorting based on the predicted loss cost of each model, the double lift chart sorts based on the ratio of the two models' predicted loss costs. Double lift charts directly compare the results of two models.

The exponential family is a class of distributions that share the same density form and have certain properties that are used in fitting GLMs. It includes many well-known distributions, such as the Normal, Poisson, Gamma, Tweedie, and Binomial distributions, to name a few.

The Fair Credit Reporting Act (FCRA), 15 U.S.C. § 1681 (FCRA) is U.S. Federal Government legislation enacted to promote the accuracy, fairness, and privacy of consumer information contained in the files of consumer reporting agencies. It was intended to protect consumers from the willful and/or negligent inclusion of inaccurate information in their credit reports. To that end, the FCRA regulates the collection, dissemination, and use of consumer information, including consumer credit information. Together with the Fair Debt Collection Practices Act (FDCPA), the FCRA forms the foundation of consumer rights law in the United States. It was originally passed in 1970 and is enforced by the US Federal Trade Commission, the Consumer Financial Protection Bureau, and private litigants.
Generalized Linear Model - Generalized linear models (GLMs) are a means of modeling the relationship between a variable whose outcome we wish to predict and one or more explanatory variables. The predicted variable is called the target variable and is denoted $y$. In property/casualty insurance ratemaking applications, the target variable is typically one of the following:

- Claim count (or claims per exposure)
- Claim severity (i.e., dollars of loss per claim or occurrence)
- Pure premium (i.e., dollars of loss per exposure)
- Loss ratio (i.e., dollars of loss per dollar of premium)

For quantitative target variables such as those above, the GLM will produce an estimate of the expected value of the outcome. For other applications, the target variable may be the occurrence or non-occurrence of a certain event. Examples include:

- Whether or not a policyholder will renew his/her policy.
- Whether a submitted claim contains fraud.

For such variables, a GLM can be applied to estimate the probability that the event will occur.

The explanatory variables, or predictors, are denoted $x_1, \ldots, x_p$, where $p$ is the number of predictors in the model. Potential predictors are typically any policy term or policyholder characteristic that an insurer may wish to include in a rating plan. Some examples are:

- Type of vehicle, age, or marital status for personal auto insurance.
- Construction type, building age, or amount of insurance (AOI) for home insurance. [15]

Geodemographic - Geodemographics is the study of the population and its characteristics, divided according to regions on a geographical basis. This involves application of clustering techniques to group statistically similar neighbourhoods and areas with the assumption that the differences within any group should be less than the differences between groups. While the main source of data for a geodemographic study is the census data, the use of other sources of relevant data is also prevalent. Geodemographic segmentation (or analysis) is a multivariate statistical classification technique for discovering whether the individuals of a population fall into different groups by making quantitative comparisons of multiple characteristics with the assumption that the differences within any group should be less than the differences between groups.

Geodemographic segmentation is based on two principles:

1. People who live in the same neighborhood are more likely to have similar characteristics than are two people chosen at random.
2. Neighborhoods can be categorized in terms of the characteristics of the population that they contain. Any two neighborhoods can be placed in the same category, i.e., they contain similar types of people, even though they are widely separated.
Granularity of Data - divided

Granularity of data is the level of segmentation at which the data is grouped or summarized. It reflects the level of detail used to slice and dice the data. The granularity of data refers to the size in which data fields are sub-divided. [yy]

For example, a postal address can be recorded, with coarse granularity, as a single field:
- address = 200 2nd Ave. South #358, St. Petersburg, FL 33701-4313 USA

Or, with fine granularity, as multiple fields:
- street address = 200 2nd Ave. South #358
- city = St. Petersburg
- state = FL
- postal code = 33701-4313
- country = USA

Or, even finer granularity:
- street = 2nd Ave. South
- address number = 200
- suite/apartment number = #358
- city = St. Petersburg
- state = FL
- postal code = 33701
- postal code add-on = 4313
- country = USA

Home Insurance - Home insurance covers damage to the property, contents, and outstanding structures (if applicable), as well as loss of use, liability and medical coverage. The perils covered, and the amount of insurance provided and other policy characteristics are detailed in the policy contract. [16]

Insurance Data - Data collected by the insurance company.

Interaction Term - Two predictor variables are said to interact if the effect of one of the predictors on the target variable depends on the level of the other. A GLM modeler could account for this interaction by including an interaction term of the form $X_1X_2$ in the formula for the linear predictor. For instance, rather than defining the linear predictor as $\eta = \beta_0 + \beta_1X_1 + \beta_2X_2$, they could set $\eta = \beta_0 + \beta_1X_1 + \beta_2X_2 + \beta_3X_1X_2$.

The following two plots of modeled personal auto bodily injury pure premium by age and gender illustrate this effect. The plots are based on two otherwise identical log-link GLMs, built using the same fictional dataset, with the only difference between the two being that the second model includes the Age*Gender interaction term while the first does not. Notice that the male curve in the first plot is a constant multiple of the female curve, while in the second plot the ratios of the male to female values differ from age to age.

Lift Chart - See definition of quantile plot.
Linear Predictor - A linear predictor is the linear combination of explanatory variables ($X_1, X_2, ... X_k$) in the model, e.g., $\sum_{j=1}^{k} \beta_j X_j$.

Link Function - The link function, $\eta$ or $g(\eta)$, specifies the link between random and systematic components. It describes how the expected value of the response relates to the linear predictor of explanatory variables; e.g., $g(E(Y)) = E(Y)$ for linear regression, or $\eta = \log(n)$ for logistic regression.

Missing data - Missing data occurs when some records contain blanks or "Not Available" or "Null" where variable values should be.

Non-Insurance Data - Non-insurance data is data provided by another party other than the insurance company.

Offset Variable - Offset variables (or factors) are model variables with a known or pre-specified coefficient. Their relativities are included in the model and the final rating algorithm, but they are generated from other studies outside the multivariate analysis, and are fixed (not allowed to change) in the model when it is run. The model does not estimate any coefficients for the offset variables, and they are included in the model, so that the estimated coefficients for other variables in the model would be optimal in their presence. Examples of offset variables include limit and deductible relativities that are more appropriately derived via loss elimination analysis. The resulting relativities are then included in the multivariate model as offsets. Another example is using an offset factor to account for the exposure in the records; this does not get included in the final rating algorithm.

Overfitting - Overfitting is the production of an analysis that corresponds too closely or exactly to a particular set of data and may, therefore, fail to fit additional data or predict future observations reliably.

PCA Approach (Principal Component Analysis) - The PCA method creates multiple new variables from correlated groups of predictors. Those new variables exhibit little or no correlation between them—thereby making them potentially more useful in a GLM. A PCA in a filing can be described as "a GLM within a GLM." One of the more common applications of PCA is geodemographic analysis, where many attributes are used to modify territorial differentials on, for example, a census block level.

Personal Automobile Insurance - Personal automobile insurance is insurance for privately owned motor vehicles and trailers for use on public roads not owned or used for commercial purposes. This includes personal auto combinations of private passenger auto, motorcycle, financial responsibility bonds, recreational vehicles and/or other personal auto. Policies include any combination of coverage such as the following: auto liability, personal injury protection (PIP), medical payments (MP), uninsured/underinsured motorist (UM/UIM), specified causes of loss, comprehensive, and collision.

Post-model Adjustment - Post-model adjustment is any adjustment made to the output of the model including but not limited to adjusting rating factors or removal of variables.

Probability Distribution - A probability distribution is a statistical function that describes all the possible values and likelihoods that a random variable can take within a given range. The chosen probability distribution is supposed to best represent the likely outcomes.

Proxy Variable - A proxy variable is any characteristic of interest that is used instead of a variable of interest (when that variable of interest cannot be measured or used directly), to indirectly capture the effect of another characteristic represented by the variable of interest. Whether or not that characteristic is used in the insurer's rating plan is not relevant.
Quantile Plot - A quantile plot is a visual representation of a model’s ability to accurately differentiate between the best and the worst risks. Data is sorted by predicted values from smallest to largest, and the data is then bucketed into quantiles with the same volume of exposures. Within each bucket, calculate the average predicted value and the average actual value are calculated, and also for each quantile the actual and the predicted values are plotted. The first quantile contains the risks that the model predicts have the best experience and the last quantile contains the risks predicted to have the worst experience. The plot shows two things: how well the model predicts actual values by quantile, the predicted value should be increasing as the quantile increases, and the lift of the model, the difference between the first and last quantile, which is a reflection of the model’s ability to distinguish between the best and worst risks. By definition, the average predicted values would be monotonically increasing, but the average actual values may show reversals. [23] An example follows:

Rating Algorithm – A rating algorithm is the mathematical or computational component of the rating plan used to calculate an insured’s premiums.

Rating Category - A rating category is the same as a rating characteristic, and can be quantitative or qualitative.

Rating Characteristic - A rating characteristic is a specific risk criterion of the insured used to define the level of the rating variable that applies to the insured. Ex. Rating variable: Driver age, Rating characteristic: Age 42

Rating Factor – A rating factor is the numerical component included in the rate pages of the rating plan’s manual. Rating factors are used together with the rating algorithm to calculate the insured’s premiums.

Rating Plan – The rating plan describes in detail how to combine the various components in the rules and rate pages to calculate the overall premium charged for any risk that is not specifically pre-printed in a rate table. The rating plan is very specific and includes explicit instructions, such as:

- the order in which rating variables should be considered;
- how the effect of rating variables is applied in the calculation of premium (e.g., multiplicative, additive, or some unique mathematical formula);
- the existence of maximum and minimum premiums (or in some cases the maximum discount or surcharge that can be applied);
- specifics associated with any rounding that takes place.

If the insurance product contains multiple coverages, then separate rating plans by coverage may apply [24]

Rating System - The rating system is the insurance company’s IT infrastructure that produces the rates derived from the rating algorithm.

Commented [WL36]: The graph looks like a regression line. A graph showing pure premium or loss ratio by decile based on both the average predicted and the average actual values may be a more appropriate example for the purposes of this white paper.
Rating Tier - A rating tier is rating based on a combination of rating characteristics rather than a single rating characteristic resulting in a separation of groups of insureds into different rate levels within the same or separate companies. Often, rating tiers are used to differentiate quality of risk, e.g., substandard, standard, or preferred.

Rating Treatment - Rating treatment is the manner in which an aspect of the rating affects an insured’s premium.

Rating Variable - A rating variable is a risk criterion of the insured used to modify the base rate in a rating algorithm. [https://www.casact.org/library/studynotes/werner_modlin_ratemaking.pdf]

Raw Data - Raw data is data before scrubbing, transformation etc. takes place ... “as is” when received from a source.

Sample Record - A sample record is one line of data from a data source including all variables. For example:

```
1 04251
parkway.ment $25,900
sponsored single 1880
  210\00 FORCING BOTT WAT 1880
  1 Ranch 3
```

Scrubbed Data - Scrubbed data is data reviewed for errors, where “N/A” has been replaced with a value, and where most transformations have been performed. Data that has been “scrubbed” is now in a useable format to begin building the model.

Scrubbing Data - Scrubbing is the process of editing, amending, or removing data in a dataset that is incorrect, incomplete, improperly formatted, or duplicated.

SME - Subject Matter Expert.

Sub-Model - A sub-model is any model that provides input into another model.

Variable Transformation - A variable transformation is a change to a variable by taking a function of that variable, for example, when age’s value is replaced by the value \( (age)^2 \). The result is called a transformation variable.

Voluntarily Reported Data - Voluntarily reported data is data directly obtained by a company from a consumer. Examples would be data taken directly from an application for insurance or obtained verbally by a company representative.

Univariate Model - A univariate model is a model that only has one independent variable.

Adjusting Data - TBD

Control Factor - TBD

Data source - TBD

Double-lift chart - TBD

Exponential Family - TBD

Fair Credit Reporting Act - The Fair Credit Reporting Act (FCRA), 15 U.S.C. § 1681 (FCRA) is U.S. Federal Government legislation enacted to promote the accuracy, fairness and privacy of consumer information contained in the files of consumer reporting agencies. It was intended to protect consumers from the willful and/or negligent inclusion of inaccurate information in their credit reports. To that end, the FCRA regulates the collection, dissemination and use of consumer information, including...
As adopted by the Casualty Actuarial and Statistical (C) Task Force on XX/XX/XX

consumer credit information. Together with the Fair Debt Collection Practices Act (FDCPA), the FCRA forms the foundation of consumer rights law in the United States. It was originally passed in 1970 and is enforced by the US Federal Trade Commission, the Consumer Financial Protection Bureau and private litigants.

Generalized Linear Model—TBD

Geodemographic—Geodemographic segmentation (or analysis) is a multivariate statistical classification technique for discovering whether the individuals of a population fall into different groups by making quantitative comparisons of multiple characteristics with the assumption that the differences within any group should be less than the differences between groups. Geodemographic segmentation is based on two principles:

1. People who live in the same neighborhood are more likely to have similar characteristics than are two people chosen at random.
2. Neighborhoods can be categorized in terms of the characteristics of the population that they contain. Any two neighborhoods can be placed in the same category, i.e., they contain similar types of people, even though they are widely separated.

PCA Approach (Principal Component Analysis) —The method creates multiple new variables from correlated groups of predictors. Those new variables exhibit little or no correlation between them—thereby making them potentially more useful in a GLM. A PCA in a filing can be described as “a GLM within a GLM.” One of the more common applications of PCA is geodemographic analysis, where many attributes are used to modify territorial differentials on, for example, a census block level.

DRAFTING NOTE 10/15/19: WILL NEED TO CORRECT ALL FOOTNOTES. THE FOLLOWING IS ADDED FOR DRAFTING PURPOSES:

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Draft: 10/15/2019
As adopted by the Casualty Actuarial and Statistical (C) Task Force on XX/XX/XX

[19] newonlinecourses.science.psu.edu/stat504/node/216
[yy] https://en.wikipedia.org/wiki/Granularity#Data_granularity
[xx] https://www.statisticshowto.datasciencecentral.com/correlation-matrix

To see that this second definition accounts for the interaction, note that it is equivalent to 
\[ n \beta_1 + \beta_2 x_1 + \beta_3 x_2 \] 
and to 
\[ n \beta_1 + \beta_2 x_1 + \beta_3 x_2, \] 
with \( \beta_1 = \beta_2 + \beta_3 x_2 \) and \( \beta_2 = \beta_2 + \beta_3 x_1 \). Since \( \beta_1 \) is a function of \( x_1 \) and \( \beta_2 \) is a function of \( x_2 \), these two equivalences say that the effect of \( x_1 \) depends on the level of \( x_2 \) and vice versa.

REFERENCES:
### APPENDIX C – SAMPLE RATE-DISRUPTION TEMPLATE

**State Division of Insurance - EXAMPLE for Rate Disruption**

- First, fill in the boxes for minimum and maximum individual impacts, shaded in light blue. Default values in the cells are examples only.
- The appropriate percent-change ranges will then be generated based on the maximum/minimum changes.
- For every box shaded in light green, replace "ENTER VALUE" with the number of affected insureds within the corresponding change range.
- Once all values are filled in, use the "Charts" feature in Excel to generate a histogram to visually display the spread of impacts.

**NOTE:** Values of Minimum % Change, Maximum % Change, and Total Number of Insureds must reconcile to the Rate/Rule Schedule in SERFF.

<table>
<thead>
<tr>
<th>Percent-Change Range</th>
<th>Number of Insureds in Range</th>
<th>Uncapped</th>
<th>Capped (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-30% to &lt;-25%</td>
<td>2</td>
<td>-30.000%</td>
<td>-15.000%</td>
</tr>
<tr>
<td>-25% to &lt;-20%</td>
<td>90</td>
<td>30.000%</td>
<td>15.000%</td>
</tr>
<tr>
<td>-20% to &lt;-15%</td>
<td>130</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-15% to &lt;-10%</td>
<td>230</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-10% to &lt;-5%</td>
<td>340</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-5% to &lt;0%</td>
<td>245</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exactly 0%</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;0% to &lt;5%</td>
<td>150</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5% to &lt;10%</td>
<td>160</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10% to &lt;15%</td>
<td>401</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15% to &lt;20%</td>
<td>201</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20% to &lt;25%</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25% to &lt;30%</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30% to &lt;35%</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### EXAMPLE Uncapped Rate Disruption

![Example Uncapped Rate Disruption Chart](image-url)
**EXAMPLE Capped Rate Disruption**

![Graph showing the number of insureds in different percentage intervals from -15% to 20% with corresponding dollar increases.]

**State Division of Insurance - EXAMPLE for Largest Percentage Increase**

<table>
<thead>
<tr>
<th>Uncapped Change</th>
<th>Uncapped Dollar Change</th>
<th>Current Premium</th>
<th>Proposed Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.00%</td>
<td>$82.50</td>
<td>$550.00</td>
<td>$632.50</td>
</tr>
</tbody>
</table>

**Characteristics of Policy (Fill in Below)**

- **Vehicle:**
  - **BI Limits:** $50,000 / $100,000
  - **PD Limits:** $25,000
  - **UM/UIM Limits:** $50,000 / $100,000
  - **MED Limits:** $5,000
- **2009 Ford Focus:**
  - **COMP Deductible:** $25,000 / $50,000
  - **COLL Deductible:** $50,000

No prior accidents, 1 prior speeding conviction for 25-year-old male. Policy receives EFT discount and loyalty discount.

Primary impacts are the increases to the relativities for the age of insured, ZIP Code 89105, COMP Deductible of $1,000, and symbol for 2003 Honda Accord.

**Most Significant Impacts to This Policy**

<table>
<thead>
<tr>
<th>Attribute</th>
<th>% Impact (Uncapped)</th>
<th>Dollar Impact (Uncapped)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured Age (M/25)</td>
<td>12.00%</td>
<td>$66.00</td>
</tr>
<tr>
<td>COMP Deductible</td>
<td>10.00%</td>
<td>$61.00</td>
</tr>
<tr>
<td>Territory (89105)</td>
<td>4.00%</td>
<td>$27.10</td>
</tr>
<tr>
<td>Vehicle Symbol (2003 Honda Accord)</td>
<td>1.46%</td>
<td>$10.29</td>
</tr>
<tr>
<td>Effect of Capping</td>
<td>-11.54%</td>
<td>-$82.50</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15.00%</td>
<td>$82.50</td>
</tr>
</tbody>
</table>

**COMMENTS:**

- For Auto Insurance: At minimum, identify the age and gender of each named insured, limits by coverage, territory, make / model of vehicle(s), prior accident / violation history, and any other key attributes whose treatments are affected by this filing.
- For Home Insurance: At minimum, identify age and gender of each named insured, amount of insurance, territory, construction type, protection class, any prior loss history, and any other key attributes whose treatments are affected by this filing.

**Corresponding Dollar Increase (for Insured Receiving Largest Percentage Increase)**

<table>
<thead>
<tr>
<th>Attribute</th>
<th>% Impact (Uncapped)</th>
<th>Dollar Impact (Uncapped)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured Age (M/25)</td>
<td>12.00%</td>
<td>$66.00</td>
</tr>
<tr>
<td>COMP Deductible</td>
<td>10.00%</td>
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</tr>
<tr>
<td>Territory (89105)</td>
<td>4.00%</td>
<td>$27.10</td>
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<tr>
<td>Vehicle Symbol (2003 Honda Accord)</td>
<td>1.46%</td>
<td>$10.29</td>
</tr>
<tr>
<td>Effect of Capping</td>
<td>-11.54%</td>
<td>-$82.50</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15.00%</td>
<td>$82.50</td>
</tr>
</tbody>
</table>
### APPENDIX D – INFORMATION NEEDED BY REGULATOR MAPPED INTO BEST PRACTICES

TBD

### APPENDIX E – REFERENCES

November 22, 2019

Kris DeFrain, FCAS, MAAA, CPCU
Director of Research and Actuarial Services
National Association of Insurance
Commissioners (NAIC) Central Office

Re: CASTF Regulatory Review of Predictive Models White Paper

Ms. DeFrain,

Several members of the CAS Ratemaking Research Committee have discussed the most recently exposed revisions to the draft white paper on “Regulatory Review of Predictive Models”. This document should not be construed as representing an official response from the CAS membership as a whole. The views are representative of only those members whose names appear at the conclusion of this document.

Having reviewed and discussed the changes to the document, we make the following observations:

- Given the emphasis on GLMs in the guide, should the title be reworded to indicate that the paper refers specifically to such models?
- On page 3, with respect to the issue of credibility in GLMs, we note the following
  o We disagree with the statement credibility weighting GLM outputs is not standard practice.
  o If the sample data are highly variable, then so too are the coefficient estimates. An experienced modeler will recognize this fact and so opine.
  o Estimates of standard error for coefficients and residuals permit one to develop confidence intervals around estimated quantities. Non-parametric sample estimates of the first moment of a distribution – however credible – do not support this.
  o Segmented data may be analyzed using GLMMs – generalized linear mixed models – which have substantially similar assumptions of classic Buhlman-Straub credibility estimators.
- Page 4:
  o Spurious relationships between predictors and targets may occur in smaller samples as well as in “big data” samples.
  o When controlling for non-permitted variables, validation of a rating plan isn’t straightforward. Model performance may suffer from the exclusion of variables which are available to the insurer.
- Page 5:
  o The focus on personal auto and property appears to be largely driven by the ratemaking behavior of market participants. The adoption of GLMs for commercial auto writers is noted. However, there is no comment on why the best practices advocated in the document would be inappropriate for commercial auto coverage. One might conjecture that the higher limits on offer in commercial lines would necessitate robust statistical techniques like extreme value theory. Absent clarifying language from the NAIC, this remains a supposition.
On page 7, we feel that the first paragraph oversteps the bounds of a rate filing review. We suggest that the paragraph be worded as follows:

- Documentation of the design and operational details of the model is required to ensure business continuity and transparency of models used. Granularity of documentation takes into account the level of management or key function at which it is intended to be used. Documentation should be sufficiently detailed and complete to enable a qualified third party to form a sound judgment on the suitability of the model for the intended purpose. The theory, assumptions, methodologies, software and empirical bases should be explained, as well as the data used in developing and implementing the model. Relevant testing and ongoing performance testing needs to be documented. Key model limitations and overrides need to be pointed out so that stakeholders understand the circumstances under which the model does not work effectively. End-user documentation should be provided and key reports using the model results described. Major changes to the model need to be shared in a timely manner and documented, and IT controls should be in place, such as a record of versions, change control and access to model.

Page 8:
- Point A.1.b – We have struggled to understand this point. The notion that aggregated data has not been “scrubbed” suggests that no quality audit has been performed at all. This remark would benefit from further wording which would clarify what is meant here.

Page 11:
- Point A.3.d – The modeler should make a statement as to whether there is any systemic reason for missing data.

Page 13:
- Point B.1.a – The practice guidelines are highly specific to GLMs. Although reference is made to other model types, the steps involved in compliance for other models is vague. In a sense, this penalizes GLMs, which have existed for far longer and whose development and implementation enjoys more widespread understanding. The lesser detail for non-GLM models could persuade some market participants that the compliance burden may be reduced by gravitating towards techniques which have been less tested. We not sure that’s a desirable outcome.
- Point B.1.b – Pedantic note, but the R version, as well as the version of all packages used in calculation is incredibly simple to obtain. Simply call `sessionInfo()` at an appropriate stage of the calculation (likely at the end). If I were a regulator who was told that a filer didn’t know what version of R they were using, I’d be highly suspect.
- Point B.1.c – Although the term “training” is used with little ambiguity, “test” and “validation” are terms that are sometimes interchanged, or the word “validation” may not be used at all. The practice guidelines should be clear on this point.

Page 15:
- Point B.2.e – Most software has default convergence criteria. In practice, the modeler would only need to adjust this if the model fails to converge. I would recommend changing this statement to one which requires the modeler to make a statement if they deviated from defaults.
- Point B.3.a – As worded, this seems to imply that interaction terms warrant more explanation than any other rating variable. In practice, interaction terms are used for the same reason as any other explanatory variable: they improve the model’s predictive power. The classic example is the interaction between age and smoking when predicting mortality. That variable’s use in life insurance rating has been well established and non-controversial.
- Point B.3.b – We think it is reasonable to require diagnostics for various candidate models.

Page 15, B.3.b—We have commented on this before. To reiterate, while this is listed as a Level 4 item, assembly of a list of all predictor variables is onerous. Further, can lead to companies having to disclose
intellectual property for types of variables they have experimented with. This will hamper speed to market and hinder innovation.

- Page 16
  - Point B.3.c – The wording in the comment would benefit from more context. When constructing a GLM, the modeler may measure correlation as an aid to decide the set of candidate predictors, or to interpret significance of coefficient estimates. The utility of a statement about Pearson v. Cramer, or a statement about how the matrix was produced is not immediately clear.
  - Point B.3.e – Use of PCA will obviate much of the preceding guidance about a rational relationship between a predictor and a target response.

We make the following comments with respect to terms used in the document:

- The current definition for “insurance data” is “data collected by the insurance company”. We feel that the definition would benefit by citing some examples of data sources which are not insurance data. We presume this would include items such as census or credit data.
- We recommend avoiding use of the term “predictive power” without reference to how this is measured. There are numerous statistical diagnostics – root-mean squared error, mean absolute error, to name two – which have crisp, clear definitions.
- Within the data science literature, although the term “training” is used with little ambiguity, “test” and “validation” are terms that are sometimes interchanged. The word “validation” may not be used at all. The practice guidelines should be clear on the definition of these terms.

Once again, we thank you for your consideration of these points and welcome the opportunity to discuss with you or any members of the CASTF.

Regards,

Sandra Callanan
Greg Frankowiak
Brian Fannin
Joshua Newkirk
David Terné
Honorable Steve Kelley  
Commissioner, Minnesota Department of Commerce  
Chairman, NAIC Casualty Actuarial and Statistical Task Force  
Minnesota Department of Commerce  
85 7th Place East, Suite 280  
Saint Paul, MN 55101

Honorable James J. Donelon  
Commissioner, Louisiana Department of Insurance  
Vice-Chairman, NAIC Casualty Actuarial and Statistical Task Force  
1702 N. Third Street; P.O. Box 94214;  
Baton Rouge, LA 70802

Submitted Electronically to kdefrain@naic.org


Dear Chairman Kelley and Vice Chair Donelon:

I write on behalf of the Consumer Data Industry Association (CDIA) to comment on the exposure draft concerning best practices when reviewing predictive models and analytics. This draft was released by your Casualty Actuarial and Statistical Task Force ("Task Force") on October 15, 2019. Thank you for allowing CDIA another chance to offer comments on behalf of our consumer reporting agency ("CRA") members. We offer comments on section VI in the body of the whitepaper and sections A, B and C in the modeling guide.

The Consumer Data Industry Association is the voice of the consumer reporting industry, representing consumer reporting agencies including the nationwide credit bureaus, regional and specialized credit bureaus, background check and residential screening companies, and others. Founded in 1906, CDIA promotes the responsible use of consumer data to help consumers achieve their financial goals, and to help businesses, governments and volunteer organizations avoid fraud and manage risk. Through data and analytics, CDIA members empower economic opportunity all over the world, helping ensure fair and safe transactions for consumers, facilitating competition and expanding consumers’ access to financial and other products suited to their unique needs.

Section VI, 1. c (p. 5) addresses a “Review [of] the individual input characteristics to and output factors from the predictive model (and its sub-models), as well as, associated selected relativities to ensure they are not unfairly discriminatory”. We appreciate your feedback on our initial comments expressing concerns related to including "sub-models" like Credit-Based Insurance Scores ("CBIS") into the regulatory
review process. However, we do respectfully believe this will increase the burden of regulatory compliance for CRAs, slowdown the speed to market and impede the relationship between insurers and consumers. These new burdens can inject unnecessary friction into consumers who seek quick decisions and competitive prices from their insurers.

We respectfully believe these are "new, proposed obligations". The review of CBIS models has been established and ongoing in many States for close to two decades like you highlight, but those occur in other forms of insurance and not under the forms the Casualty Actuarial and Statistical (C) Task Force is seeking to add to its handbook and make an industry wide practice. The current reviews may include the same CBIS models, but if they are not currently being reviewed then we would argue these are in fact new obligations on CRAs.

Many States have provided certain confidentiality protections from the general public for CBIS models in accordance with their State law, but many is not all states. CDIA members spend significant amounts of time and resources developing their models and complying with current regulations. only takes one employee in one state to make one mistake and decades of hard work, investment and research is available for anyone to view, replicate, deceive or use to commit fraud. We are encouraged by the inclusion of new confidentiality language in Section VII of the Whitepaper, pertaining state confidential, proprietary, or trade secret state laws and relevant contractual provisions, and request inclusion of the language as a proposed change to the Product Filing Review Handbook. Even with the new language, the lack of a national exemption from public records remains a concern because information that has never previously been requested could be subject to the myriad of public disclosure laws around the country. There is no surety to how all states will respond to public records requests.

New language in Section V of the Whitepaper suggests that reliance on state confidentiality authority, regulations, and rules may not govern if the NAIC or another third party becomes involved in the review process on behalf of the states. NAIC or third party participation in the review process causes significant trade secret and proprietary information protection concerns. It is not clear from the new language what protections, law, or authority would apply in such a case. We request clarifying language be added that, as a floor, the confidential, proprietary, and trade secret protections of the state on behalf of which a review is being performed apply.

We understand no information should be confidential from the regulators themselves. However, if the CBIS models are reviewed and accepted elsewhere, it would seem that a repetitive and costly process is occurring for not much if any added value to the final product for the consumers. The credit reporting system is a consistent nationwide process. Exposing individual characteristics of scoring models to public record requests allows competitors access to information that they can use to gain an unfair advantage over another company. It also reduces the incentive to continue to
create new solutions, reducing a competitive environment, which ultimately hurts consumers. Regulators should be able to know whether scoring models are in compliance with the law, but this information should not be accessible as a public record.

The potential for confidentiality concerns is not only with the CRAs, but the companies they work with (date furnishers and lenders) in the credit reporting system and their consumers. We are not convinced that including CBIS in this type of review is mission critical. Yet, if this review needs to be in the process, CDIA recommends the establishment of highly specific rules to protect confidentiality and proprietary information. Additionally, a separate review process of sub-models as an optional request with defined valid concerns would help in addressing concerns.

Credit-based insurance scores do not unfairly discriminatory towards any race, religion, gender, ethnicity, or other established suspect classes and there are studies that show the lack of illegal discrimination. A myth of illegal discrimination pervades many media accounts and public policy debates, but in truth, credit-based insurance scores do not promote redlining or other illegal insurance practices.

Section VI 3.a. (p. 6) addresses how to “[e]valuate how the model interacts with and improves the rating plan” and how to “[o]btain a clear understanding of the characteristics that are input to a predictive model (and its sub-models), their relationship to each other and their relationship to non-modeled characteristics/variables used to calculate a risk’s premium.” We recognize the goal of the regulator in seeking to understand how the individual components of the rating plan interrelate to produce a consumer’s premium, but we feel your comment adds further confusion to our members. The white paper only mentions “characteristics”, but your comment refers to “information that the ‘CRAs use to create CBIS’ is essential to understanding the structure of the CBIS models, the variables used, and their justification.”. CRAs could provide general characteristics of the model without having confidentiality concerns, but the “information they use to create CBIS” appears to be far more specific.

If these provisions are meant to include information relating to the scoring models that CRAs use to create CBIS, there would be a significant new regulatory burden on CRAs and this would impede the relationship between insurers and consumers. These new burdensome requirements can inject unnecessary friction on to consumers who seek quick decisions and competitive prices from their insurers. Along with heightening the risk of disclosing proprietary information that is currently kept confidential because of its importance.

In “Selecting Model Input” under subsections A.1.a “Available Data Sources”, the original wording caused concern that FCRA requirements would be extended to all external data sources. The edit to this section is appreciated, but we believe application
to contractual disclosure restriction concerns remain. For CBIS models, we feel that review should be restricted to credit variables used in the model, not all credit variables.

Regarding A.2.b of the third exposure draft, former subsection A.2.f., “Determine if the sub-model was previously approved (or accepted) by the regulatory agency,” the review level change is appreciated as it will eliminate unnecessary and duplicative reviews of third-party and vendor models that have been previously approved. To be consistent with the A.2.b review level change, a change from a review level 1 to a 3 or 4 is requested for current A.2.f., former A.2.e, “If using output of any scoring algorithms, obtain a list of the variables used to determine the score and provide the source of the data used to calculate the score”.

Section A.4.c addresses “Identif[ing] material findings the company had during their data review and obtain an explanation of any potential material limitations, defects, bias or unresolved concerns found or believed to exist in the data. If issues or limitations in the data influenced modeling analysis and/or results, obtain a description of those concerns and an explanation how modeling analysis was adjusted and/or results were impacted”. This provision should be re-categorized from its current score of 1 to a 3 or 4 score. Existing regulations around actuarial rate making standards and state regulations should prevent these items from entering a “final/proposed” model. This should be categorized as three of four (i.e. if model review uncovers issues).

We have several comments regarding Section B, “building the model”:

- Sec. B.2.c, “Obtain a description of univariate balancing and the testing that was performed during the model-building process, including an explanation of the thought processes involved and a discussion of why interaction terms were included (or not included).” Only included interactions should be discussed. Interactions not be included, but default are not in a model, and therefore should not need to be justified.
- Secs. B.3.a and B.3.c, Both subsections pose trade secret protection and confidentiality issues.
- Sec. B.3.b, “Obtain[ing] a list of predictor variables considered but not used in the final model, and the rationale for their removal”. The best practices and guidelines should be limited to only the variables that were in the final and proposed models.
- Sec. B.3.d, “Obtain[ing] an rational explanation for why an increase in each predictor variable should increase or decrease frequency, severity, loss costs, expenses, or any element or characteristic being predicted.” CDIA agrees with the current and actuarially accepted practice of rate making guidelines not requiring intuitive or rational explanations of predictive values. We support use of variables that are statistically and actuarially predictive of insurance losses.
Additionally, this subsection poses a risk exposing trade secret and confidential information.

- Secs. B.4.b, through B.4.b CDIA recommends recategorizing these scores from their current scores of two to a three or four score, along with only making this a requirement if deemed necessary.
- Sec. B.4.c “Identifying the threshold for statistical significance and explain why it was selected. Obtain a reasonable and appropriately supported explanation for keeping the variable for each discrete variable level where the p-values were not less than the chosen threshold”. This is a fairly subjective standard. We recommend that it includes more objective and actuarially sound information and decisions. We recommend adding “threshold for statistical significance” into the list of required elements and changing this score from its current one to a three or four.

We have several comments regarding “Section C, “The Filed Rating Plan”:

- Sec. C.1.c, like many other areas, this provision creates potential trade secret and confidentiality issues.
- Sec. C.2.a, “Obtain a narrative regarding how the characteristics/rating variables, included in the filed rating plan, logically and intuitively relate to the risk of insurance loss (or expense) for the type of insurance product being priced.” CDIA appreciates the edits made to the Information Element. “Logical and intuitive” was removed from the “Information Element” box, but not the “Comment” box. We recommend removal of “logical and intuitive” from the “Comment” box for consistency.
- Sec. C.7.h, this new section will impact CBIS and it appears to extend FCRA requirements on all external data. To ease FCRA requirement extension, we request changing the language in the Comment box from “…data should be documented and an overview of who…” and “…consumer verification should be addressed,….” to “…data may need to be documented and an overview…” and “consumer verification may need to be addressed…”.

The “Supporting Data” section, specifically Secs. C.6.a and C.6.b, on “Obtain[ing] an explanation of any material (especially directional) differences between model indications and state-specific univariate indications” pose some concerns for CRAs and could interfere with the insurance process for consumers.

Section VIII of the Whitepaper proposes several changes to the Handbook. Section X, “Other Considerations” of the Handbook suggest advisory organization regulation of model and algorithm vendors. As explained further in this comment, CIBS modelers are already heavily regulated.

Credit Based Insurance Scores are constructed using nationwide data sets. Scoring or grading their performance out at a state level may not be supported or
accurate with this approach. It is also a common occurrence for certain contracts to prevent model providers from sharing distinct or customer specific data with third parties. There are several factors besides credit information and CBIS that go into the rate setting process. Credit Information and CBIS may be the only ones that are consistent and transferrable across the country, while some of the other factors used can and do differ greatly on a state by state basis.

The insurance industry has been using CBIS models for decades and they have been approved by nearly every state’s insurance department for auto and home insurers. Adding the work CASTF proposes will be burdensome and repetitive. The lack of trade secret and proprietary information protection will always remain a source of concern. In the long run we see this as something only large insurers will be able to absorb and the small to medium sized insurers that rely on third parties help will get squeezed out. We strongly feel that this will give large insurers a competitive edge in the marketplace. This will come at great cost to the consumers when their options decrease because of the eventual lack of competition.

There is already a large regulatory review presence on the industry. It is already over seen at the federal level by the Consumer Financial Protection Bureau (CFPB) and Federal Trade Commission (FTC), along with several states implementing their own regulations and the Conference of State Banking Commissioners looking into the industry as well. This increased regulation not only hurts the industry, but the consumers it serves. It will significantly hamper speed to market for the products consumers need and does not appear to add much, if any, benefit to the outcome for the industry and its consumer.

In conclusion, we believe that these potential new best practices will create burdensome regulatory difficulties for our members, speed to market issues for insurance companies, their product and the consumers that need them. CDIA members provide quality products that are already regulated and accepted by the insurance industry. CDIA and its members respectfully request consideration and inclusion of its comments in the task force’s whitepaper. Thank you for the opportunity to comment and please feel free to contact us with any questions you may have.

Sincerely,

Eric J. Ellman
Senior Vice President, Public Policy & Legal Affairs

cc: Members of the Casualty Actuarial and Statistical Task Force (CASTF) of the Property and Casualty Insurance (C) Committee
   Kris DeFrain, NAIC Staff
   Jennifer Gardner, NAIC Staff
Comments for the Center for Economic Justice

To the Casualty Actuarial Task Force

Regulatory Review of Predictive Models White Paper

November 22, 2019

The Center for Economic Justice offers the following comments on the October 2019 draft of the Regulatory Review of Predictive Models White Paper.

Section VI, number 1 states: “Ensure that the selected rating factors, based on the model or other analysis, produce rates that are not excessive, inadequate, or unfairly discriminatory.” CEJ suggests the following addition to part c.:

c. Review the individual input characteristics to and output factors from the predictive model (and its sub-models), as well as, associated selected relativities to ensure they are not unfairly discriminatory in terms of both a cost-based relationship of the risk classification and an absence of intentionally or unintentional discrimination against protected classes.

The suggested addition identifies the two prongs of unfair discrimination – the absence of cost differentials necessary to justify different treatment of consumers and the direct or indirect (proxy) use of prohibited classes for different treatment of consumers.

Section VI, number 2 states: “Obtain a clear understanding of the data used to build and validate the model, and thoroughly review all other aspects of the model, including assumptions, adjustments, variables, submodels used as input, and resulting output.” CEJ suggests the addition of another item under number 2:

x. Determine if data used for model development and testing are biased against protected classes of consumers, if insurers have tested the data for such bias and if any action has been taken to eliminate or reduce bias in data.

While this type of information and testing is implied in other parts of the white paper, CEJ suggests explicit identification of this type of data and model testing.
Regarding Section VII, A.1.a:

Request details of any non-insurance data used (customer-provided or other), whether the data was collected by use of a questionnaire/checklist, whether data was voluntarily reported by the applicant, and whether any of the data is subject to the Fair Credit Reporting Act. If the data is from an outside source, find out what steps were taken to verify the data was accurate, complete and unbiased in terms of relevant and representative time frame, representative of potential exposures and uncorrelated with protected classes.

While there are important consumer protection issues associated with insurers’ use of non-FCRA compliant data, it is unclear what a filing reviewer should or might do with information sought in the first (italicized) sentence. CEJ suggests that, whatever the source of the data or the means of obtaining the data from or about consumers, the same regulatory issues and questions apply – those set out in CEJ’s proposed revisions to the second sentence of the section.

CEJ suggests a new section: Testing for and Minimizing Disparate Impact Unfair Discrimination:

While regulators must review models for the direct use of prohibited risk classifications (intentional discrimination or disparate treatment), such violations are relatively easy to identify. Insurers’ use of many new databases of non-insurance personal consumer information as well as more intensive and granular databases of insurance personal consumer information (including consumer-generated data through telematics) increases the risk of proxy discrimination against protected classes. A “protected class” of consumers is one associated with prohibited risk classifications, such as race, religion or national origin.

GLMs – like any predictive model -- are developed using historical data. If the historical data incorporates or reflects biased or atypical outcomes, the algorithm will reflect and perpetuate those biases. The scholars Barocas and Selbst note in Big Data’s Disparate Impact¹

Advocates of algorithmic techniques like data mining argue that they eliminate human biases from the decision-making process. But an algorithm is only as good as the data it works with. Data mining can inherit the prejudices of prior decision-makers or reflect the widespread biases that persist in society at large. Often, the “patterns” it discovers are simply preexisting societal patterns of inequality and exclusion. Unthinking reliance on data mining can deny members of vulnerable groups full participation in society.

Disparate impact unfair discrimination refers to practices which have the effect of discrimination against protected classes and is sometimes referred to disparate effect. Regulatory review of complex predictive models should include a requirement that insurers demonstrate:

1. Testing of bias against protected classes in data used to develop and test the predictive model;
2. Testing of disparate impact against protected classes in the development of the model;
3. Employing statistical tools to minimize disparate impact in the development of the model; and
4. Testing of model output for disparate impact.

One common approach to identifying and minimizing disparate impact unfair discrimination is to utilize a control variable for the prohibited class in the development of the model. A control variable is an independent variable used to control or neutralize effects that might otherwise distort model specifications and output. For example, an insurer developing a national personal auto or homeowners insurance pricing model might use a control variable for state to control for / remove effects of differences among the states in minimum limits requirements, tort frameworks or other state-specific issues that might impact the statistical contribution of other, national, factors to explaining the dependent variable. While a control variable is used in the development of the model, the control variable is not included in the model deployed for use.

Similarly, by using the prohibited class characteristics as independent (control) variables in the development of the model, the remaining independent variables’ contribution (to explaining the dependent variable) is shorn of that part of their contribution that is a function of correlation with the prohibited characteristics. For the independent variables other than race, religion and national origin, what remains is a more accurate picture of the remaining independent variables’ contribution to the target outcome. Consequently, using prohibited class characteristics as control variables simultaneously tests for and minimizes disparate impact.

Testing for disparate impact is consistent with the statistical and actuarial nature of unfair discrimination based on cost-based analysis. One form of insurance unfair discrimination is different treatment of consumers without any demonstrated differences in the cost of the transfer of risk of those consumers. Stated differently, a rate is unfairly discriminatory if consumers of the same risk and hazard are treated differently. The traditional test for unfair discrimination is whether an insurer can demonstrate a difference in expected claims or expenses on the basis of the risk classification.

Testing for and measuring disparate impact is completely consistent with the cost-based tests for unfair discrimination. Actuarial justification is a statistical test – that a particular characteristic of the consumer, vehicle, property or environment is correlated with a particular outcome, like pure premium (average claim cost). The same statistical test can be used to evaluate and minimize disparate impact. Stated differently – if a particular correlation and statistical significance is used to justify, say, insurance credit scoring, those same standards of correlation and statistical significance are reasonable evidence of disparate impact and unfair discrimination on the basis of prohibited factors.
Testing for and minimizing disparate impact improves cost-based insurance pricing models. To the extent that historical data reflects bias and unfair discrimination against protected classes, testing for and minimizing disparate impact can stop the cycle of algorithms reflecting and perpetuating that historic discrimination.
I would suggest the following to “fix” the issue raised (note that the first bullet is moved up a level):

Other Considerations

- Regulators are often responding to consumer inquiries regarding how a policy premium is calculated and why the premium, or change in premium, is so high. The ability of the regulator to respond to these inquiries is included in best practice 1.b, “Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers.”
  - The white paper identified the following information elements that may assist in addressing this best practice and a response to a consumer:
    - C.2.a Provide an explanation how the characteristics/rating variables, included in the filed rating plan, logically and intuitively relate to the risk of insurance loss (or expense) for the type of insurance product being priced. Include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense).
    - C.7.f Explain how the insurer will help educate consumers to mitigate their risk.
    - C.7.h Identify sources to be used at "point of sale" to place individual risks within the matrix of rating system classifications. How can a consumer verify their own "point-of-sale" data and correct any errors?
    - C.7.j Provide the regulator with a description of how the company will respond to consumers’ inquiries about how their premium was calculated.

The white paper has the following note about “best practices” but then lists one best practice and 4 information items. How should I modify the introductory sentence?

Other Considerations

- Regulators are often responding to consumer inquiries regarding how a policy premium is calculated and why the premium, or change in premium, is so high.
  - The white paper identified the following best practices:
    - 1.b. Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers. …and information elements that may assist the regulator's and consumer's understanding of the premium being charged.
    - C.2.a Provide an explanation how the characteristics/rating variables, included in the filed rating plan, logically and intuitively relate to the risk of insurance loss (or expense) for the type of insurance product being priced. Include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense).
    - C.7.f Explain how the insurer will help educate consumers to mitigate their risk.
    - C.7.h Identify sources to be used at "point of sale" to place individual risks within the matrix of rating system classifications. How can a consumer verify their own "point-of-sale" data and correct any errors?
    - C.7.j Provide the regulator with a description of how the company will respond to consumers’ inquiries about how their premium was calculated.
November 22, 2019

NAIC Casualty Actuarial and Statistical Task Force
Attn: Kris DeFrain, FCAS, MAAA, CPCU

Via Email – kdefrain@naic.org

Re: Comments on the October 15, 2019 Exposed CAS Task Force Draft White Paper –
Best Practices – Regulatory Review of Predictive Models

Dear Ms. DeFrain:

Fair Isaac Corporation (FICO) is pleased to provide its comments on the most recently released draft white paper, Best Practices – Regulatory Review of Predictive Models.

FICO is an independent analytics provider (not a data company) that is dependent on other firms (e.g., consumer reporting agencies, insurance companies, lending institutions) to provide the appropriate and necessary data for FICO analysis and for its development of predictive models. With a focus on innovation that effectively rewards all parties – insurers, lenders, and consumers alike – FICO is recognized as the pioneer in developing the algorithms and underlying analytics used to produce credit scores, credit-based insurance scores, and other risk management scores. FICO fully understands and respects the value of regulatory scrutiny and the need for regulatory flexibility to help ensure that consumers continue to benefit from these scores by enjoying quick, fair access to credit and greater access to more affordable insurance. In previous years, access to affordable insurance involved a lengthy decision process based, in some cases, on subjective and inconsistent underwriting and pricing factors.

In 1993, FICO introduced the first commercially available credit-based insurance scores to US insurers as an additional risk segmentation factor that could be used in their private passenger auto and home insurance underwriting and pricing programs. On behalf of several hundred FICO® Insurance Score clients, over these past 25 years, FICO has met with state departments of insurance and has testified before dozens of state legislative committees. Our goal in each of these interactions was to provide support for our clients’ continued use of FICO Insurance Scores by answering all appropriate regulatory questions to the best of our ability and by offering as much insight into FICO’s proprietary modeling analytics and technologies as possible, while still protecting our intellectual property.

For nearly two decades, in support of successful rate filings throughout the nation by our FICO® Insurance Score clients, FICO has provided model documentation—specific consumer credit characteristics, attributes and weights for the filed model—as well as reason code/factor definitions, and a general discussion of our model development process to all requesting departments of insurance...
able to provide the necessary protections. In addition, FICO has modified its insurance score models as required by those states with specific statutory or regulatory mandates. FICO also offers an insurance score educational website (insurancescores.fico.com) that has been accessed by consumers, regulators, legislators, insurers, agents and other interested parties throughout the nation for a more thorough understanding of FICO’s credit-based insurance scores, the insurance industry’s use of our insurance scores, and general credit management tips.

It remains our hope that home and auto insurers using credit-based insurance scores as one factor in their underwriting and pricing programs will continue to receive filing approvals, just as they have in virtually every state in the nation for the past two decades. The use of credit-based insurance scores should be allowed to continue unabated – grandfathered, as it were - under current regulatory review processes such that such long-standing use of credit by virtually every insurer would not be negatively impacted by the undue burdens proposed by the October 15, 2019 CAS TF draft white paper. State regulatory authorities want to ensure a fair playing field that allows all insurers, not just a few at the top, the opportunity to compete effectively and appropriately for their constituents’ business. The industry’s use of credit-based insurance scores that have been approved for over two decades should not be overshadowed by a newly proposed predictive model review approach that may force market participants such as FICO to withdraw their scores from use and may lead to premium increases for the majority of consumers.

Quite concerning is the fact that in recent months and weeks both Maine and Washington have apparently chosen to “jump the gun” on the traditional NAIC decision-making process. The following blog highlights the problem this is creating for effective industry competition and consumer pricing benefits - https://www.insurancejournal.com/blogs/right-street/2019/10/27/546717.htm.

As was stated in the conclusion of the FTC’s 2007 report – “Credit-Based Insurance Scores: Impacts on Consumers of Automobile Insurance” –

“…..credit-based insurance scores are effective predictors of risk under automobile insurance policies. Using scores is likely to make the price of insurance conform more closely to the risk of loss that consumers pose.....”

Industry studies have shown that the same conclusion could be drawn with respect to homeowner insurance, as well.

Having shared a bit of FICO’s background and our FICO® Insurance Score client support strategies that we certainly hope to continue, the remainder of our comments will focus on our Scores business model and the negative implications the recommendations within the draft white paper will have on FICO’s Scores business. More importantly, if the proposed predictive model review positions remain in place with respect to time-tested, regularly reviewed and approved credit-based insurance scores, there will be significant negative impact seen by virtually all auto and home insurance companies and the vast
majority of consumers – your constituents – across the nation as this key risk segmentation tool is restricted from use in rate filings.

The intellectual property underlying much of our predictive modeling and analytics technology has been developed by FICO data scientists over the past six decades. This development work has taken an enormous amount of time, money, research, know-how, and testing. Given that, however, FICO has been very transparent – sharing our models with state insurance regulators for the past two decades where appropriate protections were in place to avoid exposure of critical intellectual property.

Our goal is to continue to offer an insurance risk management tool to the benefit of the industry and to consumers alike, while still protecting the interest of our shareholders. FICO’s scoring-related trade secrets have substantial independent economic value to the company precisely because they are not generally known by others, including any potential competitors, that could unfairly obtain economic value from their disclosure or use. Forcing disclosure of these intellectual property assets would put them at risk and dissipate their value.

Given the necessary protection of FICO’s intellectual property, including its trade secrets, our belief is that the depth and breadth of the regulatory review of predictive models proposed by the draft white paper presents serious market-restriction issues for FICO, and for the hundreds of FICO® Insurance Score clients doing business in all states that allow for the industry’s significant use of credit-based insurance scores within their well-considered and comprehensive rating programs.

As mentioned previously, we believe the state regulatory practices under which FICO has supported its clients for the past two decades are appropriate and quite sufficiently protect all interests – consumers, regulators, and insurers. These scores have proven time and again over 25+ years to be highly accurate and effective in enabling insurers to more objectively and accurately price risk, while lowering premiums for the majority of consumers. As such, we believe previously approved FICO® Insurance Scores should be excluded from the draft white paper to the benefit of the industry as a whole and to the benefit of your constituents specifically.

The draft white paper’s only references to protection for the intellectual property of an independent analytics provider like FICO are too vague to offer any real protection. The proposal, as highlighted here, leaves the decision about confidentiality of a company’s intellectual property and trade secrets entirely within the discretion of each state regulator.

1. The fourth Key Regulatory Principle: State insurance regulators will maintain confidentiality, where appropriate, regarding predictive models.
2. Section V. CONFIDENTIALITY warns rate filers:

Insurers and regulators should be aware that a rate filing might become part of the public record. Each state determines the confidentiality of a rate filing, supplemental material to the filing, when filing information might become public, the procedure to request that filing information be held confidentially, and the procedure by which a public records request is made. It is incumbent on an insurer to be familiar with each
state’s laws regarding the confidentiality of information submitted with their rate filing.

FICO strongly supports the following comments from the National Association of Mutual Insurance Companies (NAMIC) stated in its June 28, 2019 letter to the NAIC Casualty Actuarial and Statistical (C) Task Force – “NAMIC wishes to continue to reiterate that exposing confidential and proprietary trade secrets, confidential information, and other business practices simply for accumulation of data in a rate filing, when otherwise unnecessary, is problematic for all involved. The data provided for these requirements subjects the regulator to increased Freedom of Information Act requests, subpoenas, and other types of litigation when there has been no demonstrated harm to consumers or trigger for the inquiry.”

Since FICO cannot be left in a precarious position with respect to the protection of its intellectual property, if the drafted white paper is adopted, as written, by any state without necessary trade secrets and other intellectual property protections in place, FICO may be forced to remove its FICO Insurance Score models from use by our insurance clients in that state, just as is now occurring in some “early adopter” states, creating wholly unnecessary market disruption.

As always, we look to the NAIC to do the right thing for consumers and insurers throughout the nation. We also look forward to working with the NAIC Casualty Actuarial and Statistical Task Force toward a regulatory review approach that protects the interests of all stakeholders, including the vast numbers of US consumers who benefit from the insurance industry’s continued use of credit-based insurance scores to enhance their underwriting and pricing policies based on proven risk characteristics.

Sincerely,

Lamont D. Boyd, CPCU, AIM
Insurance Industry Director, Scores

FICO Decisions
LamontBoyd@FICO.com
602-317-6143 (mobile)
Dear Ms. DeFrain,

Insurance Services Office, Inc. (ISO) is a countrywide licensed rating/advisory organization serving the property/casualty market. We have extensive experience and expertise in the development of advisory insurance pricing tools including prospective loss costs, rating plans and predictive analytics, including related regulatory issues.

ISO appreciates the opportunity to provide comments on the Draft White Paper on Best Practices for Regulatory Review of Predictive Models as published by the CASTF in October 2019. The CASTF has addressed the bulk of ISO’s previous comments but we have a few comments.

- B.1.c addresses how validation (hold out) data is used. The GLM paper (Generalized Linear Models for Insurance Rating) that is on the Exam 8 syllabus addresses the use of hold out data. On page 39 it says “Once a final model is chosen, however, we would then go back and rebuild it using all of the data, so that the parameter estimates would be at their most credible.”

- B.3.b asks for a list of predictor variables considered but not used in the final model and the rationale for their removal. While we appreciate that this is a level 4 item we don’t see how the variables not used in a model are relevant to reviewing the filed model. This would be analogous to asking for policy wording considered but not used in a filed policy form.

- Item C.7.h does not have a level ranking.

Respectfully Submitted,

Stephen C. Clarke, CPCU
NAIC Casualty Actuarial and Statistical (C) Task Force
c/o Kris DeFrain - kdefrain@naic.org
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: NAMIC Comments on CASTF’s Predictive Model White Paper – October 14, 2019 Exposure

Dear Task Force Chair, Vice Chair, Task Force Members, and Other Interested Regulators,

Please accept the following remarks of the National Association of Mutual Insurance Companies (hereinafter “NAMIC”)1 on behalf of its member companies regarding the task force request for comments regarding the October 14, 2019 exposure of the latest draft of the Predictive Modeling White Paper. NAMIC wishes to thank the task force for the ability to provide additional comments on the white paper and the continuing transparency of the process as a whole.

While the task force has exhaustively attempted to review and examine all comments and submitted input concerning this endeavor, NAMIC still believes there are concerns that might override any completion of this project in the near term. NAMIC respectfully suggests there remain substantial principles that must be clearly defined and/or established before moving to any type of final product as previously mentioned in our comment letters. Further, to avoid repetitive comments from continually being reiterated we would refer the task force to NAMIC’s comment letters of January 15, 2019; June 28, 2019; and September 9, 2019. While NAMIC may refer to some of the content of those letters, please do not interpret a failure to discuss as relinquishment of concerns already posited to the task force to the extent they were not formally adopted.

As for the topic of predictive modeling broadly, NAMIC does not believe as a whitepaper the document has much description of the positive aspects of analysis of large data sets for policyholders and instead moves to anecdotal or cursory concerns. Consequently, the paper almost assumes that there are “issues” that currently exist despite any real demonstration of the same. It is genuinely believed by NAMIC and its members that large data sets provide a level of detail that promotes healthy and robust insurance products and concomitant marketplaces that benefit all stakeholders.

1NAMIC membership includes more than 1,400 member companies. The association supports regional and local mutual insurance companies on main streets across America and many of the country’s largest national insurers. NAMIC member companies write $268 billion in annual premiums. Our members account for 59 percent of homeowners, 46 percent of automobile, and 29 percent of the business insurance markets. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.
NAMIC encourages the authors to integrate the positive aspects of large data set analytics more fully throughout the paper. Issues need not necessarily be presupposed, and they should not be presented without including the demonstrable benefits data yields. The ability, for instance, to provide outstanding customer service and products which is demanded by consumers should be further elucidated as there is existing support for these outcomes presently. Future regulators that review this document might be overly persuaded that imminent issues exist that in reality have not been manifested.

Using larger data sets is a natural evolution of the insurance paradigm. Its positive effects outweigh any perceived downside. Although prudent stakeholders plan for potentialities, many positive results from large data analytics are already present and being utilized for the benefit of the public and consumers. Because the insurance industry is so justifiably based on data – to understand the risks involved in order to better underwrite and price – the paper has a responsibility to prominently discuss the benefits to all stakeholders gained through improved efficiency, accuracy, and fairness.

As for the submitted comments and current draft of the white paper, NAMIC wants to thank the task force for accepting a number of comments NAMIC has made concerning this matter including but not limited to revisiting the level of importance definitions and assignments, discussion of a core set of information elements that should be in every filing that includes a model; adding additional sentences/paragraphs on confidentiality and regulatory duties in this regard; attempting to limit the scope of review of data sources; addressing consumer responsibility in data reporting; merging or deleting duplicative matter; clarifying in many instances definitions; adding terminology to the glossary, removal of vague terms such as “intuitive,” and “thought processes;” and revision of the wording in many paragraphs of the elements including adding NAMIC phraseology. This acknowledgment of existing concerns is greatly appreciated and applauded.

Nevertheless, and in continuation of concerns regarding more broad overarching principles concerning the implementation of this process, NAMIC must reiterate existing concerns and posit additional thought regarding the same.

**Unpromulgated Model Regulation**

NAMIC believes that due to the level of granularity and detail that is being requested in this paper which is, in some instances, unnecessary, excessive, overburdensome, and overly prescriptive without considering any demonstrated need or trigger for the regulator to request is essentially a regulation masked as a white paper. The upfront loading of data being sought not only subjects the same to unwarranted exposure, it is not necessary for the regulator to perform their respective duties in a timely and efficient, yet, legal manner. Inevitably, despite protestations to the contrary, this document as currently written will tie up regulatory discretion, encourage a slow-down in speed to market of products, stifle innovation and be utilized as a manual of necessity.

However, if it is the intention of NAIC to move forward in this regard, NAMIC would suggest this is on the wrong track and should be subjected to model regulation scrutiny and the accompanying process. It appears NAIC is attempting to adopt a national standard requiring uniformity amongst all states. Further, any state who intends to implement such standards
should go through their own rule-making process for the same to be effective. There are many items within regulatory functions that are less onerous or detailed that have gone through this process. Throughout the paper the term guidance is utilized. Additionally, there are too many ramifications concerning this paper including the confidential and proprietary nature of the data subject to exposure that the appropriate process should be followed to ensure maximum input and protection of the scope and concerns that are being and have been previously discussed.

Drafting Notes

In relation to the rule-making process concern described above, there are concerns that too many drafting notes are being lost in this process. When the intended paper is ultimately released as currently drafted, it will be devoid of many of the drafting statements made to essentially reject alterations, edits, or comment suggestions. When the paper ends up in the regulators’ purview, they will not necessarily have the benefit of this “guidance” concerning the thought processes that ultimately led to the document’s finality. These notes are a part of this process and should therefore be inclusive such as with a model regulation. Intentions, however well-meaning, can be misinterpreted when not fully explained.

Unresolved Work Streams – “Other Considerations”

It appears to be somewhat unfair to mention other topics, provide a brief discussion without any resolution, and then state that they are not covered in the paper. There could be a host of suggestions to include in this area from an industry standpoint as well such as exploring the positive aspects of predictive modeling and how it improves consumer experience in many aspects. Providing such a brief level of concern without more discussion leaves the potential for misimpressions and may cause readers/regulators to delve more closely into supposed aspirational conclusions without proper review/discussion or further input on such topics from all stakeholders. These unresolved issues include granularity of rating variables and plans, scientific mindset of open inquiry, correlation vs. causality, and data mining conflicts. We believe these topics should be left for further elucidation if and when such matters are decided to be thoroughly explored from all aspects in a transparent manner but not touched upon in such a cursory manner.

Continuing Concerns

While NAMIC provides comments as requested by the task force, we would like to reiterate that discussion should be revisited as to the necessity of this document as currently drafted. NAMIC would implore the task force to consider meaningful baseline analysis requirements that regulators need to review filings and fulfill their legal and regulatory obligations. Each regulator may always request further documentation to quell concerns. However, as currently drafted, we do not feel the same has been sufficiently curtailed. In fact, the paper has continued from its existence to require an extraordinary amount of data and responses that may not be necessary at all. There is a difference between an amount of information needed to perform the required duties of approving such filings and merely satisfying the inquisitive nature of a reviewer. We believe the document encourages delay and continual demand for explanatory conferences that while
important to address legitimate concerns should not be the rule but the exception. This paper is requiring each regulator to be a data modeler and then opine on the actual resultant product which in many instances deviates from traditional legal duties of a regulator. Additionally, NAMIC believes there is terminology that is open to interpretation such as “rational,” that will create confusion and delay.

In closing, NAMIC again wants to thank the task force for the ability to respond to its well-intended and open process. We look forward to providing continued input in regard to this endeavor. However, due to the existing concerns, NAMIC would suggest that there are too many unresolved matters to move forward with finalization in Austin, Texas.

Sincerely,

Andrew Pauley, CPCU
Government Affairs Counsel
National Association of Mutual Insurance Companies (NAMIC)
Dear Ms. DeFrain,

I write you as director of finance, insurance and trade policy at the R Street Institute, a nonprofit, nonpartisan public policy research organization (“think tank”). Our mission is to engage in policy research and outreach to promote free markets and limited, effective government. Since our founding in 2012, R Street has had a successful history of research into public policy regarding the business of insurance. Our most notable contribution in this space has been producing our annual Insurance Regulation Report Card, whose eighth edition will be published in early December.

R Street is not engaged as an insurance underwriter, data firm or model provider. Our thoughts on the Task Force’s Predictive Model White Paper are solely our own, grounded in the principles of limited, effective and efficient government. With that said, we would like to share some of our concerns with this exposed white paper.

While framed as a simple “best practices” document focused on generalized linear models (GLM) deployed in the personal auto and homeowners lines of business, the white paper’s scope clearly goes far beyond that. It proposes new rating standards that do not reflect any existing state actuarial review process for rating plans filed with a GLM. In some places, it even suggests that such standards be applied to other, and possibly even all, model types. Of particular concern is that the white paper in several places recommends states require the collection of information that could breach confidentiality, trade secrets and long-established Actuarial Standards of Practice (ASOPs).

Among the problematic recommendations are the paper’s various instructions concerning raw data, which it defines as “data before scrubbing, transformation etc. takes place.” Regulators should, the paper notes, “review the geographic scope and geographic exposure distribution of the raw data for relevance to the state where the model is filed” as well as “ask for aggregated data... that allows the regulator to focus on the univariate distributions and compare raw data to adjusted/binned/transformed/etc. data.”

The goal appears to be to allow regulators to reproduce a model’s outputs, rather than simply review those outputs. But submitting raw data could pose security risks and may violate contractual obligations.
with third parties. Our view is that, as a general heuristic, regulators should temper their desire to know everything that goes on inside the proverbial “black box” and instead put the appropriate focus on what comes out of it; that is, focus on rates, not the models that produced them.

The confidentiality concerns extend beyond raw data and to the models themselves. The paper has been amended to better recognize the need for confidentiality protections, but it continues to entrust regulators to determine where it is “appropriate” to guard intellectual property and trade secrets. Third-party vendors can only fiscally justify their significant investment in proprietary algorithms if they are granted certainty that such work product will be protected. Without that certainty, few new vendors will come to the market and existing models could be withdrawn. In either case, the effect would be to stifle innovation.

Needless to say, a withdrawal of existing GLMs would cause significant market disruption. State departments of insurance have been deploying well-established review processes for GLMs for years. The results have been vibrant and competitive insurance markets. As R Street has demonstrated in its annual Insurance Regulation Report Card,¹ no state currently has either a personal auto or homeowners insurance market with a Herfindahl-Hirschman Index (HHI) score that would indicate it is highly concentrated. In our forthcoming edition, we find only Alaska, Louisiana and New York had moderately concentrated auto insurance markets in 2018 and only Alaska had a moderately concentrated homeowners market.

This is a marked difference from the situation that prevailed through the 1980s, when some states saw as much as half of all auto insurance consumers shunted into residual market mechanisms. By contrast, according to the Automobile Insurance Plans Service Office (AIPSO), as of 2018, residual markets accounted for less than 0.1% of the market in 34 of the 50 states. Just four states—Maryland, Massachusetts, Rhode Island and North Carolina—have residual markets that account for more than 1% of auto insurance policies. This greatly improved ability of insurers to segment, classify and price risk effectively can be traced directly to the emergence of dynamic models like credit-based insurance scores.

Regulators should be very cautious before adopting any changes that could reverse those victories. To its credit, this updated version of the exposed draft does acknowledge a central weakness at the heart of the project, which is the degree to which regulators are expected to ask “the modeler to go beyond correlation and document their basic, causal understanding of how variables used in a model or rating plan are related to risk.” As the white paper notes, this approach significantly exceeds the requirements established in ASOP No. 12. It is, of course, reasonable to require model predictions to bear some resemblance to the subject being modeled, but causality is notorious difficult to prove, and the standards raised here could make the practice of modeling itself untenable.

What also should be noted is the irony that the white paper would recommend that regulators insist upon filings that prove not only the credibility, but the causal nature of modeling assumptions, when the Task Force itself has not begun to credibly demonstrate that such radical shifts in the rate-filing approval process would better serve markets or consumers.

Indeed, given the decades-long record for competitive insurance markets, there simply is no good reason to risk widespread market disruption via unprecedented information requests. Any best practices around regulation of predictive modeling should begin by determining what information is truly “essential” to ensure that rates are sufficient and neither excessive nor unfairly discriminatory.

R.J. Lehmann
Director of Finance, Insurance and Trade Policy
R Street Institute
SOCIETY OF ACTUARIES

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE
Saturday, December 7, 2019
10:00 – 11:30 a.m.
JW Marriott Austin—JW Grand Ballroom 1–2—Level 4

Society of Actuaries (SOA) Actuarial Research and Education Update

- Highlights of Recent Research Reports
  - Update on the Outlook for Automated Vehicle Systems published in October 2019
  - Key summaries on the following topics:
    - Consumers beginning to absorb more of the driver-assisted technologies that deliver safety, comfort and convenience
    - Light Detection and Ranging (LIDAR) costs declining in some respects. Active debate continues regarding the use of LIDAR versus optical sensors
    - Tesla in-house insurance plan for California evolving
    - Trucking between cities being tested by several companies and is expected to transition to operational deployments into 2020.
  - July – October 2019: Actuarial Weather Extremes
    - [https://www.soa.org/resources/research-reports/2019/weather-extremes/](https://www.soa.org/resources/research-reports/2019/weather-extremes/)
    - Monthly reports that identifies and examines unusual or extreme single-day or multi-day weather events across North America
    - Recent reports include:
      - Special Issue September Report on Hurricane Dorian Rainfall Extremes in North Carolina and South Carolina
October 2019: Extreme cold and snow in late October

- *International Catastrophe Pooling for Extreme Weather* published in October 2018
- Overview and analysis of a variety of Catastrophe Pooling programs such as the Florida Hurricane Catastrophe Fund, Flood Re (UK), and the Caribbean Catastrophe Risk Insurance Facility
- Additional assessment of asset exposure to long-term climate risks

- Education update on Predictive Analytics modules and examinations
**Current Research**

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<th>Project</th>
<th>Status</th>
<th>Expected publication</th>
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<tr>
<td>Fitness of Various Exposure Bases for use in Pricing cyber insurance</td>
<td>First draft response from POG</td>
<td>December 2019</td>
</tr>
<tr>
<td>Compartmental Reserving Models</td>
<td>Copy editing</td>
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<tr>
<td>Exploring the Use of Machine Learning Techniques for P&amp;C Loss Reserving</td>
<td>Copy editing</td>
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<tr>
<td>Users guide to ESGs for P&amp;C companies</td>
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<td>Demand for Microinsurance</td>
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<tr>
<td>Individual reserving techniques</td>
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<tr>
<td>Flood models using public data</td>
<td>Work underway</td>
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**Future Research**

The following projects are under development, but have not yet been submitted for approval to the CAS Executive Council.

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<th>Project</th>
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<tr>
<td>Recent changes in the risk of wildfire</td>
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<tr>
<td>P&amp;C applications of recurrent neural networks</td>
<td>Q3 2020</td>
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<tr>
<td>Credibility for excess reinsurance layers</td>
<td>Q3 2020</td>
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**Recent PE**

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<tr>
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<tr>
<td>Driverless Vehicles: Other Perspectives</td>
<td>Presentation</td>
<td>Nov. 15, 2019</td>
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<td>Use That Data! Predictive Modeling Applications for Claims and Underwriting</td>
<td>Presentation</td>
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<td>Artificial Intelligence in Auto Rating and Regulatory Considerations</td>
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<td>GLM vs. Machine Learning - A Case Study in Pricing</td>
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<td>An Application of Machine Learning in Rating</td>
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<td>Reserving with Machine Learning: Innovations from Loyalty Programs to Insurance</td>
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<td>Wildfire Risk in the West</td>
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<td>JRMS Webinar Series: Model Risk Management</td>
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<td>Flood Risk</td>
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**Upcoming PE**

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<td>Artificial Intelligence is Changing Actuarial Models</td>
<td>Presentation</td>
<td>Dec. 3, 2019</td>
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<tr>
<td>A Professional guide on how to handle data – BIG or otherwise</td>
<td>Presentation</td>
<td>Dec. 3, 2019</td>
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<td>Ensembles and Combining Models</td>
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<tr>
<td>Introduction to Python</td>
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<td>Intro to predictive modeling</td>
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<tr>
<td>Advanced predictive modeling</td>
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Draft: 12/17/19

Surplus Lines (C) Task Force
Austin, Texas
December 7, 2019

The Surplus Lines (C) Task Force met in Austin, TX, Dec. 7, 2019. The following Task Force members participated: James J. Donelon, Chair, and Stewart Guerin (LA); Al Redmer Jr., Vice Chair (MD); Lori K. Wing-Heier, represented by Michael Ricker (AK); Michael Conway represented by Rolf Kaumann (CO); Colin M. Hayashida represented by Paul Yuen (HA); Robert H. Muriel represented by Patrick Hyde (IL); Nancy G. Atkins represented by John Melvin (KY); Mike Causey represented by Fred Fuller (NC); Marlene Caride represented by Philip Gennace (NJ); Glen Mulready represented by Buddy Combs (OK); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Raymond G. Farmer represented by Lee Hill (SC); Larry Deiter represented by Johanna Nickelson (SD); Mike Kreidler represented by Jeff Baughman (WA); James A. Dodrill represented by Greg Elam (WV); and Jeff Rude represented by Donna Stewart (WY). Also participating was: Scott Greenberg (AZ); and Robert Wake (ME).

1. **Adopted its Summer National Meeting Minutes**

   Mr. Fuller made a motion, seconded by Commissioner Redmer, to adopt the Task Force’s Aug. 3 minutes (*see NAIC Proceedings – Summer 2019, Surplus Lines (C) Task Force*). The motion passed unanimously.

2. **Adopted the Report of the Surplus Lines (C) Working Group**

   Mr. Guerin reported that the Surplus Lines (C) Working Group met Sep. 26 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.

   During the conference call, the Working Group heard a summary of five applications for admission to the *Quarterly Listing of Alien Insurers*. All five of the applying companies were discussed, and four companies were admitted to the Oct. 1 edition of the listing.

   Ms. Stewart made a motion, seconded by Commissioner Redmer, to adopt the report of the Surplus Lines (C) Working Group. The motion passed unanimously.

3. **Heard Comments on an Exposure of a Blanks Proposal Regarding Home State Direct Premiums Written**

   Commissioner Donelon summarized the background on a blanks proposal to add a new column to Schedule T within the Property/Casualty (P/C) financial blank. Specifically, this new section would provide Home State direct premiums written. The blanks proposal was exposed for a 45-day public comment period ending Oct. 10. During the exposure period, comment letters were received from three interested parties.

   Commissioner Donelon said the overall intent of the proposal is to provide a means for insurance departments to arrive at an estimate of surplus lines premium tax dollars due to their states by applying the state surplus lines tax rate to the direct premiums written as would be reported on a home state basis. He said there is a general understanding that this is not a perfect solution to the surplus lines tax reconciliation issues experienced by several state insurance departments. He added that the proposal does provide the states with a starting point to begin the process of tax reconciliation. This issue came to the Task Force’s attention due to inquiries received by NAIC staff from state insurance departments seeking assistance in surplus lines tax reconciliation.

   Commissioner Donelon invited Task Force members to provide comments.

   Ms. Nickelson said the difference between home state premium and risk state premium makes it difficult to tie back to one another. She said it would be helpful if brokers and companies would report on a home state basis as it would benefit audit practices.

   Commissioner Redmer said he sees only an incremental benefit from implementing this approach, and he believes that the burden placed on the industry would not prove worthwhile. He suggested fine tuning the approach.

   David Kodama (American Property Casualty Insurance Association—APCIA) said a key concern from his comment letter related to the precedent, which would be set by using the financial statements to impose a responsibility on surplus lines insurance companies, that is not a statutory duty.
Brady Kelley (Wholesale & Specialty Insurance Association—WSIA) said he would like a reasonable method of estimating premium tax, but he thinks that the proposal may be an imperfect solution, as the company versus broker reporting will never match. He said driving this type of change in the industry would likely be troublesome. He said an alternative solution that is more reasonable may be developed with additional time.

Mr. Kodama said this proposal would not only place obligations on the insurance industry, but it would also require a commitment of additional resources from state insurance regulators at state insurance departments to review the policy level detail. He is unsure whether an actual benefit would be achieved. He said that the APCIA would remain committed to finding an alternative solution.

Ms. Nickelson said that receiving the home state premium on Schedule T would allow state insurance regulators a premium amount to compare to broker reported premium, as both would be prepared on the same basis.

Mr. Kodama said the broker is the regulated entity in the surplus lines transaction, and theirs is the statutory duty to bill, collect and remit premium taxes. He said the proposal attempts to add the insurance companies as a third party to the transaction.

Commissioner Donelon clarified that the proposal attempts to impose a statutory obligation on surplus lines insurance companies that are unregulated in all the states except for their state of domicile, while licensed surplus lines brokers are the regulated entities.

Mr. Wake said he is unsure why company reporting cannot be consistent with broker reporting since federal law provides a definition for identifying home state premium. He said the laws in his state require brokers to pay the tax and insurance companies to do thorough business reporting. He said the tax collecting authority in Maine, separate from the insurance department, has said receiving the home state premium would provide a definite benefit.

Mr. Kelley said that although it would be possible for companies to collect home state premium data, it would be difficult to accurately compare to broker reported data.

Mr. Kodama said that home state identification is not a straightforward process; and to assure consistency, new process rules would need to be created.

Commissioner Donelon said if there is inconsistency in identifying a home state, it points to a need for new rules or a model law for brokers.

Ms. Stewart added that state insurance regulators have updated their systems, statutes and procedures to recognize a home state, but many insurance companies have not.

Mr. Kelley said that the distinction of home state is not a concern of surplus lines carriers, as it does not influence risk underwriting.

Dan Maher (Excess Line Association of New York—ELANY) said surplus lines brokers have the legal duty to identify the home state, and should there be a disagreement in that identification with the company or another state, that would affect the ability to perfectly reconcile a broker versus company home state premium reporting.

Commissioner Donelon said that situations in which such disagreements occur are isolated, and the inability to have a perfect process should not prevent the creation of a tool that would allow for a more accurate accounting of premium taxes.

Ms. Nickelson said she recognizes that a perfect reconciliation between company and broker reporting will never be possible because of report timing and other factors. However, she said that it would provide a starting point for accessing whether additional investigation is necessary.

Mr. Kodama said the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRA) was written to streamline the surplus lines market, and adding additional responsibilities to surplus lines carriers would be contrary to the intent of the legislation.

Mr. Greenberg clarified that the proposal would require separate Schedule T reporting for home state premium. He noted that companies would need to discount reported premiums for the additional fees that brokers are obligated to collect, premium returns, and cancellations.

Commissioner Donelon asked whether, at this point, a vote to forward the proposal to the Blanks (E) Working Group for more discussion is appropriate.
Andy Daleo (NAIC) said that he had discussed with NAIC staff regarding the proposal, and he was told that no additional technical evaluation and discussion of the proposal would be completed by the Blanks (E) Working Group. He said that because of the technical nature of the proposal, all discussion would be limited to the Task Force.

Mr. Kodama asked whether the proposal involved a question of whether it was legal to compel insurance companies to report home state premium when it is not a statutory responsibility.

Mr. Kelley asked if there were alternative methods to assess whether accurate premiums were available, rather than imposing reporting duties on insurance companies that will have dramatic changes on current reporting requirements.

Commissioner Donelon said that based on the discussion, he views the proposal as a much more convoluted attempt to remedy an acknowledged problem faced by state insurance regulators. He added that the proposal is problematic and may be more burdensome to insurers than perceived, and it may not be legal. He also questioned what enforcement options would be available to the states other than the state of domicile to enforce compliance on nonadmitted carriers.

Commissioner Donelon asked if a postponement would be appropriate due to the amount of time spent on this issue.

Commissioner Redmer made a motion, seconded by Mr. Hill, to postpone a decision on the blanks proposal until the Task Force’s meeting at the 2020 Spring National Meeting. The motion passed unanimously.

4. **Heard an Update on its Referral to the Producer Licensing (D) Task Force**

Commissioner Donelon introduced Tim Mullen (NAIC) to provide an update on a referral from this Task Force to the Producer Licensing (D) Task Force regarding suggested modifications to the Producer Licensing Handbook to accommodate the adopted Guideline on Nonadmitted Accident and Health Coverages (#1860).

Mr. Mullen said the Producer Licensing (D) Task Force had discussed this referral at several meetings, and it had exposed the issue for comment in October. He said 11 letters were received with two primary concerns. The first concern was that the members of Producer Licensing (D) Task Force did not understand the scope of the accident & health (A&H) market in their states. The second concern was that existing state laws would not provide for the modifications to the Uniform Licensing Standards (ULS).

Mr. Mullen said that the ULS was adopted shortly after the adoption of the Producer Licensing Model Act (#218). The ULS provides for a high level of authority among NAIC member states, and it is not regarded as guidance, but as standards that the state market would need to develop and only then be modified. He said the Producer Licensing (D) Task Force would meet following this Task Force meeting; and although there would be additional discussion, he assumed that the referral would be premature at this time.

5. **Received Adjustments to Exempt Commercial Purchaser Minimum Qualifications**

Mr. Daleo stated that according to the directive within the Nonadmitted section of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), the minimum qualifying amounts for three categories of Exempt Commercial Purchaser requires adjustment every five years. The Dodd-Frank Act legislation does not provide guidance on how these adjustments are to be carried out. As a result, back in 2014, the Task Force determined that the September Consumer Price Index (CPI) would be used for the five-year period beginning Jan. 1.

The last adjustment the Task Force made was in September 2014 for the period beginning Jan. 1, 2015. He said within Section 527 of the Dodd-Frank Act, the qualifying amounts in subclauses (I), (II) and (IV) are to be adjusted effective “each fifth January 1 based on the CPI for all urban consumers.”

The percentage change calculation and adjusted minimum amounts for the categories are in your materials, and they reflect a 7.9% rise. At the 2024 Fall National Meeting, Mr. Daleo said a similar adjustment will be provided.

Commissioner Donelon said that a copy of the adjustments would be posted on the Task Force web page.

Having no further business, the Surplus Lines (C) Task Force adjourned.

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TITLE INSURANCE (C) TASK FORCE

Title Insurance (C) Task Force Dec. 8, 2019, Minutes......................................................................................................... 8-322
Title Insurance (C) Task Force Sept. 25, 2019, Minutes (Attachment One) ................................................................. 8-326
The Title Insurance (C) Task Force met in Austin, TX, Dec. 8, 2019. The following Task Force members participated: James J. Donelon, Chair, represented by Warren Byrd (LA); David Altmaier, Vice Chair, represented by Anoush Brangaccio (FL); Lori K. Wing-Heier represented by Michael Ricker (AK); Michael Conway represented by Damion Hughes (CO); Colin M. Hayashida represented by Paul Yuen (HI); Dean L. Cameron represented by Jesse Adamson (ID); Vicki Schmidt represented by Heather Droge (KS); Al Redmer Jr. represented by Robert Baron (MD); Steve Kelley represented by Paul Hanson (MN); Chlora Lindley-Myers represented by Carrie Couch and Marjorie Thompson (MO); Mike Causey represented by Fred Fuller (NC); Bruce R. Ramge represented by Peg Jasa (NE); Marlene Caride (NJ); John G. Franchini represented by Anna Krylova (NM); Barbara D. Richardson represented by Stephanie McGee (NV); Jillian Froment represented by Angela Dingus (OH); Glen Mulready represented by Holly Mills (OK); Raymond G. Farmer represented by Lee Hill (SC); Larry Deiter represented by Frank Marnell (SD); Todd E. Kiser represented by Tracy Klausmeier and Reed Stringham (UT); Scott A. White represented by Mike Beavers (VA); and Michael S. Pieciak represented by Karen Ducharme and Kevin Gaffney (VT).

1. **Adopted its Sept. 25 and Summer National Meeting Minutes**

Commissioner Caride made a motion, seconded by Ms. Droge, to adopt the Task Force’s Sept. 25 (Attachment One) and Aug. 4 (see NAIC Proceedings – Summer 2019, Title Insurance (C) Task Force) minutes. The motion passed unanimously.

2. **Heard a Presentation on the Title Industry, Including Types of Endorsements, Market Statistics, CPL Statutes, and the Effect of Mandatory Title Insurance**

Joseph L. Petrelli Jr. (Demotech) said title insurance varies from other types of property/casualty (P/C) insurance in that it looks backwards to the effective policy date. The reporting for title insurance has not caught up with this nuance. The relative frequency of the issuance of endorsements varies markedly from endorsement to endorsement. For instance, a $35 million mansion in Los Angeles, CA, is a one- to four-family residence, while a $300 thousand beer and milk drive-thru in Akron, OH, is non-residential. Mr. Petrelli provided an overview of endorsements and their coverages.

**Endorsements include:**

- **Street Assessments (American Land Title Association [ALTA] Form 1 Series)** ensures that there are no street improvements which have resulted in a lien.
- **Zoning (ALTA Form 3 Series)** insures against an adverse final court decree, which prohibits zone-specified use.
- **Condominium Assessments Priority (ALTA Form 4 Series)** insures against several risks with respect to the condominium regime and documentation.
- **Planned Unit Development—Assessment Priority—Loan Policy (ALTA Form 5 Series)** affords coverage for charges in favor of any association of homeowners referred to in Schedule B over the lien of any insured mortgage.
- **Variable Rate (ALTA Form 6 Series)** insures a variable rate mortgage, securing a loan in which the unpaid principal balance increases as the result of the addition of unpaid interest.
- **Manufactured Housing (ALTA Form 7 Series)** may be issued with an Owner’s or Loan Policy where the land described in the policy is improved with a manufactured housing unit.
- **Environmental Protection Liens (ALTA Form 8 Series)** insure the priority of the mortgage lien against existing or subsequently recorded federal or state environmental protection liens.
- **Restrictions, Encroachments, Minerals and Loan Policy (ALTA Form 9-6 Series)** covers additional improvements that encroach upon easement areas or damage resulting from using the land surface for mineral extraction.
- **Assignment (ALTA Form 10 Series)** insures against loss resulting from: 1) failure of the referenced assignment to vest title of the insured mortgage in the insured assignee; or 2) any modification recorded prior to the endorsement date.
- **Mortgage Modification (ALTA Form 11 Series)** insures against loss from modification of the insured mortgage.
- **Aggregation (ALTA Form 12 Series)** amends Section 7 to provide that the amount of insurance available to cover liability for loss shall be the policy insurance amount aggregate.
- **Leasehold—Owner’s (ALTA Form 13 Series)** modifies the Owner’s Policy for insured leaseholder estates.
Future Advance Priority (ALTA Form 14 Series) provides coverage to a lender for loss sustained if a future advance does not have the same priority as the original mortgage.

Non-imputation—Full Equity Transfer (ALTA Form 15 Series) insures the title in the existing entity that owns the land when said owning entity has a total replacement of equity holders in a full equity transfer of the entity.

Mezzanine Financing (ALTA Form 16 Series) assigns to the mezzanine lender the right to receive payments otherwise payable to the insured under the policy.

Access and Entry—Direct (ALTA Form 17 Series) provides coverage for loss if the insured lacks both actual vehicular and pedestrian access to and from a specifically identified street.

Single Tax Parcel (ALTA Form 18 series) ensures that the land identified in the policy is a single and separate tax parcel.

Contiguity—Multiple Parcels (ALTA Form 19 Series) insures against loss if the boundaries to multiple parcels are not contiguous as described.

First Loss (ALTA Form 20 Series) provides that the insurer’s liability shall be determined without requiring the maturity of the entire indebtedness.

Location Endorsement (ALTA Form 22 Series) insures against loss from failure of an improvement.

Co-insurance—Single Policy (ALTA Form 23 Series) is a transaction where total liability is assumed by two or more co-insurers, with the liability being divided between the co-insurers from the first dollar.

Doing Business (ALTA Form 24 Series) insures a lender against loss from the invalidity of the insured mortgage lien.

Same as Survey (ALTA Form 25 Series) insures against loss from failure of the land description to match the survey.

Subdivision (ALTA Form 26 Series) ensures that the land described in the policy constitutes a lawfully created parcel.

Usury (ALTA Form 27 Series) protects the insured against loss from invalidity of the lien as a result of a final judicial determination that the loan secured by the insured mortgage is usurious.

Easement—Damage (ALTA Form 28 Series) insures against loss from damage to an existing building on the land.

Interest Rate Swap Endorsement—Direct Obligation (ALTA Form 29 Series) insures against loss from the invalidity, unenforceability, or lack of priority of the insured mortgage’s lien as security for the swap obligation.

One to Four Family Shared Appreciation Mortgage (ALTA Form 30 Series) insures against loss from the invalidity of the insured mortgage’s lien as security for the indebtedness caused by the provisions for shared appreciation.

Severable Improvements (ALTA Form 31 Series) includes certain losses and costs related to “Severable Improvements” in the calculation of loss under the policy.

Construction Loan—Loss of Priority (ALTA Form 32 Series) provides coverage to a lender for loss due to the invalidity of the insured’s mortgage lien as security for construction loan advances.

Minerals and Other Subsurface Substances—Buildings (ALTA Form 35 Series) insures against loss from enforced removal or alteration of any building from the use of the land surface for mineral extraction.

Energy Project—Leasehold/Easement—Owners (ALTA Form 36 Series) issued with an Owner’s Policy, alters certain conditions to reflect that the interest insured is a leasehold interest and adds some energy project-specific definitions.

Assignment of Rents and Leases (ALTA Form 37 Series) insures against loss sustained by the insured due to a defect in the execution of an assignment of rents or any assignment of a lessor’s interest in any lease affecting the title.

Policy Authentication (ALTA Form 39 Series) ensures that the insurer will not deny liability under the policy solely on the grounds that it was issued electronically or lacks signatures in accordance.

Tax Credit—Owner’s Policy (ALTA FORM 40 Series) includes in the loss calculation certain losses related to a “Tax Credit.”

Commercial Lender Group (ALTA Form 42 Series) insures against loss from invalidity or loss of priority of the insured lien from transfers after the date of policy.

Anti-Taint (ALTA Form 43) insures against loss from loss of priority of the insured mortgage lien as security for the indebtedness advanced on the loan.

Insured Mortgage Recording (ALTA Form 44 Series) insures against loss from failure of the insured mortgage to have been recorded in the public records.

Pari Passu Mortgage—Loan Policy (ALTA Form 45 Series) insures against loss from invalidity of the insured mortgage lien solely due to the provisions of a Pari Passu Mortgage or an Intercreditor Agreement establishing lien priority.

Option (ALTA Form 46 Series) insures against loss from: 1) a defect in the option execution resulting from forgery or incapacity of the optionor; 2) failure of the option; and 3) the option not being properly signed or witnessed.
- Partnership/LLC—Permitted Transfer Fairway insures a partnership or limited liability company (LLC) against coverage denial due to the admission/withdrawal of a partner/member in the insured partnership/LLC, respectively.
- Last Dollar provides that payments to a loan secured by the insured mortgage will not cause a proportionate reduction in the amount of insurance until the aggregate principal indebtedness is reduced to the amount of the policy.
- Subdivision assures the insured that the land described in the policy constitutes a lawfully created parcel.

Mr. Petrelli said the number of title underwriters has declined over the past decade due to a consolidation trend from 2007 to 2009. Countrywide direct written premium has rebounded to almost the historic levels seen in 2003–2006. Residential policies insure dwellings intended to occupy one to four families. Non-residential policies cover everything else. Texas was the top writer in 2018, with $2.2 billion in written direct premium or 14.7% of the market. Texas, California and Florida represented over one-third of the countrywide premium in 2018. These three states also held just under one-third of the countrywide residential policies. There are substantially more transactions and written premium on the residential side than the non-residential side. In 2018, the industry had $11.1 billion in residential written premium as compared to $3.7 billion in non-residential premium. For the same year, it also had 9.7 million residential policies as compared to 1 million non-residential policies. Premium for title insurance is a graduated dollar amount per every thousand dollars of coverage, typically subject to a minimum. Thus, the single premium typically goes up over time as the value of homes goes up.

Mr. Byrd asked if Texas mandated the seller to provide the buyer with a closing protection letter (CPL) at closing. Diane Evans (Land Title Guarantee Company of Colorado—LTGC) said it is common, but not required.

Mr. Petrelli said the Task Force has discussed the coverage of CPLs. The ultimate intent of the CPL and the coverage is to make sure that the instructions of the lender are followed to the benefit of the lender, borrower and owner. This includes the financial integrity of the process and the proper authority recording. However, the CPL is a document that is only formally filed in some states. Closing protection coverage, on the other hand, is specifically filed with and approved by the department of insurance (DOI) where it is used. It is important to recognize that some states have instituted the appropriate regulation and legislation to regulate the content, coverage and premium, if applicable.

Mr. Byrd asked if these states had indicated what the coverage needs to be by statute. Mr. Petrelli said that is indeed the case, with the states indicating what needs to be in the coverage, the minimum contents of that coverage, and the filing and amendment process (usually prior approval). Louisiana amended its law in 2009 to address minimum contents, risking appropriation of settlement funds and failure to comply with instructions, prohibit other coverage indemnifying against improper acts or omissions, affirm the insurance department’s regulation of “closing protection,” and set a single premium for risk premium. Ohio revised its code to provide for the offer of closing or settlement protection to parties. Similar to Louisiana, coverage includes theft and misappropriation of funds and failure to comply with closing instructions. Additionally, the DOI’s authority is affirmed, and other coverage indemnifying against improper acts or omissions is prohibited.

Mr. Byrd asked if there are more commercial endorsements than residential endorsements. Mr. Petrelli said there are more commercial endorsements, and their compiled statistics show that much of the premium on the commercial side comes from endorsements.

3. **Heard a Presentation on the History of CPLs**

James Gosdin (Stewart Title) said the CPL is insuring the closing of a real estate transaction. CPLs began in some form in the 1940s with the early issuance of insured closing service letters (ICLs). Use of ICLs grew in the 1960s with Lawyers Title Insurance Company providing these letters for approved attorneys. They were originally developed for commercial lending institutions to cover acts of independent title agents or approved attorneys. The primary concern of the time was misappropriation of funds. ICLs provided basic coverage against: 1) acts of fraud, theft, dishonesty or negligence in handling settlement funds or documents in connection with a closing, but only to the extent that the acts affect the status or priority of title in the real estate insured by the title insurance; and 2) failure to comply with written closing instructions of a proposed insured when agreed to by the title agency or title agent relating to title insurance coverage, but only to the extent that the acts affect the status or priority of title in real estate insured by the title insurance. It is important to remember that escrow and closing services are separate from title insurance coverage. The title insurance underwriter/agent relationship is a limited agency relationship wherein the agent is only granted the authority to act on behalf of the title insurance underwriter for the purpose of issuing title insurance commitments or policies. Although both title insurance underwriters and title agents perform closing and escrow functions, these functions are outside the limited scope of title insurance underwriter’s agency contract and relationship with the policy issuing agent.
Ms. Evans said the authorized title insurance agent is allowed by contract to issue a title insurance policy on behalf of the underwriter. Oftentimes, agents are asked by the parties of the transaction to close it (referred to as an escrow on the transaction in some states). The CPL gives the closing agent and the parties to the real estate transaction the confidence that the agent is permitted to close for the underwriter.

Mr. Byrd said the title agent is also the closing attorney for the sale in many states. He asked for clarification on if the insurer is underwriting the risk of an agent absconding with funds received from the lender. Mr. Gosdin said escrow is separate from title insurance. There is indemnity with respect to the theft of transferred funds because it ultimately affects the lien on the mortgage.

Mr. Gosdin said ALTA has standardized CPLs across the industry and currently has two versions, one for single transactions and one for multiple transactions (or blanket). It has approved revisions to its CPLs over the years, with the most recent being in 2018. Current ALTA CPL coverage requirements include: 1) the issuer is contractually obligated to issue a policy for the insured’s protection in a real estate transaction; 2) the insured is a lender secured by the title’s mortgage or a purchaser/lessee of the title; 3) aggregate of funds transmitted to the issuing agent/attorney does not exceed a specified dollar amount; and 4) the loss is caused by failure to comply with closing instructions or fraud, theft or misappropriation.

Mr. Byrd asked how the transaction would work if a buyer of one piece of property placed the land into three different LLC names with the intent of developing the land associated with each LLC at different times and for different commercial purposes. Mr. Gosdin said it would be a multiple transactions and that it was only important that the lender and title agent be the same.

Ms. Evans said CPLs are one of many tools used to assure consumers that transactions are protected against errors, omissions and cyber threats. Lenders currently request CPLs at the time of title order, rather than just prior to closing, and then verify electronically. Recent trends have seen several states pass laws and companies file CPL rates. This raises a competitive question about the issuance of CPLs for transactions involving direct operations and not just agents. The CPL fee is remitted in total to the underwriter, which does not account for the agent’s process and tracking expenses. Additionally, explaining to consumers that the CPL fee protects them against fraud from the person doing the explaining is awkward and causes confusion.

Mr. Gosdin said CPLs may be issued in all jurisdictions, except New York where it is deemed to be outside the scope of a monoline title insurer’s license and writing authority. About half of the states regulate CPLs in some form. There are three types of authorizing laws. One version states that the CPL may be issued to “a party to a transaction in which a title insurance policy will be issued” (e.g., Alabama, Arizona, Arkansas, Georgia, Louisiana, Nevada and Utah). Another version allows CPLs to be issued to the seller or buyer (or lender) (e.g., Colorado and Texas, subject to limits); to the buyer, lender or seller (e.g., Georgia); or to the buyer, borrower or lender (e.g., Georgia and Maine). The third version allows CPLs to be issued to the buyer, borrower or lender (e.g., Maine). Additionally, there are several states that have special requirements. For example, a Notice of Availability is required in Alabama, Arizona, Arkansas, Colorado, Missouri and Ohio. CPLs are issued through approved websites or through an integration with the issuing agent’s title production system. If a transaction exceeds a standard liability set forth in the CPL, issuing agents can request custom coverage for higher liability transactions. Common claims under a CPL include: 1) theft of settlement funds by the title insurance agent; 2) fraudulent flips; 3) fraudulent down payment undisclosed by title insurance agents; 4) unresolved title defects; and 5) claims under both the policy and CPL.

4. Received Compiled NAIC Information on CPLs

Mr. Byrd said the materials include a compilation of discussions from the NAIC Proceedings on CPLs and CPL-related questions (namely 58–62) from the Survey of State Insurance Laws Regarding Title Data and Title Matters, which was last updated by the Task Force in March of this year. The information serves as background materials and is also posted on the Property and Casualty Insurance (C) Committee’s web page.

Having no further business, the Title Insurance (C) Task Force adjourned.
Title Insurance (C) Task Force
Conference Call
September 25, 2019

The Title Insurance (C) Task Force met by conference call on Sept. 25, 2019. The following Task Force members participated: James J. Donelon, Chair, represented by Warren Byrd (LA); David Altmaier, Vice Chair, represented by Anoush Brangaccio (FL); Lori K. Wing-Heier represented by Joanne Bennett (AK); Michael Conway represented by Dennis Newman (CO); John F. King represented by Margaret Witten (GA); Dean L. Cameron represented by Jim Scanlon (ID); Vicki Schmidt represented by James Norman (KS); Mike Causey represented by Timothy Johnson (NC); Bruce R. Ramge represented by Matt Holman and Barbara Peterson (NE); Marlene Caride represented by Carl Sornson (NJ); John G. Franchini represented by Otis Phillips (NM); Jillian Froment represented by Michelle Brugh Rafeld (OH); Glen Mulready represented by Joel Sander (OK); Jessica Altman represented by Michael McKenney (PA); Todd E. Kiser represented by Jay Sueoka (UT); Scott A. White represented by Mike Beavers (VA); and Michael S. Pieciak represented by Karen Ducharme (VT). Also participating were: Emma Hirschhorn and Susan Stapp (CA); Holly Zhu (MI); Marianne Baker and Ronda Lee (TX); Eric Slavich (WA); and Donna Stewart (WY).

1. Discussed and Adopted its 2020 Proposed Charges

Mr. Byrd stated comments on its exposed 2020 proposed charges were due Sept. 16. Its 2020 proposed charges include disbanding the Title Insurance Financial Reporting (C) Working Group and moving its charges into the Task Force directly (proposed charge D). They also include additional charges for revising the Title Insurance Consumer Shopping Tool (proposed charge E) and evaluating the effectiveness of closing protection letters (CPLs) (proposed charge F).

Its 2020 proposed charges are as follows:

A. Monitor issues and developments occurring in the title insurance industry, and provide support and expertise to other NAIC committees, task forces and/or working groups, or outside entities, as appropriate.

B. Review and assist various regulatory bodies in combating fraudulent and/or unfair real estate settlement activities. Such efforts could include working with the Antifraud (D) Task Force and other NAIC committees, task forces and/or working groups to combat mortgage fraud and mitigating title agent defalcations through the promotion of closing protection letters (CPLs) and other remedies. Report results at each national meeting.

C. Consult with the Consumer Financial Protection Bureau (CFPB) and other agencies responsible for information, education and disclosure for mortgage lending, closing and settlement services about the role of title insurance in the real estate transaction process.

D. As necessary, consider the effectiveness of changes in financial reporting by title insurance companies and identify further improvements and clarifications to blanks, instructions, Statement of Statutory Accounting Principles (SSAPs), solvency tools and other matters. Coordinate efforts with the Statutory Accounting Principles (E) Working Group.

E. Revise the Title Insurance Consumer Shopping Tool Template to include questions and answers about title insurance-related fraud topics, including, but not limited to, CPLs and wire fraud.

F. Evaluate the effectiveness of CPLs, including, but not limited to, intent, state regulation and requirements, consumer protections offered and excluded, and potential alternatives for coverage.

a. Proposed Charge E

Brenda J. Cude (University of Georgia) and Birny Birnbaum (Center for Economic Justice—CEJ) suggested the charge regarding consumer information be expanded to include the revision of the Title Insurance Consumer Shopping Tool Template (Shopping Tool). Specifically, they suggested revisions include questions and answers about title insurance-related fraud topics, including, but not limited to, CPLs and wire fraud.

Ms. Rafeld stated it is a good suggestion to incorporate discussion on fraud topics into the Shopping Tool given the numerous related consumer complaints, especially on wire fraud.
Justin Ailes (American Land Title Association—ALTA) stated the Federal Bureau of Investigation (FBI) attributes $5 billion to business email compromise. Of that, $149 million in attributed to criminal real estate closing activities alone, affecting 11,300 victims. However, the FBI estimates this likely represents only 10% to 15% of the full criminal activity, since much is not reported. ALTA supports the incorporation of fraud topics into the Shopping Tool.

Mr. Byrd stated there seems to be a consensus to add a charge to “revise the Title Insurance Consumer Shopping Tool Template to include questions and answers about title insurance-related fraud topics, including, but not limited to, closing protection letters and wire fraud.”

b. Proposed Charge F

Andrew Liput (Secure Insight) suggested the charge regarding CPLs should be expanded to include the formation of a subgroup to evaluate whether the CPL is the most effective and appropriate manner and method to protect/cover borrowers, lenders and subsequent lienholders from risk of loss from mortgage closing negligence and fraud. This evaluation should include considering adding a new product option or replacing the CPL with an insurance policy covering consumers, lenders, future lienholders and other relevant stakeholders to a mortgage closing. This insurance policy would have the advantage of being subject to traditional insurance ratings, premium approvals, terms and conditions reviews, consumer education/opt-out requirements, and traditional risk underwriting processes. Additionally, its pricing would be as a transaction-based product commensurate with the current market for a fraud/negligence hybrid policy. Alternately, such a policy could be approved as an alternative to the CPL, with consumers choosing which type of protection they would like to purchase. He advised replacing the CPL with an insurance policy is advisable because the CPL is: 1) a form of warranty letter and not a true insurance product included in the title insurance policy; 2) not available in every state; 3) being billed to consumers as a title charge and packaged in a letter format that appears to a layperson to be a form of insurance; 4) not regulated by state insurance laws addressing claims practices, licensed sales activity and typical transparency/terms explanation/notice provisions usually found when marketing and selling insurance; 5) is not being underwritten like typical insurance policies; 6) not an optional charge to consumers, with charges from $50 to $125 per transaction in many states; and 7) does not cover all potential risk to a consumer, lender and future lienholder from negligence and intentional acts that might occur at a mortgage closing. He suggested the Task Force analyze prior discussions it had in 2008–2010 on an initiative to review the CPL to determine whether an insurance alternative made sense. Additionally, the Title Escrow Theft & Title Insurance Fraud white paper adopted by the Task Force in 2013 includes a section on CPLs that the Task Force should review again.

Mr. Byrd stated he believes this to be an important issue to look at and would fit under the Task Force’s current charges, requiring no additional charge to be developed. Additionally, he stated the Task Force should undertake the initial discussions before considering the formation of a subcommittee to examine the issue. The Task Force’s recently concluded survey of state laws related to title insurance would provide a great resource in examining how the CPL is being handled across the states. Louisiana took a positive step in 2011 when it enacted La. R.S. 22:515 of the Louisiana Insurance Code with specific revisions that brought CPLs into the title insurance arena fully.

Ms. Rafeld stated this proposal would be interesting for the Task Force to investigate. Ohio requires title agents to offer the option of a CPL to consumers. However, many consumers do not fully understand closing protections, many title agents gloss over them, and disreputable title agents are not likely to offer them at all.

Mr. Byrd stated he agrees. He stated there are only a few states that handle CPLs in the same manner as Louisiana. The Task Force should gain an understanding of how other states handle CPLs by reviewing a cross-section of information related to CPLs from the survey of state laws at the Fall National Meeting.

Ms. Rafeld stated it would also be beneficial for the Task Force to review any discussions on CPLs it has had in prior years. Mr. Byrd directed NAIC staff to include this information in the Fall National Meeting.

Jennifer Gardner (NAIC) stated that NAIC staff will provide materials at the Fall National Meeting that include questions related to CPLs, including the related statutes, from the survey of state laws that was just updated earlier this year. NAIC staff will also compile discussions on CPLs from old Proceedings they have collected for review at the Fall National Meeting.

Mr. Ailes stated ALTA supports looking into CPLs and would be available to present on the history of CPLs at the Fall National Meeting. He noted charge B and charge F both address CPLs.
Mr. Byrd stated while they do cross over, charge F provides more focus on how CPLs should be addressed by the Task Force. He stated there seems to be a consensus that the Task Force should address this issue at the Task Force level, as drafted in the 2020 proposed charges.

c. Proposed Additional Considerations

Mr. Philips suggested the Task Force consider the following: 1) whether searches and title plants should remain a requirement to issue title insurance when it is issued based on algorithms and if they need to be under separate regulations; 2) if CPLs should be available upon request to everyone; 3) if insurers should back-up CPLs and hold the agents liable for error; 4) the relation of bonding and error and omissions; 5) best practice requirements; 6) assessing the current accountability of financial fiduciary responsibilities; and 7) if the Consumer Financial Protection Bureau (CFPB) enforces the federal Real Estate Settlement Procedures Act (RESPA).

Mr. Byrd stated these questions are important for the Task Force to consider and can be done within its currently drafted charges. The Task Force should consider discussing the CFPB’s potential enforcement of RESPA at the Fall National Meeting. Mr. Philips supported this approach.

Ms. Rafeld made a motion, seconded by Mr. McKenney, to adopt the Task Force’s 2020 proposed charges. The motion passed unanimously.

2. Discussed Other Matters

Mr. Byrd stated it should be noted that the Federal Trade Commission (FTC) issued an administrative complaint on Sept. 6 seeking to block the merger of Fidelity National Financial and Stewart Information Services. The FTC alleged the merger would substantially reduce competition in state markets for commercial title insurance underwriting. On Sept. 10, Fidelity National Financial stated it would pay $50 million to Stewart Information Services to terminate their $1.2 million merger.

Ms. Rafeld stated that Ohio had a situation recently where a legitimate title company’s web presence was hijacked by a Mexican timeshare resale scam operation. They were made aware of it after a consumer went to the legitimate company’s location and was told they did not know anything. Other states are experiencing similar activity. The scam looks credible because it hijacks the corporate identity of a legitimate company from corporate registration information at the Secretary of State’s Office by altering the names of corporate officers.

Having no further business, the Title Insurance (C) Task Force adjourned.
WORKERS’ COMPENSATION (C) TASK FORCE

Workers’ Compensation (C) Task Force Dec. 9, 2019, Minutes

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The Workers’ Compensation (C) Task Force met in Austin, TX, Dec. 9, 2019. The following Task Force members participated:

John G. Franchini, Chair, and Robert Doucette (NM); Lori K. Wing-Heier, Vice Chair, and Michael Ricker (AK); Allen W. Kerr represented by William Lacy (AR); Keith Schraad represented by Erin Klug (AZ); Andrew N. Mais represented by George Bradrner (CT); Stephen C. Taylor represented by Philip Barlow (DC); Trinidad Navarro represented by Fleur McKendell (DE); David Altmaier represented by Sandra Starnes (FL); John F. King represented by Steve Manders (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Travis Grassel (IA); Robert H. Muriel represented by Mike Chrysler (IL); Vicki Schmidt represented by Heather Droge (KS); James J. Donelon represented by Warren Byrd (LA); Eric A. Cioppa represented by Sandra Darby (ME); Steve Kelley represented by Tammy Lohmann (MN); Chlora Lindley-Myers and LeAnn Cox (MO); Mike Causey represented by Fred Fuller (NC); Glen Mulready represented by Cuc Nguyen (OK); Andrew Stolfi represented by TK Keen (OR); Jessica Altman represented by Shannen Logue (PA); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Raymond G. Farmer represented by Joe Cregan (SC); Larry Deiter represented by Frank Maxwell (SD); Hodgen Mainda represented by Brian Hoffmeister (TN); Todd E. Kiser represented by Tracy Klausmeier and Reed Stringham (UT); Michael S. Pieciak represented by Kevin Gaffney (VT); and James A. Dodrill represented by Tonya Gillespie (WV). Also participating was: Peg Brown (CO).

1. **Adopted its Summer National Meeting Minutes**

Mr. Ricker made a motion, seconded by Ms. Nguyen, to adopt the Task Force’s Aug. 5 minutes (see NAIC Proceedings – Summer 2019, Workers’ Compensation (C) Task Force). The motion passed unanimously.

2. **Adopted the NAIC/IAIABC Joint (C) Working Group Report and Exposed its Draft Document on the Changing Workforce**

Mr. Byrd said the NAIC/IAIABC Joint (C) Working Group has been drafting a document regarding workers’ compensation policy and the changing workforce. The document, the *Workers’ Compensation Policy and the Changing Workforce*, includes a section regarding the changing relationships with work. This section includes information regarding transformations across the workforce and the workplace over the past century. The section addresses connections to work, including: 1) employee or independent contractor issues; 2) alternative work arrangements; 3) platform work; 4) estimates of alternative or independent work; and 5) the impact of change.

The second section of the paper discusses determining employee status and includes information regarding: 1) the federal standard; 2) state standards; 3) state employment classification; 4) state employment tests; 5) marketplace contractors; and 6) the impact of legal uncertainty of employment classification.

The final section of the paper addresses alternative coverage models, including: 1) independent contractor coverage; 2) the black car fund; 3) occupational accident insurance; 4) disability insurance; and 5) portable benefits. This section further discusses policy questions and considerations.

Mr. Byrd made a motion, seconded by Ms. Darby, to adopt the Working Group’s report, as well as to expose the draft document on the changing workforce for a 30-day comment period ending Jan. 6, 2020. The motion passed unanimously.

3. **Heard a Presentation on the Official Disability Guidelines and Formularies**

Ken Eichler (MCG Health) and Ron Bordelon (Attorney and Consultant and former Texas Commissioner of Workers’ Compensation) presented to the Task Force on official disability guidelines and formularies. Mr. Bordelon said the Texas Workers’ Compensation Commission underwent many reforms during his time as commissioner. He said there is sometimes a misunderstanding regarding how a treatment guideline and a formulary are meant to be used. A treatment guideline and a formulary are not meant to be an establishment of standards of care for medicine. They are also not a directive or dictate to medical providers and doctors on how to treat a patient. A treatment guideline and a pharmacy formulary are an accumulation of evidence that simply guide a medical treatment provider, an insurance carrier or review agents on the best and appropriate evidence that suggests a treatment or a restriction is recommended or not recommended. If a treatment or restriction is recommended, the treating physician can simply provide that treatment or prescription without fear of losing a dispute because the treatment or prescription is not medically appropriate; the evidence in the treatment guideline or in the formulary will
suggest that it is in fact recommended and appropriate. If the treatment or prescription is not recommended, the treatment or prescription will need to be preauthorized; if the doctor and insurer agree through the preauthorization process that the treatment or prescription should be provided, it will be provided without fear of dispute or reprisal. There is a dispute process available if the preauthorization is rejected.

Mr. Eichler said in workers’ compensation, an injured worker is entitled to any treatment that can be medically documented as necessary, regardless of cost. The premise is that unbiased treatment guidelines and formularies can unite payers, providers and employers to confidently and effectively return employees to health. The Centers for Disease Control and Prevention (CDC) also supports treatment guidelines, and treatment guidelines serve as tools for transparency.

One of the differences between group health and workers’ compensation is that with group health, you get what you pay for, meaning prescription benefits are cost-based and are defined and limited. With workers’ compensation, any treatment that is medically appropriate and causally related should be covered, including prescription benefits.

Mr. Bordelon said workers’ compensation is not mandatory in Texas. Texas had a number of reforms, and the treatment guidelines and formularies have by far had the largest quantifiable effect. Results of the treatment guidelines and formularies include costs decreasing, disputes being resolved more quickly, premium reduction (65%) and more employers purchasing workers’ compensation insurance.

Mr. Bordelon said the state of Texas surveys injured workers at various points in their recovery process. Survey results have shown that injured workers’ satisfaction and return to work rates have improved. The state of Texas released a report, Analysis of Injured Employee Outcomes After the Texas Pharmacy Closed Formulary, in October, which provides more detailed information regarding the survey. The report also includes information regarding treatment guidelines.

Implementation of the treatment guidelines and formularies resulted in the total number of claims receiving not-recommended drugs decreasing by 67%. The total number of not-recommended prescriptions decreased by 77%, and the total cost associated with those not-recommended drugs decreased by almost 80%. Additionally, the total number of claims receiving high levels of not-recommended opioids decreased by almost 15,000 from before the formulary went into effect to less than 500. Texas worked very closely with the medical community, resulting in a positive outcome.

The average return to work rate increased following the implementation of treatment guidelines and formularies. Additionally, mental and physical functioning scores improved. The time it took for an injured worker to access care decreased, as well as physicians being paid more quickly. The number of disputes decreased by approximately 40% and were due to a number of factors; however, most of it was due to the transparent process.

The surveys conducted from injured employees following the use of treatment guidelines and formularies indicated that almost 80% of injured employees said they had no problem receiving their prescriptions or medical treatment. An additional 10% of injured workers said problems encountered were minor. The overall result indicated that almost 90% of injured employees are reporting that they have no problem, or very little problem, obtaining the treatment or prescriptions they need.

Mr. Eichler said MCG Health provides a formulary free of charge, and there are nearly 360 different drugs listed on the formulary. The formulary lists drugs that are preferred drugs that do not require preauthorization. Preauthorization in most states takes anywhere between 24 hours to three days. The formulary allows drugs to be sorted by class so the treating physician can sort by drug class, generic prescription name or by brand name. The formulary can be used by the treating physician to educate the patient.

Mr. Eichler said National Council of Insurance Legislators (NCOIL) has been working on a formulary model law for the past year. He said the model formulary bill is being sponsored by U.S. Rep. Matt Lehman (R-IN), who is the president-elect of NCOIL. Mr. Lehman also sponsored the formulary bill in Indiana. Mr. Eichler said Indiana has a limited number of workers’ compensation staff members, so Indiana asked for a prescriptive bill. This bill rolled out with no issues. The opioid prescriptions in Indiana precluded employees from going back to work; employees were unable to go back to work if they tested positive or were prescribed any of these medications.

Mr. Eichler said the International Association of Industrial Accident Boards and Commissions (IAIABC) conducted a return to work study. This study found that incrementally, the longer a person is out of work, the less chance there is the person will return to work. The sooner a person gets treatment for an injury, the sooner he or she is able to get back to work. Additionally, many states have caps on benefits. Therefore, injured workers will become part of other state systems once they hit the workers’ compensation cap.
Mr. Eichler said data-driven medicine is a benchmark, and there has been a decrease over the past few years of evidence-based studies. This makes it important to consider data-driven medicine. In the age of technology, published studies are not necessarily needed to get information out. With quality data, as long as the data is clarified and verified, data is worth measuring.

It is important to note that more than 700,000 people died from opioid overdoses from 1999 to 2017. 68% of the 70,000 drugs involved in an overdose death involved an opioid. There are 130 Americans that die every day from an opioid overdose. There are several states where there are more prescriptions being written than there are citizens in the state. The formula for success is the appropriate diagnosis plus timely care plus appropriate care plus expedited dispute resolution minus injured workers’ frustrations equals improved outcomes.

Mr. Eichler said there needs to be a focus on functional restoration as part of a treatment option and to focus on function. Isolated treatments and medication are a small but costly and potentially dangerous piece of the treatment plan puzzle and need to be looked at like a picture within a picture, meaning the specific drug versus the alternative drug options versus the alternatives to drugs. The return to the activities of daily living (ADLs) and work are often among the best therapies.

Transparency in the rollout process is important, and stakeholder education is key to the success. Additionally, states need to compare formulary models with states having common traits.

Mr. Bordelon said results across the country are positive with respect to formularies. Mr. Byrd asked what the top arguments received for parties not wanting to adopt treatment guidelines or formularies. Mr. Bordelon said misinformation or misunderstanding of the purposes of the treatment guidelines and formularies cause the most resistance. The arguments generally say using treatment guidelines or formularies are like cookbook medicine or telling treating physicians how to treat their patients. Sometimes physicians feel the treatment guidelines and formularies get in between the physician and the patient relationship. Mr. Bordelon said this is a misunderstanding because the treatment guidelines and formularies are informing a doctor how a claim is going to be reviewed when it is being processed for payment. It is also showing the physician this process up front before the doctor provides the treatment. A doctor can still choose the way he or she wants to treat. However, the guidelines state that it is not recommended and so the carrier and the utilization review agent will be looking at this anyway, and the guidelines are providing the doctor this information. It is meant to be a tool for the doctor as well as the guideline do not tell the physician how to treat the patient; rather, it is a procedural tool.

Having no further business, the Workers’ Compensation (C) Task Force adjourned.
MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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State Licensing Handbook, Dec. 9, 2019, Draft (Attachment Four) ....................................................................................... 9-38
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Blue Cross and Blue Shield Association (BCBSA) and America’s Health Insurance Plans (AHIP) Letter Regarding Health Industry Interested Parties’ Proposed Health MCAS Blank Filing Date, Oct. 22, 2019 (Attachment Seven-B) ................................................................. 9-143
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Market Regulation Certification (D) Working Group Nov. 20, 2019, Minutes (Attachment Nine) ............................................. 9-150
Privacy Protections (D) Working Group Dec. 8, 2019, Minutes (Attachment Ten) ................................................................. 9-151

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The Market Regulation and Consumer Affairs (D) Committee met in Austin, TX, Dec. 9, 2019. The following Committee members participated: Chlora Lindley-Myers, Chair (MO); Allen W. Kerr, Vice Chair, and Russ Galbraith (AR); Trinidad Navarro represented by Frank Pyle (DE); John F. King represented by Martin Sullivan (GA); Colin M. Hayashida represented by Paul Yuen (HI); Stephen W. Robertson represented by Holly Williams-Lambert (IN); Vicki Schmidt (KS); Anita G. Fox represented by Michele Riddering (MI); Mike Causey represented by Tracy Biehn (NC); Barbara D. Richardson (NV); Kent Sullivan and Ignatius Wheeler (TX); Todd E. Kiser (UT); and Mike Kreidler and John Haworth (WA). Also participating were: Maria Ailor (AZ); Cynthia Amann (MO); Timothy Schott (ME); Bruce R. Ramge (NE); Jessica Altman (PA) and Larry Deiter (SD).

1. **Adopted its Oct. 1 Minutes**

   The Committee met Oct. 1 and took the following action: 1) adopted its Summer National Meeting minutes; and 2) appointed the Privacy Protections (D) Working Group.

   Commissioner Kerr made a motion, seconded by Mr. Haworth, to adopt the Committee’s Oct. 1 minutes (Attachment One). The motion passed unanimously.

2. **Adopted its 2020 Proposed Charges**

   Director Lindley-Myers said the Committee’s 2020 proposed charges are similar to its 2019 charges, except for some revisions to the charges of the Market Conduct Annual Statement Blanks (D) Working Group. She said the first charge of Working Group was changed to reflect that the review of Market Conduct Annual Statement (MCAS) data elements should be for the lines of business in effect longer than three years, rather than for all lines. Additionally, the reference to completing work by June 1 was deleted to reflect that the Working Group’s tasks are completed as necessary and appropriate.

   Commissioner Kerr made a motion, seconded by Mr. Haworth, to adopt the Committee’s 2020 proposed charges (see NAIC Proceedings – Fall 2019, Executive (EX) Committee and Plenary, Attachment Two). The motion passed unanimously.

3. **Adopted the Workers’ Compensation In-Force SDR and the Travel Insurance Examination Standards**

   Director Ramge said the Market Conduct Examination Standards (D) Working Group met Aug. 29 and adopted a new workers’ compensation in-force standardized data request (SDR) that will be incorporated into the reference documents of the Market Regulation Handbook.

   Director Ramge said the Working Group also met Oct. 9 and adopted new travel insurance examination standards (for inclusion in the Market Regulation Handbook). He said the examination standards were discussed during the Working Group’s May 30, June 18, July 18, Aug. 29 and Oct. 9 conference calls. He said the Working Group’s revisions to the exposure draft were drafted with input from the U.S. Travel Insurance Association (UStiA) and the American Property Casualty Insurance Association (APCIA).

   Commissioner Richardson made a motion, seconded by Commissioner Schmidt, to adopt the workers’ compensation in-force SDR (Attachment Two) and the travel insurance examination standards (Attachment Three). The motion passed unanimously.

4. **Adopted Revisions to the State Licensing Handbook and the 2019 Continuing Education Reciprocity Agreement**

   Director Deiter said the Producer Licensing (D) Task Force met Dec. 7 and adopted revisions to the State Licensing Handbook (Handbook), which was revised to be consistent with established NAIC policy on producer licensing. He said the Producer Licensing Uniformity (D) Working Group began its review of the Handbook in April 2019. He said the Working Group met six times from August through October and adopted the proposed revisions to the Handbook during its Oct. 30 conference call. The Producer Licensing (D) Task Force subsequently adopted the proposed revisions to the Handbook during its Dec. 7 meeting at the Fall National Meeting.
Director Deiter said the more significant changes to the Handbook are as follows: 1) exact language from the *Producer Licensing Model Act* (#218) was added where appropriate; 2) the appendix to the Handbook will be removed from future hardcopy versions and will be posted as a separate electronic appendix on the NAIC website; 3) the Handbook was updated to provide a link to the NAIC webpage where the most current information about the National Association of Registered Agents and Brokers (NARAB) is posted because of ongoing uncertainty about when NARAB will be formed; and 4) additional clarification was added to the licensing reciprocity examples in Chapter 4 of the Handbook.

Director Deiter said the Producer Licensing (D) Task Force also adopted the 2019 Continuing Education Reciprocity Agreement (CER Agreement) during its Dec. 7 meeting at the Fall National Meeting. He said the Uniform Education (D) Working Group drafted the CER Agreement throughout 2019 and adopted the agreement during its Oct. 31 conference call.

Director Deiter said the CER Agreement supports the use of the Uniform Continuing Education Reciprocity Course Filing Form (CER Form). He said continuing education (CE) providers may use the CER Form to streamline the course-approval process in multiple states. He noted that through the reciprocal approval process, the CE provider’s home state conducts a substantive review of the CE course; therefore, non-resident states do not need to perform a similar review for a course previously approved by the home state.

Commissioner Schmidt made a motion, seconded by Commissioner Kerr, to adopt the proposed revisions to the *State Licensing Handbook* (Attachment Four) and the 2019 CER Agreement (Attachment Five). The motion passed unanimously.

5. **Adopted its Task Force and Working Group Reports**

Director Lindley-Myers said the reports of the Committee’s task forces and working groups were circulated for this meeting. She said the Market Actions (D) Working Group met Dec. 7 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. She asked if any of the chairs of the task forces or working groups, committee members, or interested parties would like to make any comments on the reports.

a. **Advisory Organization Examination Oversight (D) Working Group**

Mr. Schott said the Advisory Organization Examination Oversight (D) Working Group issued a survey to collaborative action designees (CADs), market analysis chiefs (MACs) and market chief examiners (MCEs) concerning whether to add three new advisory organizations to be overseen by the Working Group for regularly scheduled examinations. The Working Group meets in regulator-to-regulator session pursuant to paragraph 3 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. He encouraged any state that has not yet responded to do so.

b. **Market Analysis Procedures (D) Working Group**

Mr. Haworth said the Market Analysis Procedures (D) Working Group met Dec. 8 and adopted its Nov. 21 minutes. He said that during the Nov. 21 conference call, the Working Group: 1) agreed to not include fraternals in the MCAS until a formal proposal is received for their inclusion; 2) adopted “other health” as a line of business in the MCAS; and 3) discussed a uniform process for addressing MCAS extension requests.

Mr. Haworth said that during the Working Group’s Dec. 8 meeting, it continued its discussion of adding “other health” to the MCAS and assured all interested parties that the development of the blank will be done by the Market Conduct Annual Statement Blanks (D) Working Group, and it will include state insurance regulators, carriers and consumer representatives. The goal, as always, will be to develop a blank with all the parameters and data elements fully and clearly defined.

Mr. Haworth said the Working Group also heard an update on the short-term limited duration (STLD) data call. He said a reminder letter was sent to all companies Dec. 5 reminding them of the Dec. 13 due date. He said only one filing has been received as of Dec. 7. He said the Working Group encouraged companies to complete their filings or notify NAIC staff that they do not write STLD.

Mr. Haworth said the Working Group also began work revising the MCAS Best Practices Guide and other MCAS materials in order to build consistency in how the states handle extension and waiver requests.

Finally, Mr. Haworth said the Working Group discussed its plans for meeting its 2020 proposed charges.
Samantha Burns (America’s Health Insurance Plans—AHIP) said the development of the “other health” MCAS blank will be a significant undertaking. She said AHIP has concerns about the scope of the blank and the definitions. She said even though the Market Conduct Annual Statement Blanks (D) Working Group is charged with developing the blank, it is the purview of the Market Analysis Procedures (D) Working Group to adopt the line of business before it is created. She said the Working Group should better define what is expected to be included as “other health.” By not being specific, the Working Group is setting a bad precedent.

Ms. Burns said the discussion about the other health line of business was tabled in 2018 and the Working Group focused on STLD. When discussions were renewed in November, the line of business was adopted without any discussion about what products are included in “other health.” Ms. Burns noted that packaged indemnity products were mentioned as being included in other health, but they are not packaged or sold at the carrier level. She said the MCAS would not be the best avenue for obtaining data on packaged indemnity plans. Ms. Burns said more discussion is needed, and she asked the Committee to not adopt other health as the next line of business and instruct the Working Group to continue its discussions about what is included in the line of business.

Chuck Piacentini (American Council of Life Insurers—ACLI) agreed with Ms. Burns. He said “other health” is not a common term, and if the intent is to obtain information on plans other than major medical plans, the Working Group should be more specific. There may be better methods for getting data for different types of products.

Birny Birnbaum (Center for Economic Justice—CEJ) said there was an extended discussion during the Working Group’s Dec. 8 meeting about the process for developing an MCAS blank. He said the Market Analysis Procedures (D) Working Group is charged with identifying the need for a new MCAS line of business. The Working Group did that. He said the Market Conduct Annual Statement Blanks (D) Working Group will then consider the coverages and data that will be collected in the MCAS blank. He said if the Market Conduct Annual Statement Blanks (D) Working Group decides that packaged indemnity products should not be collected in an MCAS blank, it can decide not to include them. As an example, he said the Market Conduct Annual Statement Blanks (D) Working Group eliminated coverages from both the flood insurance and lender-placed insurance MCAS blanks. He said the industry is encouraged to take part in the development of the MCAS blanks.

Commissioner Kerr agreed with Mr. Birnbaum. He said state insurance regulators need to know what is being sold in the marketplace.

Commissioner Altman also agreed and said the Working Groups should move forward with the creation of the “other health” MCAS blank.

Commissioner Richardson made a motion, seconded by Commissioner Kerr, to adopt the report of the Market Analysis Procedures (D) Working Group (Attachment Six), including the adoption of “other health” as the next line of business in the MCAS. The motion passed unanimously.

c. Market Conduct Annual Statement Blanks (D) Working Group

Ms. Ailor said the Market Conduct Annual Statement Blanks (D) Working Group did not meet at the Fall National Meeting. She said the Working Group met Oct. 23 and Nov. 21 via conference call.

Ms. Ailor said that during its Oct. 23 conference call, the Working Group heard an update on the Life and Annuity MCAS Data Element Review Project, and it decided to issue a survey to the states to determine if any data elements need to be added, deleted or revised for the homeowners and auto lines of business in the MCAS.

Ms. Ailor said that during its Nov. 21 conference call, the Working Group made two changes to due dates. She said the first change involves situations where the MCAS due date occurs on a weekend or federal holiday. She said that in that instance, the Working Group agreed that the due date will be moved to the next business day.

Ms. Ailor said the second change is to the due date for the health MCAS. She said the Working Group extended the health MCAS filing due date to June 30 for data to be reported in 2020, 2021 and 2022. She said that after three years, the due date will automatically revert to April 30 unless health companies request a re-evaluation. She said that because this is an extension of the April 30 due date, the Working Group received assurances from industry that companies would not request extensions beyond the June 30 due date except for extraordinary circumstances.
Joe Zolecki (Blue Cross Blue Shield Association—BCBSA) thanked Ms. Ailor, Ms. Dingus and the Working Group for overseeing a collaborative process to address issues raised by the health insurance industry regarding its MCAS filings.

d. Privacy Protections (D) Working Group

Ms. Amann said the Privacy Protections (D) Working Group met Dec. 8. She said the Working Group was appointed Oct. 1, noting that she is chair Ron Kreiter (OK) is vice chair. She said the Working Group is in the process of building the membership, as well as the distribution lists for interested state insurance regulators and interested parties. She the Working Group will work closely with the other working groups in this arena, such as the Artificial Intelligence (EX) Working Group and the Accelerated Underwriting (A) Working Group. She noted that each of these working groups has its unique set of issues that, nevertheless, require coordination.

Ms. Amann said that during its Dec. 8 meeting, the Working Group discussed its proposed workplan to meet every six weeks via conference call to keep on track so it can accomplish its charges by the deadline established. She said the Working Group also heard a presentation by Jennifer McAdam (NAIC) in which she reviewed: 1) the NAIC Insurance Information and Privacy Protection Model Act (#670); 2) the Privacy of Consumer Financial and Health Information Regulation (#672); 3) the European Union’s General Data Protection Regulation (GDPR); 4) the California Consumer Privacy Act (CCPA); and 5) the states’ data privacy legislation.

Ms. Amann said the Working Group also received an update from Kendall Cotton (MT) on current legislative activities in Montana. Additionally, the Working Group discussed comments received from the CEJ, the National Association of Mutual Insurance Companies (NAMIC) and the APCIA.

David Snyder (APCIA) said the Antifraud (D) Task Force summary report in the Committee materials references a BuzzFeed article bringing awareness to a potential threat claiming that an alliance between insurers and law enforcement is working against innocent consumers. He said the report says the Task Force decided to review and provide an additional update at the 2020 Spring National Meeting. He said the APCIA challenges the validity of the article and asked to participate in the review of the allegations in the article. He noted that the insurer antifraud efforts and law enforcement have cooperated to effectively protect consumers, not harm them.

Mr. Pyle said he is a member of the Antifraud (D) Task Force, and although he cannot speak for the chair, he is certain the APCIA’s participation would be welcomed by the Task Force.

Mr. Birnbaum said the CEJ is responsible for forwarding the article to the Task Force and the Market Regulation and Consumer Affairs (D) Committee chairs to illustrate the need to review the algorithms being used in antifraud efforts to be sure that they are not biased in some way. He said it was not meant to cast any aspersion of the work of antifraud entities.

Commissioner Kerr made a motion, seconded by Commissioner Kreidler, to adopt the reports of the Committee’s task forces and working groups: the Antifraud (D) Task Force, the Market Information Systems (D) Task Force; the Producer Licensing (D) Task Force; the Advisory Organization Examination Oversight (D) Working Group; the Market Actions (D) Working Group; the Market Analysis Procedures (D) Working Group; the Market Conduct Annual Statement Blanks (D) Working Group (Attachment Seven); the Market Conduct Examination Standards (D) Working Group (Attachment Eight); the Market Regulation Certification (D) Working Group (Attachment Nine); and the Privacy Protections (D) Working Group (Attachment Ten). The motion passed unanimously.

6. Discussed Updates to Best Practices and Guidelines for Consumer Information Disclosures

Director Lindley-Myers said the review of the Best Practices and Guidelines for Consumer Information Disclosures is in response to a request from the NAIC funded consumer representatives for the NAIC membership to consider best practices for consumer information disclosures. She said that in response to requests for comments prior to the Summer National Meeting and again in October, the Committee received extensive, suggested revisions from the NAIC funded consumer representatives. She said no state insurance regulators or other interested parties submitted comments.

Mr. Birnbaum said the consumer representatives provided proposed revisions to the Best Practices and Guidelines for Consumer Information Disclosures to incorporate new information on how consumers learn to make consumers disclosures more effective. He said it also highlights the work of state insurance regulators to get consumer engagement, notably Commissioner Sullivan and the Texas Department of Insurance. He said the consumer representative asks that the proposed revisions be exposed for another comment period to add additional information.
7. **Heard a Presentation on Mental Health Parity Examinations**

Joel Ario (Manatt Health), Daniel Blaney-Koen (American Medical Association—AMA) and Tim Clement (American Psychiatric Association—APA) gave a presentation to the Committee on the urgency of the state insurance departments to use their mental health and substance use disorder (MH/SUD) parity oversight authority to address the opioid epidemic in the U.S.

Mr. Blaney-Koen provided recommendations including: 1) removing prior authorization regulations for medication-assisted treatment (MAT); 2) increased oversight and enforcement of MH/SUD parity laws; 3) ensuring network adequacy for those needing treatment for opioid use disorder; 4) enhancing access to comprehensive, multi-disciplinary multimodal pain care; 5) expanding access to naloxone; and 6) evaluating the results to identify what is working, and building on the most successful efforts.

Mr. Clement said when conducting a market conduct examination regarding MH/SUD parity, examiners should not assume that a company is necessarily complying with the easiest parts of the federal Mental Health Parity and Addiction Equity Act (MHPAEA), such as defining MH/SUD, classifying benefits, or using quantitative treatment limitations and financial requirements. He said many carriers are setting non-quantitative treatment limitations, such as requiring prior authorizations on all formulations of naloxone, all inpatient MH/SUD benefits, and blanket exclusions on benefits. He also said examiners should look to see if the carrier has more stringent written processes, evidentiary standards, and triggers for utilization review. Finally, he encouraged examiners to look closely at claims to see if the company’s utilization review approvals for MH/SUD are more limited, whether MH/SUD requests are more often sent for peer review, and whether the peer reviewers are adhering to medical necessity criteria and level of care guidelines.

Commissioner Kreidler asked whether the use of blanket prior authorizations is more of an issue when a consumer changes carriers or plans, rather than when a consumer has a continuity of coverage.

Mr. Blaney-Koen said it is more common when switching plans, but it occurs in both instances.

Commissioner Kreidler also recommended that a review of the thorough study being conducted by the Washington State Office of the Insurance Commissioner to evaluate consumer access to services for MH/SUD in state-regulated individual, small group, and large group health insurance plans.

Commissioner Sullivan asked if there are tools available to consumers to help them inquire of a company about their MH/SUD parity and compare companies.

Mr. Clement said there are some resources, but they are written at too high a level. He asked Commissioner Sullivan and other members of the Committee to contact him for more information on consumer tools that are available.

Mr. Ario said some of the state insurance department websites contain useful consumer assistance.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.
The Market Regulation and Consumer Affairs (D) Committee met via conference call Oct. 1, 2019. The following Committee members participated: Chlora Lindley-Myers, Chair (MO); Allen W. Kerr, Vice Chair (AR); Trinidad Navarro represented by Frank Pyle (DE); Stephen W. Robertson represented by Holly Lambert (IN); Vicki Schmidt (KS); Anita G. Fox represented by Michele Riddering (MI); Barbara D. Richardson represented by Nick Stosic (NV); Mike Causey represented by Tracy Biehn (NC); Kent Sullivan represented by Ignatius Wheeler (TX); Todd E. Kiser represented by Tanji Northrup (UT); Michael S. Piesciak represented by Christina Rouleau (VT); and Mike Kreidler and John Haworth (WA). Also participating were: Pam Pugsley (NH); Mark McLeod (NY); Angela Dingus and Don Layson (OH); Ron Kreiter and Joel Sander (OK); Rebecca Nichols (VA); Tom Whitener (WV); and Sue Ezalarab and Jo LeDuc (WI).

1. **Adopted its Summer National Meeting Minutes**

Commissioner Kerr made a motion, seconded by Ms. Biehn, to adopt the Committee’s Aug. 5 minutes (see NAIC Proceedings – Summer 2019, Market Regulation and Consumer Affairs (D) Committee). The motion passed unanimously.

2. **Discussed the New Charge on State Insurance Privacy Protections and Appointed a New Working Group**

Director Lindley-Myers said the Innovation and Technology (EX) Task Force has a charge to monitor developments in the area of cybersecurity. During the Summer National Meeting, the Task Force received an update on cybersecurity and data privacy. Director Lindley-Myers said that cybersecurity is focused on information technology (IT) system security and that data privacy is about what insurance companies do with consumer data and how they communicate their activities to consumers. After receiving updates from NAIC staff regarding federal activity on data privacy and NAIC model laws addressing data privacy, Director Lindley-Myers said the Task Force decided it would be appropriate for the Market Regulation and Consumer Affairs (D) Committee to pursue further investigation into state insurance privacy protections and to evaluate where there may be gaps or omissions that may require some type of additional work. The Task Force referred the following charge to the Committee: “Review state insurance privacy protections regarding the collection, use and disclosure of information gathered in connection with insurance transactions, and make recommended changes, as needed, to certain NAIC models, such as the NAIC Insurance Information and Privacy Protection Model Act (#670) and the Privacy of Consumer Financial and Health Information Regulation (#672), by the 2020 Summer National Meeting.” Director Lindley-Myers said the Executive (EX) Committee and Plenary adopted this charge at the Summer National Meeting.

Director Lindley-Myers asked Jennifer McAdam (NAIC) to provide an update on the research NAIC legal staff have completed on state data privacy initiatives and the NAIC models that govern data privacy. Ms. McAdam said the NAIC has three model laws governing data privacy: 1) the Health Information Privacy Model Act (#55); 2) the NAIC Insurance Information and Privacy Protection Model Act (#670); and 3) the Privacy of Consumer Financial and Health Information Regulation (#672).

Ms. McAdam said Model #670 was the first NAIC model and was adopted in 1980. To put this into historical context, she said the federal Fair Credit Reporting Act was enacted in 1970, and this Act addresses the fairness, accuracy and privacy of the personal information contained in the files of the credit reporting agencies. Then the federal Privacy Act was enacted in 1974. This Act governs the collection, maintenance, use and dissemination of personally identifiable information about individuals that is maintained in systems of records by federal agencies. The NAIC drafted this model when those two federal laws were in place. Ms. McAdam said Model #670 sets standards for the collection, use and disclosure of information gathered in connection with insurance transactions. It requires insurers to provide notice that alerts the individual of the insurer’s information practices. It gives consumers the right to request that an insurer: 1) give access to recorded personal information; 2) disclose the identity of the third parties to whom the information disclosed the information; 3) provide the source of the collected information; 4) correct and amend the collected information; 5) amend the personal information; and 6) delete the collected personal information. Seventeen jurisdictions have adopted the model.

Ms. McAdam said the NAIC adopted Model #55 following the federal enactment of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Model #55 sets standards to protect health information from unauthorized collection, use and disclosure by requiring carriers to establish procedures for the treatment of all health information.

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Following HIPAA, Ms. McAdam said the federal Gramm-Leach-Bliley Act (GLBA) was enacted in 1999. The GLBA imposes privacy and security standards on financial institutions and directs state insurance commissioners to adopt certain data privacy and data security regulations. In response to this, Ms. McAdam said the NAIC adopted both Model #672 and the Standards for Safeguarding Customer Information Model Regulation (#673). Model #672 is about consumer privacy, and Model #673 is about data security and was used as the basis for drafting the Insurance Data Security Model Law (#668).

Ms. McAdam said data privacy and data security are often conflated, but the focus of the regulations is different. Data security regulations focus on how the information that a business collects is protected from unauthorized access once it is in the possession of the business. On the other hand, data privacy regulations focus on the consumer’s right to privacy and how companies are allowed to collect and then disclose the personal information of a consumer.

Ms. McAdam said Model #672 was intended to be enforced via a state’s unfair trade practices law. Model #672: 1) requires that insurers provide notice to consumers about its privacy policies and practices; 2) describes the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and 3) provides methods for individuals to prevent a licensee from disclosing that information—“opt out” for financial info and “opt in” for health info. The provisions governing protection of health information were taken directly from Model #55 and the health information privacy regulations promulgated by the U.S. Department of Health and Human Services (HHS) pursuant to HIPAA. The provisions governing protection of financial information are based on privacy regulations promulgated by federal banking agencies. Ms. McAdam said the key difference between the treatment of financial information and health information is that insurers must give consumers the right to “opt out” of the disclosure or sharing of their financial information, but insurers must obtain explicit consumer authorization to “opt in” prior to sharing health information. Every state has a version of this model regulation, with 19 jurisdictions having only adopted the provision regarding financial information and not the one regarding health information.

Ms. McAdam said data privacy started receiving more attention when the European Union’s (EU) General Data Protection Regulation (GDPR) became effective in May 2018. Although it is an EU law, Ms. McAdam said it affects many U.S. companies if they collect data from citizens of the EU over the internet. It requires companies to obtain explicit consent from consumers to collect their data (“opt in”), with an explanation of how the data will be used. It also contains standards for safeguarding the data. Ms. McAdam said California then became the first U.S. state to adopt an “omnibus” privacy law, which imposes broad obligations on businesses to provide consumers with transparency and control of their personal data. The California Consumer Privacy Act (CCPA) was signed into law in June 2018, amended in September 2018 and will become effective in 2020. The CCPA gives consumers the right to request that a business: 1) disclose the categories and specific pieces of personal information collected; 2) disclose categories of sources the information was collected from; 3) disclose the business purpose for collecting the information; 4) disclose the categories of third parties with whom the information is shared and the specific pieces of personal information that were shared; and 4) delete any personal information. Ms. McAdam said the CCPA also gives consumers the right to opt-out of their information being disclosed to third parties and has separate opt-in requirements for minors. In addition, there is a nondiscrimination provision that prohibits companies from discriminating against consumers who exercise their rights under the law. Finally, there is a full exemption for protected health information governed by HIPAA and a partial exemption for information subject to the GLBA.

Ms. McAdam said several states introduced similar data privacy bills during the 2019 legislative session. There were 24 states considering some type of data privacy legislation, but only three states enacted laws: Illinois, Maine and Nevada. Illinois’ law bans insurers from using genetic testing information to set health or accident rates. Maine’s law bans internet providers from selling personal information without consent. Nevada’s law requires businesses to allow consumers to opt out of any sale of their personal information. There are exemptions for entities subject to the GLBA and HIPAA. Ms. McAdam said NAIC staff created a chart listing general state data privacy laws applicable to all businesses and not specific to insurers. The chart lists: 1) the entity responsible for enforcing the law; 2) what exemptions there are, if any; 3) whether it is “opt-in” or “opt-out”; and 4) what consumer notice requirements there are.

Director Lindley-Myers asked for the circulation of the research to the Market Regulation and Consumer Affairs (D) Committee and interested parties. She asked if the Committee should address the charge or if a new Privacy Protections (D) Working Group should be appointed. Mr. Haworth questioned if the discussion would include the use of electronic disclosures. Director Lindley-Myers said this would be included but provided an example of Missouri consumers wanting hard copies of insurance documents. Because of this, she suggested the models should address both the use of the electronic and hard copy disclosures. Mr. Haworth said he supports the formation of a Working Group and suggested a more detailed list of issues to be addressed. Peter Kochenburger (University of Connecticut School of Law) suggested the working group discuss best practices for disclosures and the limitations of disclosures for consumer protection.
Commissioner Schmidt made a motion, seconded by Ms. Northrup, to appoint a Privacy Protections (D) Working Group. The motion passed. Director Lindley-Myers said Cynthia Amann (MO) would chair the Working Group unless there is interest from another state.

Birny Birnbaum (Center for Economic Justice—CEJ) said insurers are relying more on consumer, nonfinancial data from third-party vendors. In addition, Mr. Birnbaum said insurers are using consumer data generated through telematics and health monitoring devices. Mr. Birnbaum said the NAIC models should address the concept of consumer digital rights, such as whether a consumer has provided insurers the permission to have access and use this type of data.

Director Lindley-Myers said NAIC research would be shared with all parties by the end of the week and asked Mr. Birnbaum to submit written comments for consideration of the workplan. Director Lindley-Myers asked state insurance regulators to contact Tim Mullen (NAIC) if they want to be a member of the Privacy Protections (D) Working Group and asked all parties to submit comments regarding the issues that should be addressed. Director Lindley-Myers said a workplan would then be shared with the Committee by Oct. 25 for its review.

3. **Discussed Other Matters**

Director Lindley-Myers said the Committee will consider the adoption of its 2020 proposed charges in November. Draft charges will be circulated to Committee members in October and then circulated to all interested parties.

Director Lindley-Myers said the Committee will discuss the proposed revisions to the *Best Practices and Guidelines for Consumer Information Disclosures*, which were adopted in 2012. The NAIC consumer representatives provided a document with extensive revisions at the Summer National Meeting. Director Lindley-Myers asked for the submission of additional comments by Oct. 15 and said she would work with NAIC staff to revise the document for further discussion by the Committee in November.

Director Lindley-Myers said the Committee will also consider the adoption of Market Conduct Annual Statement (MCAS) disability ratios and the workers’ compensation in force standardized data request during its November conference call.

Director Lindley-Myers said Mr. Birnbaum submitted an Aug. 15, 2019, BuzzFeed article titled “Insurance Companies Are Paying Cops to Investigate Their Own Customers.” She said the article sets forth allegations of insurers’ unfair and abusive anti-fraud investigations against consumers in the settlement of homeowners and automobile claims. Mr. Birnbaum asked the Committee to review the role of third-party databases and algorithms use for claim settlement and antifraud and the revised antifraud model proposed by the Coalition Against Insurance Fraud (CAIF), which was recently adopted by National Council of Insurance Legislators (NCOIL). Director Lindley-Myers said that the Antifraud (D) Task Force would review these issues and that some preliminary thoughts would likely be shared with the Committee during its November conference call.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.
**POLICY IN FORCE STANDARDIZED DATA REQUEST**  
Property & Casualty Line of Business  
Workers Compensation

**Contents:** This file should be downloaded from company system(s) and contain one record for each workers compensation policy issued in [applicable state] which was in force at any time during the examination period.

For any fields where there are multiple entries, please repeat field as necessary.

**Uses:** Data will be used to determine if the company follows appropriate procedures with respect to the issuance and/or termination of workers compensation policies in [applicable state] within the scope of the examination.

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<td>Anniversary rating date of policy [MM/DD/YYYY]</td>
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<td>D</td>
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<td>Initial classification description for 1st covered class</td>
</tr>
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<td>Initial classification description for 1st covered class</td>
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<td>InLC</td>
<td>350</td>
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<td>Initial loss cost multiplier for 1st covered class</td>
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<td>365</td>
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<td>Initial remuneration payroll for 1st covered class Repeat Field as necessary for each additional covered class</td>
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<tr>
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<td>Loss cost multiplier Losses reported as gross (G) or net (N) Plan</td>
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<td>2</td>
<td>Losses reported on gross (G) or net (N) basis</td>
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<td>EaAccLmt</td>
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<td>10</td>
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<td>2</td>
<td>Employers liability limit for bodily injury by accident - each accident</td>
</tr>
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<td>EaEmpLmt</td>
<td>402</td>
<td>10</td>
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<td>2</td>
<td>Employers liability limit for bodily injury by accident - each employee</td>
</tr>
<tr>
<td>EaDisease</td>
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<td>Limit for bodily injury by disease - each employee</td>
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<td>2</td>
<td>Losses reported on gross (G) or net (N) basis</td>
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<td>Losses reported on gross (G) or net (N) basis</td>
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<td>SrAdm</td>
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<td>Administrative surcharge factor</td>
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<tr>
<td>SrSIF</td>
<td>472</td>
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<td>2</td>
<td>Second injury fund surcharge rate</td>
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<td>Initial amount of second injury fund surcharge</td>
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<td>A</td>
<td></td>
<td>Audit remuneration payroll for 1st covered class Repeat Field as necessary for each additional covered class</td>
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<td>Field Name</td>
<td>Start</td>
<td>Length</td>
<td>Type</td>
<td>Decimals</td>
<td>Description</td>
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<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>AuAdm</td>
<td>542</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Final administrative surcharge amount due to audit</td>
</tr>
<tr>
<td>AuSIF</td>
<td>552</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Final second injury fund amount due to audit</td>
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<td>A</td>
<td></td>
<td>Reason for exceeding the required deadline to complete the audit</td>
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<tr>
<td>AuTyp</td>
<td>572</td>
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<td>A</td>
<td></td>
<td>Type of audit (i.e., physical, mail, phone, etc.) Please provide a list of codes and their descriptions</td>
</tr>
<tr>
<td>FPrmAmt</td>
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<td>10</td>
<td>N</td>
<td>2</td>
<td>Final premium for [examination state] after audit, prior to second injury fund and administrative surcharges</td>
</tr>
<tr>
<td>PremMo</td>
<td>592</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Policy premium, including second injury fund and administrative surcharges, for [examination state] only</td>
</tr>
<tr>
<td>Par</td>
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<td>A</td>
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<td>Is the policy participating in a dividend plan? (Y/N)</td>
</tr>
<tr>
<td>DPlanCd</td>
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<td>A</td>
<td></td>
<td>Dividend plan code If codes are used, provide a list of dividend plan codes and their descriptions</td>
</tr>
<tr>
<td>DivAmt</td>
<td>613</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Dividend amount paid</td>
</tr>
<tr>
<td>CanReqDt</td>
<td>623</td>
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<td>D</td>
<td></td>
<td>Date cancellation requested, if applicable [MM/DD/YYYY]</td>
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<tr>
<td>CanTerRs</td>
<td>687</td>
<td>64</td>
<td>A</td>
<td></td>
<td>Reason for cancellation/termination of coverage (i.e., lapse, insured request, company cancellation) If codes are used, please provide a list of codes and their descriptions</td>
</tr>
<tr>
<td>CanTer</td>
<td>688</td>
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<td>A</td>
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<td>Who cancelled the coverage C=Consumer or I=Insurer</td>
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<td>CanTerDt</td>
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<td>D</td>
<td></td>
<td>Date policy cancelled/terminated [MM/DD/YYYY]</td>
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<td>CanTerNt</td>
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<td>D</td>
<td></td>
<td>Date the cancellation/termination notice was mailed [MM/DD/YYYY]</td>
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<td>PremRef</td>
<td>719</td>
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<td>2</td>
<td>Amount of premium refunded to the insured</td>
</tr>
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<td>RfndDt</td>
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<td>D</td>
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<td>Date premium refund mailed [MM/DD/YYYY]</td>
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<td>RefMthd</td>
<td>754</td>
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<td></td>
<td>Refund method (i.e., 90%, pro rata, etc) If codes are used, please provide a list of codes and their descriptions</td>
</tr>
<tr>
<td>IndLgDed</td>
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<td>A</td>
<td></td>
<td>Is the individual risk large deductible account on file with the department? (Y/N)</td>
</tr>
<tr>
<td>DedLDP</td>
<td>766</td>
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<td>A</td>
<td></td>
<td>Is the large deductible rating plan (including rates) on file with the department? (Y/N)</td>
</tr>
<tr>
<td>DtIndFil</td>
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<td>10</td>
<td>D</td>
<td></td>
<td>Date individual risk large deductible account was filed [MM/DD/YYYY]</td>
</tr>
<tr>
<td>DtLDPFil</td>
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<td>10</td>
<td>D</td>
<td></td>
<td>Date large deductible rating plan was filed [MM/DD/YYYY]</td>
</tr>
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<td>SERFFNo</td>
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<td>SERFF tracking number for large deductible rating plan (or filing number if not filed in SERFF)</td>
</tr>
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<td>SERFFNum2</td>
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<td>A</td>
<td></td>
<td>SERFF tracking number for individual large deductible account (or filing number if not filed in SERFF)</td>
</tr>
<tr>
<td>Field Name</td>
<td>Start</td>
<td>Length</td>
<td>Type</td>
<td>Decimals</td>
<td>Description</td>
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<tr>
<td>------------</td>
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<td>--------</td>
<td>------</td>
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<td>-------------</td>
</tr>
<tr>
<td>PremM</td>
<td>815</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Manual premium = [(payroll/100) * rate]</td>
</tr>
<tr>
<td>SpDs</td>
<td>825</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Supplementary disease factor</td>
</tr>
<tr>
<td>SpDsPrm</td>
<td>835</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Supplementary disease premium = [subject payroll/100) * disease rate]</td>
</tr>
<tr>
<td>USLH</td>
<td>845</td>
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<td>N</td>
<td>2</td>
<td>US Longshore and Harbor Workers (USL&amp;H) exposure non-F class codes factor</td>
</tr>
<tr>
<td>USLHPrm</td>
<td>855</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>USL&amp;H exposure non-F class codes premium = [(subject payroll/100) * (rate*USL&amp;H factor)]</td>
</tr>
<tr>
<td>TManPrm</td>
<td>865</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Total manual premium including supplementary disease and USL&amp;H exposures</td>
</tr>
<tr>
<td>WSub</td>
<td>875</td>
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<td>N</td>
<td>2</td>
<td>Waiver of subrogation factor = [% applied to portion of total manual premium where waiver is applicable]</td>
</tr>
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<td>WSubPrm</td>
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<td>N</td>
<td>2</td>
<td>Waiver of subrogation premium</td>
</tr>
<tr>
<td>ELILF</td>
<td>895</td>
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<td>N</td>
<td>2</td>
<td>Employers liability increased limits factor = [% applied to total manual premium]</td>
</tr>
<tr>
<td>ELILCh</td>
<td>905</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Employers liability increased limits charge</td>
</tr>
<tr>
<td>ELAdmF</td>
<td>915</td>
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<td>N</td>
<td>2</td>
<td>Employers liability increased limits factor (Admiralty, FELA) = [Factor applied to the portion of the manual premium where Admiralty/FELA coverage is applicable]</td>
</tr>
<tr>
<td>ELAdmCh</td>
<td>925</td>
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<td>N</td>
<td>2</td>
<td>Employers liability increased limits (Admiralty, FELA) charge</td>
</tr>
<tr>
<td>ELVCmpCh</td>
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<td>10</td>
<td>N</td>
<td>2</td>
<td>Employers liability (liability/voluntary compensation flat charge = [Coverage in monopolistic state funds])</td>
</tr>
<tr>
<td>SmDedCr</td>
<td>945</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Small deductible credit = [% applied to total manual premium]</td>
</tr>
<tr>
<td>SmDedPrm</td>
<td>955</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Small deductible credit amount of premium</td>
</tr>
<tr>
<td>LgDedCr</td>
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<td>10</td>
<td>N</td>
<td>2</td>
<td>Large deductible credit = [% applied to total manual premium]</td>
</tr>
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<td>LgDedPrm</td>
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<td>N</td>
<td>2</td>
<td>Large deductible credit amount of premium</td>
</tr>
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<td>TSubjPrm</td>
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<td>2</td>
<td>Total subject premium</td>
</tr>
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<td>Experience modification factor</td>
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<td>Experience modification premium amount (debit/credit)</td>
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<td>Total modified premium</td>
</tr>
<tr>
<td>CCPAP</td>
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<td>N</td>
<td>2</td>
<td>Contracting class premium adjustment program factor = [1-CCPAP credit %]</td>
</tr>
<tr>
<td>CCPAPPrm</td>
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<td>10</td>
<td>N</td>
<td>2</td>
<td>Contracting class premium adjustment program premium</td>
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<td>SRTFact</td>
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<td>10</td>
<td>N</td>
<td>2</td>
<td>Schedule rating factor = (1 - SR credit %) or (1 + SR debit %)</td>
</tr>
<tr>
<td>SRTPrm</td>
<td>1055</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Schedule rating premium (debit/credit)</td>
</tr>
<tr>
<td>SpDsExp</td>
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<td>2</td>
<td>Supplemental disease exposure charge (asbestos, NOC)</td>
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<td>AERadExp</td>
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<td>N</td>
<td>2</td>
<td>Atomic energy radiation exposure charge – NOC</td>
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<td>CatLoad</td>
<td>1085</td>
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<td>N</td>
<td>2</td>
<td>Charge for non-ratable catastrophe loading</td>
</tr>
<tr>
<td>AirSrch</td>
<td>1095</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Aircraft seat surcharge</td>
</tr>
<tr>
<td>MPrmSt</td>
<td>1105</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Balance to minimum premium (State Act) = [Balance to minimum premium at standard limits]</td>
</tr>
<tr>
<td>MPrmAdmF</td>
<td>1115</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Balance to minimum premium (Admiralty, FELA)</td>
</tr>
<tr>
<td>TStdPrm</td>
<td>1125</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Total standard premium for [examination state]</td>
</tr>
<tr>
<td>Field Name</td>
<td>Start</td>
<td>Length</td>
<td>Type</td>
<td>Decimals</td>
<td>Description</td>
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<td>StdPrmR</td>
<td>1135</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Standard premium for the entire policy (risk), including other states</td>
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<tr>
<td>PrmDisc</td>
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<td>N</td>
<td>2</td>
<td>Premium discount factor = % applied to standard premium</td>
</tr>
<tr>
<td>PrmDisAm</td>
<td>1155</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Premium discount amounts</td>
</tr>
<tr>
<td>CMineChg</td>
<td>1165</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Coal mine disease charge = [underground, surface, surface auger]</td>
</tr>
<tr>
<td>ExpCons</td>
<td>1175</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Expense constant charge</td>
</tr>
<tr>
<td>TerFact</td>
<td>1185</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Terrorism premium factor</td>
</tr>
<tr>
<td>TerPrm</td>
<td>1195</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Terrorism premium amount = [(Payroll/100) * [terrorism value]</td>
</tr>
<tr>
<td>RtDev</td>
<td>1205</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Additional deviation factor (outside class code exposure or schedule rating plan)</td>
</tr>
<tr>
<td>RtDevTyp</td>
<td>1215</td>
<td>10</td>
<td>A</td>
<td></td>
<td>Type or name of deviation description (outside class code exposure or schedule rating plan)</td>
</tr>
<tr>
<td>EstAnPrm</td>
<td>1225</td>
<td>10</td>
<td>N</td>
<td>2</td>
<td>Estimated annual premium as per the NCCI algorithm</td>
</tr>
<tr>
<td>EndRec</td>
<td>1226</td>
<td>1</td>
<td>A</td>
<td></td>
<td>End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.</td>
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</table>

End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.
Chapter 21A—Conducting the Property and Casualty Travel Insurance Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state’s own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a format for conducting travel insurance company examinations. Procedures for conducting property/casualty insurance company examinations and other types of specialized examinations—such as third-party administrators and surplus lines brokers—may be found in separate chapters.

The examination of travel insurance operations may involve any review of one or a combination of the following business areas:

A. Marketing and Sales
B. Producer Licensing
C. Policyholder Service
D. Underwriting and Rating
E. Claims

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the company is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.
A. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, Chapter 21—Conducting the Property and Casualty Examination, and the standards set forth below.

1. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate priority of the standard.
STANDARDS
MARKETING AND SALES

Standard 1

Ensure the advertising and/or sales materials being utilized by the limited lines travel insurance producer and travel insurer (i) provide the information required by Section 4(C) of the model law [or state equivalent], (ii) are consistent with the travel protection plan being offered, (iii) are not deceptive or misleading, and (iv) otherwise comply with state law.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ The travel insurer’s approved brochures or other written materials used in offering or disseminating travel insurance to prospective purchasers.

_____ Policy forms and fulfillment materials are accurately represented in advertising and sales materials

_____ Producers’ own advertising and sales materials, including travel retailers under the direction of a limited lines travel insurance producer

NAIC Model References

Travel Insurance Model Act (#632)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Examiners should request a listing of all marketing materials and select a sample according to the jurisdiction’s sampling protocols. If the examiner is unable to obtain the requested information from the travel insurer or the limited lines travel insurance producer, the examiner may request the information directly from the travel retailer.

Review specimen or actual copies of all of the brochures or other written materials in conjunction with the appropriate policy forms, endorsements, policies, rate filings, and certificates of insurance.

Materials should not:

• Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous; and

• Make false, deceptive or misleading statements or representations with respect to any person, company or organization
Materials should:

- Clearly disclose name and address of insurer;
- If using a trade name, disclose the name of the insurer, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer, or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Clearly describe the type of policy being advertised;
- Indicate that the travel protection plan being marketed is insurance; and
- Comply with applicable statutes, rules and regulations.

Determine if the travel insurer approves producer sales materials and advertising.
STANDARDS
MARKETING AND SALES

<table>
<thead>
<tr>
<th>Standard 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The disclosures combinations of travel insurance, non-insurance travel assistance services, and cancellation fee waivers are compliant with applicable statutes, rules, and regulations.</td>
</tr>
</tbody>
</table>

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy forms and fulfillment materials are accurately represented in advertising and sales materials

_____ Producers’ own advertising and sales materials and travel retailers acting under the direction of a Limited lines travel insurance producer

NAIC Model References

*Travel Insurance Model Act (#632)*
*Unfair Trade Practices Act (#880)*

Review Procedures and Criteria

Examiners should request information from the travel insurer or limited lines travel insurance producer that is sufficient to determine compliance with this standard. If the examiner is unable to obtain the information from the travel insurer or the limited lines travel insurance producer, the examiner may request the information directly from the travel retailer.
STANDARDS
MARKETING AND SALES

Standard 3
The limited lines travel insurance producer has established and maintains a register of each travel retailer
that offers travel insurance on the producer’s behalf.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria
STANDARDS
MARKETING AND SALES

| Standard 4 | The limited lines travel insurance producer has documentation sufficient to demonstrate compliance that the travel retailers (acting under the limited lines travel insurance producer’s license) comply with 18 USC § 1033. |

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria
STANDARDS
MARKETING AND SALES

Standard 5
Determine that consumers were provided with information and an opportunity to learn more about the pre-existing condition exclusions (i) at any time prior to the purchase and (ii) in the fulfillment materials.

Apply to: All property and casualty travel insurance products
Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations
_____ Policy form, fulfillment materials, advertising/sales materials, and disclosures

Others Reviewed

_____ _________________________________________
_____ _________________________________________

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

Determine that information about pre-existing condition exclusions is provided prior to the time of purchase, including whether the purchaser of travel insurance (i) has the ability to waive the pre-existing condition exclusion, (ii) under what circumstances it can be waived; and (iii) the purchaser of travel insurance has been advised that the coverage for pre-existing conditions can be purchased, if applicable.

Determine that the fulfillment materials provide information about pre-existing condition exclusions

Determine that the policies or certificates and fulfillment materials clearly define pre-existing conditions as intended in the exclusions
Standard 6  
Determine that descriptions of the following are provided to the purchasers of travel insurance: (i) material or actual terms of the insurance coverage, (ii) process for filing a claim, (iii) review or cancellation process for the travel insurance policy, and (iv) the identity and contact information of the travel insurer and limited lines travel insurance producer.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

*Travel Insurance Model Act (#632)*
*Unfair Trade Practices Act (#880)*

Review Procedures and Criteria

Examiners should request information from the travel insurer or limited lines travel insurance producer that is sufficient to determine compliance with this standard. If the examiner is unable to obtain the information from the travel insurer or the limited lines travel insurance producer, the examiner may request the information directly from the travel retailer.
STANDARDS
MARKETING AND SALES

Standard 7
The limited lines travel insurance producer has an adequate training program in place, containing
instructions on the types of insurance offered, ethical sales practices, and required consumer disclosures,
that is required of each employee and authorized representative of the travel retailer whose duties shall
include offering and disseminating travel insurance.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Limited lines travel insurance producer’s policies and procedures, including the standards for product training

_____ Limited lines travel insurance producer’s instruction/training files and training materials for travel retailer employees and authorized representatives offering or disseminating travel insurance

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

Review policies and procedures to ensure that the limited lines travel insurance producer has adequate procedures in place to provide instruction and training that is appropriate for and consistent with the type(s) of travel insurance being offered. Review the limited lines travel insurance producer’s procedures used to inform travel retailers of the regulated entity’s standards for travel insurance product training and of applicable state statutes, rules or regulations regarding the solicitation and sale of travel insurance products.

Determine that the limited lines travel insurance producer has adequate procedures in place to verify that the employees and authorized representatives of a travel retailer have completed necessary training, as required by applicable state statutes, rules and regulations, before allowing the employees and authorized representatives to sell travel insurance for that insurer.

Contact other regulators that may have conducted a recent review of the training standards.

Determine if the training materials are appropriate and accurately reflect the coverage provided by the travel insurance product.

Review regulated entity’s records to determine if, when and how training occurred prior to the employees or authorized representatives of a travel retailer’s recommendation of a travel insurance product.
Standard 8
The Limited lines travel insurance producer has designated a “Designated Responsible Producer.”

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria
### STANDARD
### MARKETING AND SALES

<table>
<thead>
<tr>
<th>Standard 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sales practices do not include “negative option or opt out”.</td>
</tr>
</tbody>
</table>

**Apply to:** All property and casualty travel insurance products

**Priority:** Essential

**Documents to be Reviewed**

- Applicable statutes, rules and regulations
- Sales and marketing

**Others Reviewed**

- _________________________________________
- _________________________________________

**NAIC Model References**

*Travel Insurance Model Act (#632)*
*Unfair Trade Practices Act (#880)*

**Review Procedures and Criteria**

Review a sampling of marketing materials and policies to confirm that customers were not offered or sold a policy through negative option or opt out.
STANDARDS
MARKETING AND SALES

Standard 10
Blanket coverage is not marketed or described as “free” coverage.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

Review the use of the words/phrases “free,” “no cost,” “without cost,” “no additional cost,” “at no extra cost” or words/phrases of similar import. Such words/phrases should not be used with respect to any benefit or service being made available with a policy, unless true.
STANDARD MARKETING AND SALES

Standard 11
If the aggregator’s website provides a short summary of the coverage, determine that the consumer has access to the full provisions of the policy by electronic means.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ ________________________________

_____ ________________________________

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria
B. **Producer Licensing**

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, Chapter 21—Conducting the Property and Casualty Examination, and the standards set forth below.
STANDARD
PRODUCER LICENSING

Standard 1
Determine that the travel insurer or limited lines travel insurance producer has provided the information required in Section 4(B)(1) [or state equivalent] to the purchasers of travel insurance.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Travel Insurance Model Act (#632)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Determine if the requested coverage is issued.

Examiners should request proof from the travel insurer or limited lines travel insurance producer sufficient to demonstrate that the actual information was provided. If the examiner is unable to obtain proof from the travel insurer or the limited lines travel insurance producer, the examiner may request the information directly from the travel retailer.
C. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, Chapter 21—Conducting the Property and Casualty Examination, and the standards set forth below.
STANDARD POLICYHOLDER SERVICE

Standard 1
Fulfillment materials were provided to the policyholder or certificateholder as required.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All applications

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

*Travel Insurance Model Act (#632)*
*Unfair Trade Practices Act (#880)*

Review Procedures and Criteria

Examiners should request documentation from the travel insurer or limited lines travel insurance producer that is sufficient to demonstrate that the fulfillment documents were provided to the purchasers of travel insurance.
STANDARD POLICYHOLDER SERVICE

Standard 2
The policy documents disclosed whether the travel insurance was primary or secondary to other coverage.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All applications

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

Examiners should request documentation from the travel insurer or limited lines travel insurance producer that is sufficient to demonstrate that the policy documents state whether the coverage provided is primary or secondary to other coverage.
D. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, Chapter 21—Conducting the Property and Casualty Examination, and the standards set forth below.
### STANDARD
**UNDERWRITING AND RATING**

<table>
<thead>
<tr>
<th>Standard 1</th>
</tr>
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<tbody>
<tr>
<td>Minimum data collection standards to ensure proper allocation for payment of premium tax have been established.</td>
</tr>
</tbody>
</table>

**Apply to:**
All property and casualty travel insurance products

**Priority:**
Essential

**Documents to be Reviewed**

- [ ] Applicable statutes, rules and regulations
- [ ] All applications

**Others Reviewed**

- [ ]

**NAIC Model References**

*Travel Insurance Model Act (#632)*

**Review Procedures and Criteria**
E. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, Chapter 21—Conducting the Property and Casualty Examination, and the standards set forth below.
STANDARD CLAIMS

Standard 1
The policies issued contain benefits for which a claim and claim payment could have been made.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

____ Applicable statutes, rules and regulations
____ Review policy forms and endorsements
____ Claim files
____ Claim complaint records
____ Claim procedure/underwriting manuals

NAIC Model References

Travel Insurance Model Act (#632)
Unfair Trade Practices Act (#880)
Unfair Property/Casualty Claims Settlement Practices Act (#902)

Review Procedures and Criteria

To determine compliance with this requirement, examiners will (i) review a sample set of policies to confirm that benefits are being offered under the policies issued and a payment for a claim could have been made; and (ii) review a sample of denied claims to confirm that the denials were appropriate based on the policy language.
Chapter 1

Modern Producer Licensing

The process for licensing insurance producers has had numerous phases. The first NAIC model on this subject was the NAIC Agent and Broker Model. The next phase was the NAIC Single License Procedure Model. Although development of the newest model began in the late 1990s, it was Congress’ passage of the GLBA in 1999 that caused the NAIC to speed the development of the PLMA Producer Licensing Model Act.

Uniformity Provisions of the Gramm Leach Bliley Act Adopted in 1999

In order to achieve the licensing uniformity standards of GLBA, a majority of states had to satisfy all five of the following requirements:

1. Adoption of uniform criteria regarding a producer’s integrity, personal qualifications, education, training and experience, which must include qualification and training on suitability of products for a prospective customer.
2. Adoption of uniform continuing education (CE) requirements.
3. Adoption of uniform ethics course requirements in conjunction with other CE requirements.
4. Adoption of uniform suitability requirements based on financial information submitted by the customer.
5. Elimination of nonresident requirements posing any limitation or condition because of the place of the producer’s residence or business, except for countersignature requirements.

One of the major provisions of the GLBA was a provision to create NARAB. While much progress was made to improve uniformity and streamline nonresident producer licensing, the NAIC endorsed the provisions of Terrorism Risk Insurance Program Reauthorization Act of 2015 (Public Law 107-297), which modified NARAB. These provisions, commonly referred to as NARAB II, were signed by President Barack Obama on Jan. 12, 2015. At the time of the publication of this handbook, NARAB has not been completed for additional updated information please see the NAIC link. (https://content.naic.org/cipr_topics/topic_producer_licensing.htm)

NARAB II is intended to streamline the nonresident producer licensing process while preserving the states’ ability to protect consumers and regulate producer conduct. NARAB II does not create a federal insurance regulator but establishes a nonprofit corporation, known as NARAB, controlled by its board of directors. The stated purpose of the legislation is to provide “a mechanism through which licensing, CE, and other nonresident insurance producer qualification requirements and conditions may be adopted and applied on a multistate basis without affecting the laws, rules and regulations, and preserving the rights of a state pertaining to certain specific producer-related conduct.”

NARAB is to be governed by a 13-member governing board comprised of eight state insurance commissioners and five insurance industry representatives subject to presidential appointment and Senate confirmation. NARAB, acting through its board of directors, will establish membership criteria through which producers can obtain nonresident authority to sell, solicit or negotiate insurance. Satisfaction of membership criteria means a producer can sell, solicit or negotiate insurance (and perform incidental activities) in any state for which a producer pays that state’s licensing fee for any line(s) of insurance for which the producer is licensed in the home state. NARAB membership is not mandatory for producers.

The law preserves the rights of a state pertaining to resident licensing and CE, supervision and enforcement of conduct, and disciplinary actions for nonresident producers, and leaves intact a state’s full range of authorities for resident producers. The PLMA also includes important disclosures to the states, addresses business entity licensing and protects state revenues.

Through the efforts of the Producer Licensing (DEX) Task Force and the its Producer Licensing (EX) Working Group, the NAIC monitors state compliance with reciprocity guidelines. The NAIC also set a goal to create uniform licensing practices. The Producer Licensing (DEX) Working Group Task Force has adopted a number of Uniform Licensing Standards and guidelines, and continues to strive toward a more efficient licensing system among the states.
National Insurance Producer Registry

The NAIC has long advocated for increased use of technology to streamline licensing processes. In 1996, the NAIC collaborated with industry to create the Insurance Regulatory Information Network (IRIN) as a nonprofit affiliate of the NAIC. In 1999, the organization changed its name to the National Insurance Producer Registry (NIPR). The purpose of the NIPR is to work with the states and the NAIC to re-engineer, streamline and make more uniform the producer licensing process for the benefit of insurance regulators, the insurance industry and consumers. The NIPR worked with the NAIC to develop and implement: 1) the Producer Database (PDB), which includes licensing information from 50 states, the District of Columbia and three U.S. territories, utilized by the industry for licensing and appointment information; and 2) the State Producer Licensing Database (SPLD) for use by insurance regulators.

States use the NIPR to link state insurance departments with the entities they regulate. Applicants and licensees can transmit licensing applications, insurers can transmit appointments and terminations, and both can transmit other information to insurance regulators in multiple states, thereby creating electronic solutions that are easy and efficient to use by the states and industry.

Additionally, using the subsequent launch of the Attachment Warehouse, an applicant who answers “yes” to any background question on the NAIC Uniform application can submit the required supporting documentation at the time he or she is applying for or renewing a license. The submission of a document to the Attachment Warehouse will trigger an email alert to the appropriate state(s) notifying the state(s) that supporting documentation has been submitted to fulfill document requirements pertaining to the “yes” answer on the background. The advantage to the producer and the state(s) is that the documentation can be sent to the Attachment Warehouse once, and all appropriate states will be notified and have the ability to view, download or print the document. The Attachment Warehouse also allows a producer to meet the requirement from the states to report and submit documentation related to any regulatory action taken against him/her. This enables the producer to meet this regulatory obligation quickly in order to comply with the typical state requirement for producers to report an action within 30 days. Through the use of the Attachment Warehouse, all states in which the producer is licensed are notified with an email alert and have access to the document.

A complete list of jurisdictions using NIPR products and services is available at www.nipr.com. The website has an updated list of the states that are making active use of NIPR electronic processing. (Product List by State)
Chapter 2

Producer Licensing Model Act

Uniformity Provisions of the Producer Licensing Model Act

Through the PLMA, the NAIC created a system of reciprocity for producer licensing and also established uniform standards in key areas of producer licensing. The PLMA was initially adopted in January 2000. It was subsequently amended in October 2000 and in January 2005.

In December 2002, the Producer Licensing (EX) Working Group adopted a set of Uniform Resident Licensing Standards (URLS). In December 2008, the standards were revised and updated to incorporate standardization and uniformity for both resident and nonresident licensing. The standards were, therefore, renamed the ULS. The PLMA and the ULS are designed to complement each other and assist the states in creating a uniform system of producer licensing. In 2008, the Producer Licensing (EX) Working Group was charged with reviewing the ULS. Subsequent revisions were made to the ULS in August 2010 (limited lines definitions) and in August 2011 (definitions for certain non-core limited lines). The revised standards are included in the Appendix, and updates can be found on the Producer Licensing (EX) Working Group's State Licensing Handbook web page on the NAIC website. (https://content.naic.org/state_licensing_handbook.htm)

The key uniformity provisions of the PLMA are:

1. Definitions for “negotiate,” “sell” and “solicit,” and uniform exceptions to licensing requirements.
2. An application process for both resident and nonresident producer license applications that uses the NAIC Uniform Application for resident and nonresident producers.
3. Definitions for the six major lines of insurance: Life, Accident and Health or Sickness, Property, Casualty, Personal Lines, and Variable Life or Annuity Products.
4. Exemptions from completing prelicensing education and examinations for licensed producers who apply for nonresident licenses.
5. Standards for license denials, non-renewals and revocations.
6. Standards regarding which individual producers and business entities may receive a commission related to the sale of an insurance policy.
7. Standards for producer appointments for states that have an appointment system.
8. Procedures for insurance regulators, companies and producers to report and administratively resolve “not for cause” and “for cause” appointment terminations.
9. A definition for limited lines insurance. The Producer Licensing (EX) Working Group has adopted a recommended list of limited lines licenses, as set forth in the ULS, and has encouraged states to eliminate licensing categories for other lines of insurance.

Other Key Provisions of the Producer Licensing Model Act

The PLMA also contains a number of provisions that promote simplified licensing procedures.

Home State

The intent of the PLMA is for a producer to have one state of residence. Section 2(B) of the PLMA defines this concept as the home state:

“Home state” means the District of Columbia and any state or territory of the United States in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer.”

A producer is permitted to designate either the actual state of residence or the principal place of business as the home state. The PLMA does not specifically prohibit the existence of two home state licenses. The producer may select either the resident state or the principal place of business. This option was intended to accommodate a producer who lives in one state but maintains his or her business in another state. However, it was the intent of the drafters for one state to be designated as the home state to prevent forum shopping. The Producer Licensing (DEX) Working Group has discouraged any state from adopting a stance that a producer can maintain two home states.
Change of Home State

Under the PLMA, there is now a simplified process for producers who move from state to state and were in good standing prior to the change of residence.

Section 9 of the PLMA provides a mechanism for licensed producers to maintain an active license when changing the state of residence. Section 9(A) creates an exemption from prelicensing education or examination for a producer who moves into a state who was previously licensed for the same lines of authority in another state. In this scenario, the producer receives a new resident license for the same lines of authority, so long as the producer applies for a resident license within 90 days of the cancellation of the producer’s previous license and the producer was in good standing in the prior state.

Section 9(B) creates an exemption from prelicensing education or examination for a line of authority held by a former nonresident producer who moves into a state and becomes a resident of that state. In practice, when a nonresident becomes a resident, that producer is to be granted the same lines of authority previously held, so long as the producer applies for a resident license within 90 days of establishing legal residence. States are not to impose prelicensing education or an examination on a nonresident producer who subsequently moves into another state and declares it to be the home state, unless “the commissioner has determined otherwise by regulation.”

Under the PLMA, letters of certification were eliminated as a prerequisite to granting a nonresident license. The SPLD provides verification of good standing in the producer’s home state.

One unresolved issue is the long-established practice of requiring a letter of clearance for producers changing their resident state. Despite the fact that the PLMA does not contain any reference to a letter of clearance, some states still require the producer to provide a letter of clearance from the former state before the new state will grant the producer an active resident status. Other states grant the new nonresident license but continue to monitor the producer’s record to make sure that the prior resident license changes in status from resident to nonresident. This is done to prevent the producer from holding two active resident licenses.

The Producer Licensing (EX) Working Group and NIPR have identified this as an issue that could best be resolved by the establishment of an electronic method for the producer to communicate the desired changes to all affected states in one transaction. NIPR’s launch of the Contact Change Request (CCR) service allows producers for many states to change their physical addresses, email addresses, phone numbers and fax numbers. The Producer Licensing (EX) Working Group will turn its attention to solving the issues surrounding a change of resident state once all states have fully implemented the CCR service.

Commissioner Discretion

The PLMA contains language that allows a state to adopt regulations to cover a state-specific situation. States should carefully consider the impact that deviation from the PLMA might have on NAIC uniformity and reciprocity initiatives.

Section-by-Section Summary of the Producer Licensing Model Act

The full text of the PLMA is in the Appendices.

Section 1: Purpose and Scope

- To promote efficiency and uniformity in producer licensing.

Section 2: Definitions

- Defines the terms “home state,” “limited lines insurance,” “sell,” “solicit,” “negotiate” and other pertinent terms.

Section 3: License Required

Section 4: Exceptions to Licensing

- Lists the persons and entities that do not need licenses, even though they participate in the insurance industry.
Section 5: Application for Examination

- Requires that producers must pass an examination in the lines of authority for which application is made.
- Allows use of outside testing services to administer examinations.

Section 6: Application for License

- Sets forth the qualifications for licensure as an individual or business entity.
- Provides that limited line credit insurers must provide instruction to individuals who will sell credit insurance.

Section 7: License

- Sets forth the six major lines of authority, the limited line of credit insurance and any other line of insurance permitted under state laws or regulations.
- Provides guidelines for license continuation and reinstatement.
- Provides for hardship exemptions for failure to comply with renewal procedures.
- Lists the information the license should contain.
- Requires licensees to notify the insurance commissioner of a legal change of name or address within thirty (30) days of the change.

Section 8: Nonresident Licensing

- Requires states to grant nonresident licenses to persons from reciprocal states for all lines of authority held, including limited lines and surplus lines insurance, if those persons are currently licensed and in good standing in their home states.
- Requires a nonresident licensee who moves from one state to another to file a change of address and certification from the new resident state within thirty (30) days with no fee or application.

Section 9: Exemption from Examination

- Exempts licensed individuals who change their home state from prelicensing and examination.
- Requires a licensed nonresident who becomes a resident to register in the new home state within ninety (90) days of establishing legal residence, unless “the commissioner determines otherwise by regulation.”

Section 10: Assumed Names

- Requires a producer to notify the insurance commissioner prior to using an assumed name.

Section 11: Temporary Licensing

- Allows temporary licensure for up to 180 days without requiring an exam when the insurance commissioner deems that the temporary license is necessary for the servicing of an insurance business in specific cases.

Section 12: License Denial, Non-renewal or Revocation

- Lists 14 grounds for denial, non-renewal or revocation of a producer license.
• Provides that a business entity license may be revoked if an individual licensee’s violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation, and the violation was not reported to the insurance commissioner nor was corrective action taken.

Section 13: Commissions

• Prohibits payment of commissions or other compensation to or acceptance by an unlicensed person for “selling, soliciting or negotiating” insurance.

• Allows payment of renewal commissions to an unlicensed person if the person was licensed at the time of the sale, solicitation or negotiation.

• Permits payment or assignment of commissions or other compensation to an insurance agency or to persons who do not sell, solicit or negotiate, unless the payment would violate rebate provisions.

Section 14: Appointments (optional)

• Prohibits a producer from acting as a producer for an insurer unless appointed. The insurer appoints the producer either within 15 days from the date the agency contract is executed or within 15 days from the date that the first insurance application is submitted.

• Sets forth processes for initial and renewal appointments.

Section 15: Notification to the Insurance Commissioner of Termination

• Requires the insurer to notify the insurance commissioner within 30 days following the effective date of termination of a producer’s appointment, if the termination is for cause. The insurer also has a duty to promptly notify the insurance commissioner of any new facts learned after the termination. When requested by the insurance commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the producer.

• If termination of a producer is not for cause, the insurer must notify the insurance commissioner within 30 days following the effective date of termination.

• Sets forth a detailed process for notifying the producer and for a producer to submit comments to the state.

• Provides that in the absence of actual malice, insurers have immunity from any actions that result from providing information required by or provided pursuant to this section.

• Contains penalties for insurers who fail to report or who report with actual malice.

• Requires that documents furnished to the insurance commissioner pursuant to this section shall be confidential and privileged.

Section 16: Reciprocity

• A state cannot impose additional requirements on nonresident license applicants who are licensed in good standing in their home state other than the requirements imposed by Section 8 of the PLMA, if the applicant’s home state grants nonresident producer licenses on the same basis.

• A nonresident’s satisfaction of CE in the producer’s home state shall constitute satisfaction of all CE requirements in the nonresident state, if the home state practices CE reciprocity. A nonresident producer’s satisfaction of his or her home state’s continuing education requirements for licensed insurance producers shall constitute satisfaction of this state’s continuing education requirements if the non-resident producer’s home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this state on the same basis.”

Section 17: Reporting of Actions (By Producers)

• A producer must report any administrative actions taken in another jurisdiction or by another government agency in the home jurisdiction within thirty (30) days of the final disposition of the matter.
• A producer shall report any criminal prosecution taken in any jurisdiction within 30 days of the initial pretrial hearing date. The report must include the legal order, relevant court documents and the original complaint.

Section 18: Compensation Disclosure

• In any instance when a producer will receive compensation from a customer for placing an insurance policy and also will receive compensation from an insurer for that placement, prior to placing that policy, the producer is required to disclose to the customer the amount and sources of compensation the producer will receive, if the customer makes an insurance purchase.

Section 19: Regulations

• The insurance commissioner may promulgate reasonable regulations to carry out the purposes of the PLMA.

Section 20: Severability

Section 21: Effective Date

Frequently Asked Questions

The Producer Licensing (EX) Working Group has created several documents that answer frequently asked questions (FAQ) about reciprocity, uniformity and how to administer the PLMA. The current version of the FAQ as of the publication date appears below. The latest version of these documents can be found on the State Licensing Handbook webpage under the appendix section. The latest version of these documents can be found on the Producer Licensing (EX) Working Group’s web page on the NAIC website.

PLMA Implementation - FAQ

This document has been prepared by the NAIC’s Producer Licensing (D) Working Group for informational purposes only. The following questions and answers are based upon the language of the PLMA. This document is not intended as legislative history or to replace a state insurance department’s independent review and analysis of these questions. The contents of this document should not be interpreted as representing the views or opinions of the NAIC or of any individual NAIC member or state insurance department.

Question 1: Is Section 14 of the PLMA regarding appointments, which is labeled “optional,” intended to be optional for adoption by a state that requires insurer appointments of producers?

Answer 1: No. If a state requires appointments, it should adopt Section 14. It was labeled “optional” only to accommodate those states that do not require appointments—e.g., Colorado.

Question 2: PLMA Section 14B starts a clock of 15 days for insurer compliance by providing that “the appointing insurer shall file … within 15 days from the date the agency contract is executed or the first insurance application is submitted” (emphasis added). When is an application deemed “submitted”?

Answer 2: An application is submitted when it is dated received by the insurer. The use of any other event will undermine the ability of the states and insurers to achieve uniform national practice for regulatory notifications. This is because any other temporal event is unknown to the insurer, which has the compliance responsibility. That is, “submitted” should not mean when a producer mails an application, since different producers might use different means of communicating applications; different producers will mail applications at different times; mail pick-up and delivery varies among localities, etc. The one certain time of submission is when the application is dated received by the insurer.

Question 3: If a state adopts PLMA Section 14, is there an option for the state to require an insurer to execute an agency contract with a producer prior to accepting the first insurance application from a producer that has not yet been appointed?

Answer 3: No. PLMA Section 14B provides that “the appointing insurer shall file, in a format approved by the insurance commissioner, a notice of appointment within 15 days from the date the agency contract is executed or the first insurance application is submitted” (emphasis added). The use of the word “or” in the model act clearly allows an insurer to notice
appointment upon the earliest of the two events. Pennsylvania has adopted modified language and is not in complete agreement with this answer.

**Question 4:** Since the PLMA works toward uniform national procedures by eliminating the traditional distinctions between agents and brokers for purposes of licensure, is it appropriate to require appointments of producers acting as brokers?

**Answer 4:** No. PLMA Section 14A makes clear that an insurer need only appoint producers “acting as agents on behalf of the insurer.” Inasmuch as brokers are not appointed, notification of appointments of brokers is not required.

**Question 5:** Must a business entity reside in a state to obtain a producer license?

**Answer 5:** No. Section 8 outlines the requirements that a person must fulfill in order to obtain a nonresident license, and the definition of “person” (see PLMA §2L) makes clear that this section applies to the licensing of both individuals and business entities. Section 8 is devoid of any residency requirement, and a nonresident business entity should be able to obtain a nonresident producer license if business entities are required to be licensed by the insurance department at all. In addition, states that impose residency requirements on business entities are likely not compliant with National Archives and Records Administration (NARA) provisions of the GLBA.

**Question 6:** Should the record of producer qualifications obtainable from the NIPR SPLD satisfy all certification requirements for state licensing?

**Answer 6:** Yes. PLMA Section 7G, Section 8B and Section 9 make clear that states should adopt and use the SPLD record for all regulatory purposes.

**Question 7:** Should a state require that a resident be licensed as a producer if he or she is entitled to renewal or other deferred commissions produced in another state?

**Answer 7:** No. PLMA Section 3 and Section 13C indicate that a producer license is required to sell, solicit or negotiate the sale of insurance, but do not suggest that a license is needed after such activity has ceased. The person’s receipt of renewal or other deferred commissions does not result in any licensing requirement.

**Question 8:** Are insurers alone responsible for educating those persons who sell limited lines credit insurance products?

**Answer 8:** Yes. PLMA Section 6D requires such insurers to furnish the program of instruction to those who sell limited lines insurance. The program is filed with the insurance commissioner in most states.

**Question 9:** Does reciprocity pursuant to Section 8 of the PLMA require recognition of a nonresident line of authority when the state in which the nonresident license is sought does not recognize a line of authority for resident producers?

**Answer 9:** Yes. For example, the reciprocity mandates of Section 8E should be respected for a limited line of authority, as is the case with any other line of authority. Consequently, states should be prepared to recognize the authority on a nonresident basis.

**Question 10:** What process is to be followed by a producer in identifying a new “home state” without the loss of his or her license to do business in the prior home state?

**Answer 10:** The producer should notify the prior home state of his or her change of address and intent to apply for a resident license in the new home state. The producer must apply for resident license in his or her new home state. Pursuant to Section 9 of the PLMA, the producer or applicant is not required to complete any prelicensing education or examination in order to secure the new resident license.

**Question 11:** What process is to be followed by the new home state insurance regulator with regard to a producer changing his or her state of residency?

**Answer 11:** The new home state should process the producer’s application, issue a resident license if warranted and, if issued, notify the SPLD of the producer’s new status as a resident licensee.
Question 12: What is the process to be followed by the prior home state insurance regulator?

Answer 12: At the time the producer notifies the prior home state insurance regulator of a change of address, the prior home state insurance regulator should send to the SPLD a report of “active with notice of transfer of residency to [the new home state],” identifying the new state of residency. Upon PDB notification of the new resident state licensure, the prior home state resident license is replaced with a nonresident license for the duration of its term. It is noted that time frames for notice to the states of a change in address are stated in the PLMA.

Question 13: If a commission is paid to enroll a customer in a group credit insurance policy, must the enroller be licensed?

Answer 13: Yes. An individual who enrolls customers under a group insurance policy must obtain a limited lines license if a commission is paid. PLMA Section 4B(2) provides an exception from licensing if no commission is paid to the enroller and the enroller does not engage in selling, soliciting or negotiating.

Question 14: May an individual sell, solicit or negotiate group credit insurance coverage without a license?

Answer 14: No. An individual must have a limited lines license before he or she can sell, solicit or negotiate the purchase of group insurance. While PLMA Section 4B(2) provides an exception for securing and furnishing information in connection with group insurance coverage, there is no such exception from licensing for selling, soliciting or negotiating group insurance coverage.

Question 15: Can a person enrolling someone in a group insurance policy secure and furnish information about the policy to a customer and still be exempt from licensure?

Answer 15: Yes. As set forth in Section 4B(2) of the PLMA, there is an exception that allows a group enroller to secure and furnish information about the group insurance policy to a customer, provided no commission is paid or there is no selling, solicitation or negotiation. However, Section 4B(2) generally recognizes an exception for purposes of enrolling individuals under plans, issuing certificates under plans, assisting with the administration of plans, and performing administrative services related to the mass marketing of property/casualty (P/C) insurance.

Note: It is important to note that individual state laws and factual circumstances will control in determining whether an activity involves selling, solicitation or negotiation. Likewise, the states will have discretion in interpreting what activities constitute the “securing or furnishing” of information.

Question 16: With regard to products sold by life insurers, does the qualification in the PLMA that a person shall not sell, solicit or negotiate insurance “in this state” without a license mean that the producer must be licensed in the state(s) where the: 1) sale, solicitation or negotiation occurs; or 2) policyholder principally resides?

Answer 16: In those states that have adopted the PLMA, licensure should be based upon where a producer “sells, solicits or negotiates” insurance, as specifically stated in the PLMA. In traditional insurance sales transactions, licensure should be determined solely by this PLMA standard without reference to the state of residence of the insured. Application of the “sells, solicits or negotiates” standard where an insurance transaction takes place purely by electronic or telephonic means is more complex. In such transactions, application of the PLMA licensure standard should turn on the state of residence of the customer.

Question 17: Section 14B of the PLMA states: “To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the insurance commissioner, a notice of appointment within 15 days from the date the agency contract is executed or the first insurance application is submitted.” In a situation where a producer is not currently appointed by an insurer, but was previously appointed by and submitted an application to that insurer, must that producer now obtain a new appointment before submitting a new application to that insurer because it would not be the first application the producer ever submitted to that insurer?
Answer 17: No. Section 14B of the PLMA requires appointment within 15 days of the date an insurer receives the first application submitted by a producer who is not currently appointed, even if that producer was previously appointed by that insurer and submitted business in the past. Reference to the agency contract or the first application is based on the current time period. If a producer’s prior appointment with the insurer was terminated, each jurisdiction would consider the time period to start again with the new contract execution or the time period when the agent submits his first insurance application following the prior termination.
Chapter 3

Uniform Licensing Standards

In 2002, the Producer Licensing (EX) Working Group adopted the Uniform Resident Licensing Standards (URLS). The standards were revised and updated to incorporate standardization and uniformity for both resident and nonresident licensing. The standards were renamed to the ULS in 2008. These standards will be referenced throughout this Handbook. The full text of the ULS is in the Appendices. The latest version of the appendix can be found on the State Licensing Handbook webpage. The latest information can be found on the Producer Licensing (EX) Working Group’s web page on the NAIC website.

These standards establish an important baseline to assure insurance regulators that all states are applying the same standards to resident applicants. The Producer Licensing (DEX) Working Group Task Force and its Working Groups monitors compliance with the uniform standards. Since the adoption of the ULS, the Producer Licensing (EX) Working Group Task Force has adopted interpretative guidelines and clarifications to further explain the proper implementation of the ULS.

The ULS contain guidelines in the following categories:

1. Licensing qualifications.
2. Prelicensing education training.
3. Producer licensing test.
4. Integrity/personal qualifications/background checks.
5. Application for licensure/license structure.
6. Appointment process.
7. CE Requirements.
8. Limited lines uniformity.
9. Surplus lines standards.
11. Commission sharing.

Initial and Renewal Producer License Applications

The Producer Licensing (DEX) Working Group Task Force has adopted initial and renewal NAIC Uniform Applications for resident and nonresident individuals and business entities. Under the ULS, states are directed to use the Uniform Applications rather than state-specific applications. The Producer Licensing (DEX) Working Group Task Force has established a schedule for review and update of the applications. States are encouraged to use the most current form of the Uniform Applications. The forms are available on the NAIC website. All NIPR online applications use the most recent approved uniform initial and renewal application forms.
Recommended Best Practices for Insurance Regulators

- Conduct a regular review of state business rules, as well as any state-specific requirements for paper and electronic applications that are posted on NIPR’s website, with the NIPR or other vendor to maintain compliance with reciprocity and the ULS.
- Consider whether existing business rules are statutorily required. To the extent they are not statutorily required, they should be removed. To the extent they are statutorily required, the state licensing director should consider whether they are necessary. To the extent they are not necessary for consumer protection, the insurance commissioner should take steps to attempt to have such statutory requirements repealed (e.g., sponsor legislation).
- Carefully consider whether licensing staff should be given authority to change internal business rules or to give direction to a vendor without the licensing director’s approval. A change in procedure that may seem to be appropriate could cause problems with reciprocity or the ULS.
- If a state uses an outside vendor to receive and process license applications, monitor the vendor to ensure that applicants are provided only the most current NAIC uniform application, whether the applicant applies or renews online or via paper application.
- Adapt the department website to direct applicants to a single electronic location to obtain the most current version of the NAIC uniform forms, or specifically to the link for the electronic process.
- Departments should encourage the use of electronic processes, when available, rather than paper processes to expedite the licensing process.
- Eliminate all state-specific application forms, and use only the most recent version of the NAIC uniform forms.
- Develop a procedure manual, and cross-train staff so that several personnel can perform all licensing tasks.
- Provide adequate notice of changes to licensing and appointment fee structures, as well as changes to applications and other forms required to be submitted by applicants. With regard to the transition from an old application form to a new form, states should continue to accept original, signed applications up to a reasonable transition period beyond the inception date for the new form. Prior to the effective revision date, the state should provide adequate notice by way of email, website updates and any other appropriate communication device to interested parties.
Chapter 4

Nonresident Licensing

The previous reciprocity provisions of the GLBA adopted in 1999 required that barriers to nonresident producer licensing be eliminated. The PLMA contains specific guidance on this issue. A producer licensed in good standing in the home state must be granted a nonresident license unless good cause for denial exists under Section 12 of the PLMA.

There are four key components to licensing reciprocity:

1. Administrative procedures.
2. CE requirements.
3. Elimination of any limitations on nonresident.
4. Reciprocity with other States.

Administrative Procedures

Under the previous administrative procedures for reciprocal licensing mandated by the GLBA, a nonresident person received a nonresident producer license if:

1. The person was currently licensed as a resident and is in good standing in the person’s home state.
2. The person submitted the proper request for licensure and paid the fees required by the nonresident state’s law or regulation.
3. The person submitted or transmitted to the insurance commissioner the application for licensure that the person submitted to the person’s home state or, in lieu of that, a completed NAIC Uniform Application.
4. The person’s home state awarded nonresident producer licenses on the same basis to residents of the state in which the applicant is seeking a nonresident license.

States were required to license nonresident applicants for at least the line of authority held in the home state. This was true even if the line of authority held in the applicant’s home state may not have precisely aligned with the major or limited lines of authority in the other state. States were not allowed to charge a licensing fee to a nonresident that was so different from the fee charged a resident so as to be considered a barrier to nonresident licensure. States also were not allowed to collect fingerprints from nonresident applicants.

Section 8(C) of the PLMA makes it clear that a licensed nonresident producer who changes residency is not required to surrender the license and submit a new application. All that is required is a change of address within thirty (30) days of the change of legal residence. The model provides that a state should not charge a fee for processing this change of address.

The reciprocity provisions of the PLMA also extend to surplus lines producers. A majority of states treat surplus lines as a distinct license type. Persons holding surplus lines producer licenses in their home states shall receive nonresident surplus lines producer licenses, unless some other reason for disqualification exists.

A producer holding a limited line of insurance is eligible for a nonresident limited lines producer license for the same scope of authority as granted under the license issued by the producer’s home state. The nonresident state may require only what is permitted under Section 8 of the PLMA for limited lines applicants. A limited line is any authority that restricts the authority of the licensee to less than the total authority prescribed in the associated major line.

Continuing Education Requirements

Pursuant to the PLMA, a nonresident state must accept the producer’s proof of the completion of the home state’s CE requirements as satisfaction of the nonresident state’s CE requirements, if the nonresident producer’s home state recognizes the satisfaction of its CE requirements imposed upon producers from the nonresident state on the same basis.
Limitations on Nonresidents

States had to eliminate licensing restrictions that required a nonresident producer to maintain a residence or office in the nonresident state so long as the nonresident’s license was from one of the United States, the District of Columbia or the U.S. territories. The NARAB Working Group stated it was not a violation of GLBA reciprocity requirements if a state required nonresidents to provide proof of citizenship; however, under the ULS, it is the responsibility of the resident state to verify an applicant’s citizenship status.

Reciprocity with other States

To comply with the reciprocity provisions of the GLBA, a majority of the states had to meet all three of the above components and grant reciprocity to all residents of the other states who have met those components.

Reciprocity Examples

The PLMA contains specific guidance on the proper reciprocal treatment that a state licensing director should grant. This chapter contains illustrative examples of these provisions. Unless otherwise specified, these examples assume that the applicant is in good standing in the home state and has not requested a change in line of authority (LOA). There are some states that did not adopt all the reciprocity standards previously required by the GLBA in 1999 and currently reflected in the PLMA. The answers to the following examples will vary when a nonreciprocal state is involved. Examples also can be found in the Producer Licensing (EX) Working Group Frequently Asked Questions contained in Chapter 1.

- **Example A**

  A producer whose home state is State A has a nonresident license from State B and State C and moves to State D as the producer’s new home state.

  What should happen: The producer timely files a change of address in State A, State B and State C. State A places the producer’s resident license on inactive status. Within 90 days of cancelling the resident state license in State A, the producer applies for a resident license in State D. Using the SPLD, State D confirms the producer was in good standing in State A and applies for the same line of authority the producer held in State A. State D issues the producer a resident license. State A confirms the producer’s new resident license in State D and converts the producer’s inactive resident license to an active non-resident license. State B and State C also confirm the producer now holds a resident license in State D and record the producer’s change of address. Because the producer held the same line of authority in State A that the producer applied for in State D, the producer should not be required to take and pass a license examination or complete prelicensing education.

- **Example B**

  A producer holds a line of authority for surety in State A, and applies for a nonresident license in State B. However, State B does not have a separate surety line of authority.

  What should happen: State B issues a license that includes surety (which may have additional authority) but the producer is limited to the surety LOA held in the producer’s resident state.

- **Example C**

  A producer’s home state is State A. State A does not have a prelicensing education requirement for the life LOA. The producer holds a license with the life LOA in State A. The producer applies for a nonresident license in State B. State B has a resident license prelicensing education requirement.

  What should happen: State B issues a nonresident license with the life LOA and does not require any prelicensing education.

- **Example D**

  A producer’s home state is State A. State A does not have a prelicensing education requirement for any LOA. The producer holds a license with the life insurance LOA. The producer holds a nonresident license from State B. State B has a resident license prelicensing education requirement. The producer moves to State B.
What should happen: State B should issue a resident license to the producer with the life LOA. State B should not require prelicensing education or completion of an examination before issuance, “except where the commissioner determined otherwise by regulation.” (See PLMA Section 9B.)

- **Example E**

A producer’s home state is State A. Both State A’s resident prelicensing education and CE requirements are less than the ULS. The producer holds a resident license with the life insurance LOA in State A. The producer applies for a nonresident license in State B. State B has both prelicensing and CE requirements that match or exceed the ULS.

What should happen: State B issues the nonresident license with the life LOA and does not require the completion of either additional prelicensing education or additional CE.

- **Example F**

A producer’s home state is State B. The producer applies for a nonresident license with the variable products LOA in State A. A check of the PDB reveals that the applicant is not licensed for the variable products LOA in State B. Upon investigation, it is learned that State B either issues life or variable as a combined LOA or has a requirement for variable products licensing, but it is not specifically tracked by the Department of Insurance (DOI).

What should happen: This is a challenge, as State B has failed to adopt the variable products line of authority as defined in the PLMA. A second challenge is that the records on the SPLD and/or the NIPR may not accurately reflect the home state business rule. In this example, the nonresident state will have to pend the application and contact the home state to verify if the applicant is in compliance with the home state law on variable products. The nonresident state must then decide if the applicant should be granted a license.

- **Example A**

A producer whose home state is State A has a nonresident license from State B and State C and moves to State D as the producer’s new home state.

What should happen: The producer timely files a change of address in State A, State B and State C. State A changes the license from resident to nonresident. State B and State C record a change of address. The producer should apply for a license with State D within 90 days. State D should issue the license and may not require the producer to complete either an examination or prelicensing education. State D should verify that the license was in good standing in State A via the SPLD.

- **Example B**

A producer who holds a line of authority for surety in the home state, State A, applies for a nonresident license in State B, which does not have a separate surety line of authority.

What should happen: State B issues a license that has multiple LOAs, including surety, LOA, that the producer holds in the home state, but the producer is limited to the surety LOA held in his or her home state.

- **Example C**

A producer’s home state, State A, does not have a prelicensing education requirement for any LOA, and the producer holds a life insurance LOA. The producer applies for a nonresident license in a state that has a prelicensing education requirement.

What should happen: State B issues a nonresident license with the life LOA and does not require any prelicensing education before issuance.

- **Example D**

A producer’s home state, State A, does not have a prelicensing education requirement for any LOA, and the producer holds a life insurance LOA. The producer holds a nonresident license from State B that has a prelicensing education requirement. The producer moves into that state.
What should happen: State B should issue a resident license to the producer with a life LOA and does not require prelicensing education or completion of an examination before issuance, “except where the commissioner determined otherwise by regulation.” (See PLMA Section 9B.)

**Example E**

A producer’s home state, State A, has a prelicensing education requirement and a CE requirement that is less than the ULS, and the producer holds a life insurance LOA. The producer applies for a nonresident license in State B, which has a prelicensing requirement that matches or exceeds the ULS and a CE requirement that matches the ULS.

What should happen: State B issues the nonresident license with the life LOA and does not require the completion of either additional prelicensing education or additional CE.

**Example F**

A nonresident producer applies for the variable products LOA in State A. A check of the SPLD reveals that the applicant is not licensed for variable products in the home state, State B. Upon investigation, it is learned that State B either issues life or variable as a combined LOA or has a requirement for variable products licensing, but it is not specifically tracked by the Department of Insurance (DOI).

What should happen: This is a challenge, as State B has failed to adopt the variable products line of authority as defined in the PLMA. A second challenge is that the records on the SPLD and/or the NIPR may not accurately reflect the home state business rule. In this example, the nonresident state will have to pend the application and contact the home state to verify if the applicant is in compliance with the home state law on variable products. The nonresident state must then decide if the applicant should be granted a license.
Chapter 5
Activities Requiring Licensure

License Required to Sell, Solicit and Negotiate

The PLMA uses three key words to determine when a person is required to have an insurance producer license:

“Sell” means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

“Solicit” means attempting to sell insurance, or asking or urging a person to apply for a particular kind of insurance, from a particular company.

“Negotiate” means the act of conferring directly with, or offering advice directly to, a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

The specific requirement to hold a license is found in Section 3 of the PLMA and reads as follows:

A person shall not sell, solicit or negotiate insurance in this state for any class or classes of insurance, unless the person is licensed for that line of authority in accordance with this Act.

The Producer Licensing (EX) Working Group clarified in 2006 that in traditional life insurance sales transactions, licensure should be determined solely by the PLMA’s “sells, solicits or negotiates” standard, without reference to the insured’s state of residence. The key is to determine if the producer was properly licensed in the state in which the activity requiring a license took place. See also FAQ Number 16 in Chapter 2.

During the drafting of the PLMA, there was considerable discussion about who should be required to hold an insurance producer license. Prior to the adoption of the PLMA, the Producer Licensing (EX) Working Group discussed guidelines for “licensable” and “non-licensable” activities. The main thrust of that effort was to distinguish acts that constitute the sale, solicitation or negotiation of insurance from administrative or clerical acts. The guidelines document gives numerous examples of “Agent” activities that do require an insurance producer license and “Clerical” activities that do not. The document is included in the Appendices. The latest version of these documents can be found on the State Licensing Handbook webpage under the appendix section. Check the Producer Licensing (EX) Working Group’s web page for any updates.

Commissions

Section 13 of the PLMA provides guidance regarding the relationship between being licensed and receiving commissions. Section 13(A) prohibits the payment of commission to a person who is required to be licensed. Section 13(B) prohibits a person from receiving a commission if that person was unlicensed and was required to hold a license under the Act.

Section 13(C) of the PLMA states that it is not necessary nor should any state require a producer to maintain an active license solely to continue to receive renewal or deferred commissions.

Section 13(D) of the PLMA provides that an insurer or a producer licensed in a state may assign commissions, services fees, brokerages or similar compensation to an insurance agency (business entity) or to persons (individuals) who are not selling, soliciting or negotiating in that state and who are not licensed in that state, unless the payment would violate a state’s antif-rebating statutes. For example, if a regional manager in State A is, by contract with an insurer, to receive an override commission on all sales activities from subagents located in States B and State C, but the manager does not engage in any activity that would require licensure under Section 3 of the PLMA, no license should be required by State B or State C in order for the manager to receive commission payments.

Another example: A trade association with members in all states is headquartered in State A. An insurer pays a fee to the association for each member who purchases insurance from that insurer through an affinity marketing program. The association does not have to be licensed in any state because the association does not sell, solicit or negotiate insurance.
In 2008, the Producer Licensing (EX) Working Group provided guidance on uniform interpretation of the commission sharing provision in PLMA and recommended that adoption of Section 13 be included in the ULS. The Commission Sharing guidance document is included in the Appendix of this Handbook.

Exceptions to Licensing

The PLMA contains two key sections that clarify when a license is not required. When considering whether to require a license, states should carefully review Section 4 and Section 13 of the PLMA.

Section 4 of the PLMA contains a specific list of exceptions from the licensing requirement. States should take special note of Section 4(B)(6), which provides an exception for producers placing commercial insurance for a multistate risk with an incidental exposure in several states. As the section provides, in this situation a license is only required in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state.

The following is a summary of types of persons and entities that are exempted from licensing:

1. An officer, director or employee of an insurer or insurance producer, provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in the state.
2. A person who secures and furnishes information for, or enrolls individuals in, group life insurance, group P/C insurance, group annuities or group, or blanket accident and health insurance, where no commissioner is paid to the person for the service.
3. An employer or association; its officers, directors, employees; or the trustees of an employee trust plan, not in any manner compensated, directly or indirectly, by the company issuing the contracts.
4. Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks.
5. A person whose activities in a state are limited to advertising without the intent to solicit insurance in that state.
6. A person who is not a resident of a state who sells, solicits or negotiates a contract of insurance for commercial P/C risks to an insured with risks located in more than one state insured under that contract.
7. A salaried, full-time employee who counsels or advises the employer relative to the insurance interests of the employer who does not receive commission.

Recommended Best Practice for Insurance Regulators

- For uniformity purposes, states that still use a “transaction-based licensure” approach should eliminate that standard and change to the PLMA standard.
Chapter 6

Prelicensing Education

Prelicensing education is required in some states as a condition of licensure for resident insurance producers. Neither the PLMA nor the ULS suggests that a state must have a requirement for prelicensing education. States that have a prelicensing education requirement should follow the uniform standards as adopted by the Producer Licensing (EX) Working Group.

The ULS set a minimum credit hour requirement for prelicensing education. In 2010, the Producer Licensing (EX) Working Group was charged with reviewing this standard. Updated information, if there are any changes to this standard, can be found on the Producer Licensing (EX) Working Group’s web page.

States that require prelicensing education shall require 20 credit hours of prelicensing education per major line of authority. States must accept both classroom study and verifiable self-study, which includes both text and online courses. The ULS does not have a limit on the number of credits that can be obtained by self-study. States shall independently determine the content requirements for prelicensing education. The ULS require that a state have a method to verify completion of prelicensing education, but they do not prescribe a method.

The ULS provide that a person who has completed a college degree in insurance shall be granted a waiver from all prelicensing education requirements. The ULS also provide that individuals holding certain professional designations approved by the insurance department should be granted a waiver from the prelicensing education requirement. In 2008, the ULS were updated to indicate the following list of designations be provided as guidance for designations that would waive prelicensing education, but the list is not exhaustive:

Life: CEBS, ChFC, CIC, CFP, CLU, FLMI, LUTCF

Health: RHU, CEBS, REBC, HIA

P/C: AAI, ARM, CIC, CPCU

Under both reciprocity standards and the ULS, no state shall require prelicensing education for nonresident applicants or nonresident producers who change their state of residency.
Chapter 7
Application Review for Initial Licenses

Individual Application Forms

The Producer Licensing (EX) Working Group adopted a uniform application, and the ULS require its use for all producer applicants. Section 6 of the PLMA outlines the process a state is to follow in reviewing the application and in making the determination as to whether to grant a resident producer license.

Before issuing a resident producer license to an applicant, the state must find that an applicant for a resident license:

1. Is at least 18 years of age.
2. Has not committed any act that is a ground for denial, suspension or revocation set forth in the PLMA Section 12.
3. Where required by the insurance commissioner, has completed a prelicensing course of study for the lines of authority for which the person has applied.
4. Has paid the appropriate fees.
5. Has successfully passed the examinations for the lines of authority for which the person has applied. Note that the ULS provide that examinations are not generally required for limited lines, but that it is acceptable for examinations for areas such as crop and surety.

Business Entity Applications

The following requirements are optional and would apply only to those states that have a business entity license requirement.

The Producer Licensing (EX) Working Group adopted a uniform application form for business entities, and the ULS require its use. Section 6 of the PLMA requires that before approving an application for a resident business entity, the state shall find that:

1. The business entity has paid the appropriate fees.
2. The business entity has designated a licensed producer responsible for the business entity’s compliance with the insurance laws, rules and regulations of the state.

Section 6 also gives the insurance commissioner authority to require any documents necessary to verify the information contained in an application. In 2010, the Producer Licensing (EX) Task Force considered methods to expedite and streamline business entity licensing. Updated proposals can be found on the Producer Licensing (EX) Working Group’s web page.

Background Checks

The GLBA allows states to perform criminal background checks on resident applicants. The ULS contain guidelines on how to perform background checks, including the following three-step process for background checks:

A. States will ask and review the answers to the standard background questions contained on the Uniform Applications;
B. States will run a check against the NAIC Regulatory Information Retrieval System (RIRS)/SPLD and 1033 State Decision Repository (SDR) – Data Entry Tool; and

C(1) States will fingerprint their resident producer applicants and conduct state and federal criminal background checks on new resident producer applicants; or
C(2) If a state lacks the authority or resources to accept and receive data from the Federal Bureau of Investigation (FBI), it shall conduct a statewide criminal history background check through the appropriate governmental agency for new resident producer applicants until such time as it obtains the appropriate authority.
Fingerprints

Under the ULS, the goal is that all states will electronically fingerprint their resident producers as part of the initial resident producer licensing process. States that lack the authority to run criminal history background checks through the FBI are encouraged to at least run a statewide background check until such time that state and national fingerprinting is implemented.

The Producer Licensing (EX) Working Group adopted model language that will allow a state to access federal databases. (See the Authorization for Criminal History Record Check Model [#222].) States are encouraged to adopt this language. The Model #222 can be found on the State Licensing Handbook web page on the NAIC website. (https://content.naic.org/state_licensing_handbook.htm)

1033 Consent Waivers

The Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. §§ 1033 and 1034, commonly referred to as “1033,” establishes a ban on individuals who have been convicted of certain felony crimes involving dishonesty or breach of trust from working in the insurance business. The law provides that a banned person can apply to the state insurance commissioner for a written consent to work in the insurance business. If an individual with a felony involving dishonesty or breach of trust obtains a 1033 consent waiver from that person’s resident state, the person cannot be prosecuted for engaging in the business of insurance in violation of 18 U.S.C. §§1033 and 1034.

When one state grants a written consent waiver to an individual pursuant to 18 U.S.C. §1033, the consensus of legal opinion is that this written consent waiver is effective nationwide.

The Producer Licensing (EX) Working Group determined that the resident state bears responsibility for consideration of applications for consent waivers. Nonresident applicants should not be subject to additional procedures, nor should producers seeking nonresident licenses have to go through the 1033 process in all states after the producer’s resident state has issued a waiver. However, producers who have received waivers are required to attach them to applications for nonresident licenses. To assist these applicants, states should include a specific reference to 18 U.S.C §1033 within the text of the document that grants a waiver. States may exercise their discretion to deny licenses based on the types of criminal convictions disclosed in consent waivers. The NAIC Antifraud (D) Task Force adopted guidelines for review and granting of these consent waivers. Under the guidelines, states are to report all activity on these consent waivers to the (1033 SDR – Data Entry Tool). The full text of the guidelines are included State Licensing Handbook web page on the NAIC website. (https://content.naic.org/state_licensing_handbook.htm)

is available through I-Site.

NAIC Databases Relevant to Initial Application Review

The NAIC maintains three databases that should be consulted as part of application review.

1. The Complaint Database System (CDS) contains information on closed complaints as reported by the states.
2. The RIRS contains any action taken by a state insurance department where the action is against an entity and where the disposition is public information. All final adjudicated actions taken and submitted by a state insurance department are reflected in the RIRS. The information typically includes: administrative complaints, cease and desist orders, settlement agreements and consent orders, receiverships, license suspensions or revocations, corrective action plans, restitutions, closing letters, and letter agreements. The RIRS does not include exam report adoption orders without regulatory actions.
3. A record of 1033 actions is maintained in 1033 SDR – Data Entry Tool. The 1033 State Decision Repository (SDR) application allows regulators to enter and search for 1033 decisions (approved or denied), which state regulators have made for individuals who requested to work in the business of insurance but who have been prohibited to do so by section 1033 of the Violent Crime Control and Law Enforcement Act of 1994.

Review of Applications When Criminal History is Disclosed

As part of the 2009 charges for the Producer Licensing (EX) Working Group, the Producer Licensing (EX) Task Force asked the Producer Licensing (EX) Working Group to develop uniform guidelines for background check reviews of producers. For all jurisdictions to have a comfort level with licensing determinations made by a resident state when the applicant has a criminal

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history, a uniform process of review is warranted. If all jurisdictions implement these guidelines, in most situations, nonresident states will be able to defer to the resident state’s licensing decision. A copy of the Uniform Criminal History and Regulatory Actions Background Review Guidelines is included in the Appendix of this Handbook.
When an application contains a disclosure with a “yes” answer to a criminal history question, in determining whether to issue a license, states should consider the following factors:

- **Resident vs. Nonresident**

  If the application is for a resident producer license, it is incumbent upon the resident state to scrutinize all “yes” answers on the application and to request and obtain documentation and a detailed explanation for all criminal charges. Nonresident applicants’ criminal histories also should be documented and explained with consideration given the fact that the resident state already has issued a license to the applicant.

- **Severity and Nature of the Offense**

  Felony convictions should always be considered in determining whether to issue a license to an individual and may require the applicant to apply for a 1033 consent waiver prior to application. (See the section on 1033 consent waivers.)

  A criminal conviction is only relevant to the licensing decision if the crime is related to the qualifications, functions or duties of an insurance producer. Examples include theft; burglary; robbery; dishonesty; fraud; breach of trust or breach of fiduciary duties; any conviction arising out of acts performed in the business of insurance; or any actions not consistent with public health, safety and welfare. Special scrutiny should be given to financial and violent crimes.

- **Frequency of Offenses**

  While a producer’s past criminal history is a red flag and may be a predictor of future behavior, the frequency of offenses should be considered, with more weight given to a pattern of illegal behavior than to a one-time minor indiscretion.

- **Date of the Offense**

  The application form requires the applicant to disclose all criminal charges, except minor traffic offenses. A reviewer should consider when the offenses occurred and the age of the applicant at the time of the offense.

- **Completion of Terms of Sentencing**

  Applicants should provide evidence that they have completed all the terms of their sentences, including paying restitution, or completing any probationary periods or community service.

- **Evidence of Rehabilitation**

  The applicant should be required to provide evidence of rehabilitation. Completion of the terms of sentencing alone does not demonstrate rehabilitation. A state may request a statement from the applicant’s probation officer or other appropriate official.

**Statutory Obligations and Discretion**

Insurance regulators should review state law to determine guidelines for approval or denial of the application. After consideration of the above factors, the insurance regulator has several options:

1. Request additional information or documentation.
2. If the producer failed to report an action, contact the producer and request an explanation from the producer. (Technical violations, such as bad address or failure to timely report, generally do not merit formal action. However, the failure to report an action in itself can be cause for administrative penalty or a warning letter, depending on the particular state’s law).
3. Approve the application with no conditions.
4. Approve the application with conditions.
5. Deny the application.

In some cases, it may be appropriate to grant a conditional license. This option may not be available in all states and may be limited by state law or regulation. Some options include:
1. Issue a probationary license that will expire after six months or a year, or that will coincide with the applicant’s criminal probationary period. At the end of the probationary period, and prior to consideration of full licensure, the insurance regulator should confirm that the applicant successfully completed all terms of the sentence and probation. This option also can be used for a producer with a record of prior administrative action.

2. Enter into a supervisory agreement, whereby another established licensed producer agrees to be responsible for the applicant during a certain period of time of the applicant’s license term. This is a good option for producers who have criminal records in another state or some other evidence of past bad conduct. The supervisory agreement should include a requirement that the supervising producer report to the insurance regulator any inappropriate behavior that is relevant to the agreement and to the applicant’s license status.

3. Issue only a limited or restricted license for a particular product, such as credit life insurance. The theory of this option is that some types of products present individuals with less opportunity to commit bad acts.

4. Issue the license along with a requirement that the producer must report all complaints received against the producer and under the condition that there will be an immediate suspension for any bad act.

#### Recommended Best Practices for Insurance Regulators

- Work with state officials to adopt a fingerprint program that allows your state criminal justice agency to receive electronic prints, as well as electronically submit the reports back to the state DOI.
- If no fingerprint program is in place, inquire of the state criminal investigation department to determine if an alternative system for meaningful state background checks can be arranged.
- Allow pre-exam and post-exam fingerprinting.
- Make electronic fingerprinting available at test sites.
- Allow re-fingerprinting, if necessary, on a walk-in basis with no additional cost.
- Include registration for fingerprinting with registration for the exam, or link the online websites to allow for electronic registration.
- Streamline the background check process to avoid delay in the overall licensing process such as allowing for a temporary work authority pending receipt of the background check results.
- Check with other state agencies to determine what vendor(s) are used for the submission of electronic fingerprints (agencies that oversee programs such as teachers, bus drivers, social workers, foster parents, etc.)
- Adopt the NAIC’s Authorization for Criminal History Record Check Model Act (#222) for all license classes. (Allow some lag time before the effective date to provide sufficient time to establish procedures.) Note that ULS 14 has since been updated to fingerprint new resident producers and that fingerprints are no longer required for additional lines of authority under an existing home state license.
- The PLMA allows a producer to reinstate a lapsed license within 12 months of expiration, so only resident producers who are reinstating a license lapsed over 12 months should be required to submit fingerprints.
- Work with your state district attorney official to coordinate review and approval of the enabling statute, which must be approved by the U.S. attorney general to access the Criminal Justice Information Services (CJIS) division of the FBI criminal history record information.
- Establish a set number of times an applicant should be re-fingerprinted. (At times, fingerprints are rejected.) If re-fingerprinting is required, and the fingerprints are still rejected, establish a process to perform a state and federal NAME check.
- If your state is unable to use a vendor to electronically collect the cost of the criminal history background check from applicants, work with NIPR to collect this fee from new resident producer applicants during the electronic resident licensing application.
- Work with state officials to establish a reimbursement services agreement (RSA) for the payment of fingerprint or background checks.
- If your jurisdiction is just implementing fingerprinting, reach out to other jurisdictions for suggestions and best practices.
- Develop a system for review of 1033 consent waiver applications and post relevant information on the department website.
- Post all information regarding 1033 consent waiver requests, approvals and denials on the 1033 SDR – Data Entry Tool.
- Accommodate applicants to the greatest extent possible with flexible hours of operation.
- Allow payment by check, credit card or debit card.
Chapter 8

Testing Programs

Introduction

The states have a responsibility to ensure that licensing examinations are fair, sound, valid and secure. Directors must consider how an exam is developed, who is involved in the development process, how the exam is offered and how security is maintained. Nearly every state has contracted with an outside vendor to assist in examination development and administration. These testing vendors employ test development experts and psychometricians to construct and evaluate examinations.

The primary purpose of a state examination and licensing program is to protect consumers. Examinations should be consistent across the states in difficulty level, content and subject matter. They should be uniformly administered and scored. Examinations should be psychometrically sound, using methods for setting and maintaining passing standards (i.e., cut scores) that are in accordance with testing industry best practices. They should use resources such as: 1) the Standards for Educational and Psychological Testing, developed jointly by the American Educational Research Association (AERA), American Psychological Association (APA) and National Council on Measurement in Education (NCME); and 2) the U.S. Equal Employment Opportunity Commission’s (EEOC) Uniform Guidelines on Employee Selection Procedures (29 CFR 1607). Through valid, reliable and legally defensible test development practices, candidates will have a fair and equitable opportunity to pass an exam, regardless of which state exam they take. Ideally, pass rates should be consistent throughout the states; however, statistics from national examination administration have shown that the pass rates for examinations for the same line of insurance vary significantly among the states. Other variables may contribute to pass rates, such as state education systems, demographics, the existence of a prelicensing education requirement and the quality of such prelicensing education, but the states should work with their test vendors to be sure that they eliminate any practices that do not measure the entry-level knowledge, duties and responsibilities of an insurance producer.

Different states take different approaches to the development and administration of producer license examinations. Some of the states exercise significant control over test development and review. Other states rely almost entirely on outside experts. In most of the states, the state does not pay any fee to a testing vendor, and the cost of test development and administration is passed through to the test-takers. Most of the states reserve the right to preapprove any fees charged by testing vendors.

With the state licensing system increasingly built on reciprocity, it is in the best interest of consumers, insurance regulators, industry, producers and prospective producers for state licensing directors to establish guidelines that promote efficiency and consistency throughout the licensing process. Directors also should reduce or eliminate artificial barriers that impede qualified applicants from obtaining a license.

The purpose of this chapter is to recommend best practices for states in testing administration in the following areas:

1. Test development and review.
2. Test administration.
3. Test results.
4. Expectations for test vendors.

This chapter was developed with assistance from insurance test vendors, industry representatives, education providers and insurance regulators.

PLMA Guidelines on Examinations

Section 5 of the PLMA contains guidance for administering licensing examinations. Under Section 5, all residents are expected to complete a written examination, which should include the following:

1. The entry-level knowledge required for an individual concerning the lines of authority for which the application is made.
2. The duties and responsibilities of an insurance producer.
3. The applicable insurance laws and regulations of the state.

Section 5 grants the insurance commissioner authority to hire an outside testing service to administer examinations and impose nonrefundable examination fees.
The PLMA contains several exemptions from prelicensing education and examination requirements. An individual who is licensed as a nonresident in a state and who moves into that state, or an individual who moves from his or her home state to another state and seeks a resident license, is not required to complete an examination for the line(s) of authority previously actively held in the prior resident state as long as application is made within 90 days of the change in residence and the prior resident state indicates the producer was licensed in good standing. In this situation, a nonresident state should never impose prelicensing education or examination requirements.

The ULS provide that examinations are not generally required for limited lines, but that it is acceptable to require examinations for areas such as crop and surety.

The PLMA leaves test development and administration to the discretion of the individual states. Section 5(A) of the PLMA requires that “[a] resident individual applying for an insurance producer license shall pass a written examination” and requires that the examination must test the knowledge of the individual in three areas:

1. The specific lines of authority for which the application is made.
2. The entry-level duties and responsibilities of an insurance producer.
3. The applicable insurance laws and regulations of the state.

Beyond these broad subject matter categories, Section 5 states that tests “shall be developed and conducted under rules and regulations prescribed by the insurance commissioner.”

In order to provide more uniformity in state licensing practices, the 2012 revised ULS for Exam Content or Subject Area and Testing Administration Standards establishes implementation of the “Exam Content and Testing Administration Recommended Best Practices found in Chapter 8 of the NAIC State Licensing Handbook” as the uniform standard.

Test Development and Review

Test development experts believe that licensing examinations should measure the minimum competency required for a candidate to perform at an entry level. Therefore, test content and curriculum development should be focused on assessing whether a candidate demonstrates sufficient knowledge to pass an examination that is appropriately targeted to an entry-level producer.

The examination should not dictate the curriculum that an entry-level insurance producer should master. Instead, the test content should be developed using the steps outlined below. Examinations and curriculums should be updated to reflect any changes in insurance laws, regulations or industry practice. An online candidate guide should be available and should provide detailed testing and licensing procedures, as well as content outlines with cross-references to the curriculum.

Input from trainers who conduct test preparation courses may assist in the development of the curriculum and the exam content outline; however, some insurance regulators believe it is not appropriate to invite these trainers to participate in reviewing final examination questions. Education providers who do not offer prelicensing education courses (such as CE providers) sometimes are used during test development. There are generally two approaches to examination construction. A bank-based test generates individual examinations from a large bank of items. A form-based examination will consist of a specified set of predesigned test forms that are rotated. The states use both methods, and both are psychometrically acceptable. Although contracted outside experts play a major role in test development in most jurisdictions, the state should have a regular process and procedures for developing and reviewing licensing examinations to ensure that those examinations are properly focused on the minimum competencies required of an entry-level producer. Some items that should be included in the plan include:

1. Procedures to ensure that a job analysis survey that includes input from insurance regulators and the industry is conducted at regular intervals to determine the requirements and work performed by an entry-level insurance producer.
2. Regular, ongoing review and assessment of producer licensing examinations in the event of legislative or regulatory changes that could affect the accuracy of exam content.
3. An annual review of the examination development process conducted with the state and the testing vendor.
4. Depending on test volume, test performance and the need for content changes, either an annual (or at least biannual) substantive review of the examination and the psychometric properties of the test. These efforts should include the involvement of content or test development professionals, department personnel and industry representatives, industry including recent, entry level producers, representatives should include a mix of both recently licensed and more experienced producers.
Developing the Questions

Developing a valid and sound bank of test questions, often called “items,” is perhaps the most critical piece of any testing program. The items need to be at the appropriate level of difficulty. Items should be relevant to the profession and should be effective in evaluating whether the person taking the exam possesses the knowledge, skills and abilities critical to competently performing the job and safely practicing in the profession. To create this balance, most of the states use a combination of local subject-matter experts (SMEs) and content or test development professionals. The local panel should include new and experienced producers to help establish such a balance.

Using multiple item writers to develop test content is a common practice, but it can lead to variation in test item style, format and difficulty. Developing a style guide with templates, development standards and rules can go a long way in improving item consistency, format and variety. Content development training can ensure that writers have the tools they need to develop credible, legally defensible items and templates that can be leveraged to create multiple variations of the same question.

Passing Score vs. Pass Rate

A passing score, sometimes called a “cut score,” is the minimum score one needs to achieve in order to pass the exam. The “pass rate” is the percentage of candidates who actually pass the exam. The test development process will consider data from actual tests and data from reviewers rating the items and exams in evaluating the cut score.

In some of the states, the cut scores are arbitrarily established by rule or regulation. This is not a valid testing practice. Cut scores should be based on data collected through the test-development process. Regulatory licensing exams typically target a level referred to as “minimum” competency rather than “average” competency. Licensing examinations try to determine who has the minimum competency to safely practice in a profession without compromising the health and safety of the public. An arbitrary cut score, which is the practice in some of the states, tends to focus on the average, rather than minimum, competency. Thus, qualified candidates could be cut because they fall below the average, not because their competency is unacceptable.

Exam Scoring

Some of the states administer a one-part or one-score exam, while others administer two-part exams. In the one-part exam, general product knowledge and state-specific content are scored together. In the states with a two-part exam, the candidate must separately pass both the general knowledge exam and the state-specific exam in order to be eligible to apply for a license for the line of authority requested. A third variation is to require the first-time test-taker to pass an exam on state-specific insurance laws and regulations once. All additional lines of authority are tested on general product knowledge only.

Preliminary review of pass rates indicates a tendency for more candidates to fail in the states that require two-part exams. There is no evidence that two-part exams increase consumer protections or that the states that administer one-part exams license producers who do not know applicable state law. The states are encouraged to move to one-part exams to allow for more success among candidates without jeopardizing consumer protections.

Exam Content

As of May 2013, the states have no standard exam curriculum. The NAIC is encouraging more uniform approaches by considering the best practices for testing programs listed at the end of this chapter to be standards for all jurisdictions to work toward. The Producer Licensing (EX) Task Force formed a subgroup of five states to develop a draft national content outline using the life and annuity line of authority as a pilot. The national content outline provides guidance for entry-level subject matter that the states should test for, as well as information that will assist candidates in identifying relevant knowledge to study in preparation for the exam.

Some experts have recommended that examinations should be constructed with the following considerations in mind:

1. The states should not target examinations to an artificially set passing score. A state should determine whether its test is focused on assessing the knowledge needed by potential new producers, and only applicants who lack that
The states should use legally defensible, recognized methodology when establishing a cut score.

2. Prior to releasing items into an exam form, the editing and review process employed is critical. This editing process should include the psychometric evaluation of the cognitive level of the items and the reading level of the items, as well as such editorial issues as grammar, sensitivity and style. Psychometric editing is best performed by test development professionals, not state SMEs or item writers. Individuals trained in the complexity of psychometric editing evaluate items in a different, critical light than SMEs or item writers. It is critical, however, to have all final items reviewed and approved by state and national SMEs in the given field for accuracy and relevancy.

3. Each examination should consist of pre-test questions that are being evaluated for performance and questions that previously have been evaluated (pre-tested) and determined to be statistically effective. Each candidate’s score should be based only on the previously pre-tested and approved questions. Any time used to respond to pre-test items should not be counted against the test-takers, and responses to pre-test items should not be calculated in the test-taker’s score. Pre-test items should not be used as scored items until they have been statistically proven to be effective. The test questions for any new examination should be chosen from the pool of test questions to properly represent the subject-matter outline of the examination.

4. Reports regarding exam pass rates, candidate demographics when collected and number of exams administered should be made available to the public. Reports should include first-time pass success by subject area. Whenever possible, this information should be tracked by, and be made available to, each education provider so they may evaluate their programs and instructors, and be provided with data needed for course development. The states may ask for, but generally cannot require, information on candidate population, gender, ethnicity, education level and income level. When candidate demographics are collected, reports should include the percentage and number of examinees who passed the examination by race, ethnicity, gender, education level and native language. This information is necessary for the selection of future test questions, and will aid in making testing transparent and assessing whether differences in test scores are correlated with relevant demographic factors.

5. A state advisory committee consisting of insurance regulators and the industry—including, where possible, recently licensed producers—should annually (or, if changes are not needed every year, at least biannually) work with the testing vendor to review the questions on each examination form or bank of items for substantive and psychometric requirements. Adjustments should be made to the examination to eliminate any questions that might be inaccurate or unclear, that might test subject matter that is beyond what a new producer should know or that exhibit unsatisfactory psychometric properties.

6. Licensing examinations should be reviewed at least annually, but if, during any rolling 12-month period, a licensing examination exhibits uncharacteristically high or low pass rates (such as less than 60% or more than 80%), unexplained fluctuations in testing volume or other significant deviations, that examination should be reviewed immediately.

A state testing program should include statistical analysis of test items in the field and gather feedback on the candidate performance on the individual items. The most obvious and critical use of this information is to ensure that exams are equivalent, and to evaluate the accuracy with which items differentiate between candidates who are minimally qualified and candidates who are not. The psychometric review can result in the continued use of items, the modification of items or the deletion of items from the bank.

A professional test vendor should use a comprehensive strategy for developing test items and ensuring measurement of the knowledge, skills and abilities necessary for initial insurance licensees to perform their jobs effectively. The steps may include:

1. Conducting a committee-based job analysis.
2. Developing content specifications and weightings.
3. Developing items.
4. Editing and reviewing items with SMEs to ensure items meet the required criteria.
5. Obtaining item difficulty (e.g., Angoff method) estimates to establish a passing score.
6. Developing item sampling groups to structure each examination.
7. Creating equivalent forms.
Test Development Deliverables

A state licensing director should expect to receive the following items to ensure that the testing vendor has provided all items necessary to administer a successful testing program:

1. Finalized task and knowledge statements reflecting the requirements of each licensed insurance position.
2. Content specifications for each licensing examination.
3. A set of approved, relevant and important items for use on each licensing examination.
4. A list of references used to develop the test items.
5. Candidate Information Bulletins (CIBs).
6. A technical report describing the procedures used and results obtained from the test development process for each licensing examination.

Candidate Information Bulletin

A CIB should describe the examinations, examination policies and procedures, and the consequences of violating security procedures. A testing vendor should be capable of making changes to the information contained within the CIB during any contract year at the state’s request.

The CIB should be available at no charge to candidates, trainers and insurers in hard copy or in electronic format via the Internet. The state licensing director should consider including the following topics in the CIB:

1. How to contact the testing vendor.
2. Requirements for taking an examination.
3. How to apply for an examination, including receiving authorization of eligibility from the state, prelicensing education and background checks.
4. Links to current application forms.
5. How to obtain current forms in hard copy (if available in hardcopy).
6. Examination fees.
7. Scheduling procedures.
8. The content outline and format of the examination.
9. Supplies provided at the test center.
10. The time limit for the examination.
11. The scoring system.
13. Examination process and procedures.
14. Appropriate examination-taking strategies (e.g., “There is no penalty for incorrect answers, so be sure to answer every question.”).
15. Appropriate use of scratch paper, calculators and/or other support material.
16. Sample questions.
17. Specific information about taking the test on the computer.
19. List of test centers, alternative test centers and driving directions to each.
20. Procedures for requesting special accommodation.
21. Examination registration forms.
22. Licensing requirements and procedures.
23. Refund policies.
24. Holiday or weather-related test center closures.
25. Instructions about how to contact the state insurance department.

A state should approve each CIB before it is published. The licensing director should work with the vendor to set a timeline that will allow for final publication of an updated CIB in advance of the expiration of the prior edition of the CIB. The new edition should be provided to test preparation trainers at least six weeks in advance of implementation so that training materials can be updated.

Technology Issues

A licensing director should consult with the state’s information technology (IT) staff to ensure that the testing vendor can deliver data to the state insurance department. This is critical when a state changes testing vendors. This also is critical if the
state directs a vendor to send data to a different location than the state insurance department. Any transition should include a testing phase for hardware, software and state insurance department staff.

The state and the testing vendor should jointly agree on a timeline for introducing new or updated examinations. State IT staff also should be consulted.

**Legal Defensibility**

Items developed also must be legally defensible to protect the state in the event of a legal challenge. To protect the state from liability, each exam should be critically reviewed from a content and psychometric perspective to ensure that the exam was developed according to recognized standards. Validation procedures for licensing examinations should be designed to comply with content validation requirements of the EEOC’s Uniform Guidelines on Employee Selection Procedures (29 CFR 1607).

The states should require testing vendors to follow and document standardized methods. This should include appropriate test development personnel in the process. Using the appropriate, credentialed professionals is critical, as there are multiple steps involved in the test development process and various methodologies that can be used for each step. State licensing directors should discuss all options with qualified professionals.

**Vendor Responsibilities**

Test vendors should be able to meet minimum guidelines for sufficient availability, facilities, personnel and openness in terms of providing information related to their operations.

The states, and not the test vendors, must be responsible for all examination content and content outlines. The vendor should provide accessible information regarding the registration system through the Internet, toll-free telephone numbers, interactive voice response, fax and other available technologies. The available information should include permitting candidates to view exam test dates and to access forms and content guidelines without requiring prior payment and scheduling of an exam.

The vendor should promptly provide the state with all pertinent information, including prompt notification of any candidate complaints, changes to test administration, conflicts at examination test sites or other information requested or required by the state.

The vendor should provide quality, accessible facilities, with an established system of examination site supervision that ensures that competent site administrators consistently provide accurate information to applicants.

Where a vendor operates test sites in multiple states, the vendor should permit any applicant to take a state’s examination in another state, under the same conditions that would apply if the exam were taken at an in-state location.

Vendors should be required, on an ongoing basis, to collect the data on customer satisfaction and, if directed by the state, to make those data available to insurance regulators, the industry and the public.

**Test Administration**

The testing process should be fair and accessible for all candidates. A state should consider including the following elements below in its licensing process to ensure applicants have equal access to examinations.

**Secure Administration**

The security of the test center network is important in maintaining the integrity of a test. A vendor should be equipped with adequate security features and qualified test center administrators. Each proctor should be trained and tested on his or her ability to supervise exams. A vendor should have systems in place to ensure the fair, consistent and even administration of the exam in every location. A vendor also should have a method to detect attempts to record questions. For example, a vendor should track multiple examination attempts by individuals to assess if the candidate is intentionally failing the exam so it can be repeated. A vendor should be required to notify the state immediately if the vendor suspects that the integrity of an examination has been compromised.

**Test Locations and Registration**

Test locations should be set up to provide flexibility and convenience. Realizing that the states have different geographic challenges and diverse population density, a state should consider, where possible, requiring the following elements:
1. Testing should be made available at locations convenient to residents of all areas of the state.
2. Test locations should provide enough testing capacity so a candidate can test at the desired location within two to five business days of registration.
3. Exam site hours should include evening and weekend hours.
4. Test vendors should provide regular reports as required by the state detailing site usage and availability data.
5. Test registration should be available online or by telephone and allow for next day testing when space is available. A state should consider tracking telephone hold and wait times to monitor how long callers wait.
6. State guidelines should provide for flexible means for payment of fees for testing, fingerprinting and other licensing. The states should consider methods which facilitate payment by companies.

**Disabilities**

A state should require a vendor to develop a system that accommodates the physically impaired that is not related to a testing candidate’s knowledge of insurance. Visually impaired and hearing-impaired persons should be accommodated through all steps of the licensing process, pursuant to national standards set by the federal Americans with Disabilities Act (ADA).

**Examinations in Languages Other Than English**

Some industry experts suggest caution about using translated or interpreted exams. The material may not directly translate into equivalent terms or meaning. Cultural biases might cause incorrect interpretation of a meaning. Some experts recommend that tests should be developed and administered in English, especially if other materials necessary to perform job duties for the profession (such as contracts) are in English. State licensing directors should review state law and consult with legal counsel about the appropriateness of offering examinations in a foreign language.

**Reporting Examination Results**

State licensing procedures should include guidelines that facilitate the prompt issuance of licenses once an applicant passes a test. Elements might include:

1. Pass/fail notices should be issued at exam sites upon completion of the exam. If an applicant has not achieved a passing score, the applicant should receive immediate notification of failure. The states vary as to whether successful completion is reported with a precise score or merely an indication that the candidate passed the exam. When a candidate does not pass the exam, the state should provide the precise score and the percentage of questions in each subject area that the applicant answered incorrectly.
2. If a state issues a paper license, and if it has been predetermined that an applicant has met all requirements necessary for licensure, including any required fingerprint report, a license should be issued at the exam site, or within 48 hours of completing all necessary requirements.
3. The state should send an email or other timely communication to a candidate to whom a license has been issued outside the test site or provide information to applicants as to how to check online.
4. Within 24 hours of license issuance, the new licensee’s information should be added to the state’s database, and the updated status should be sent to NIPR.
5. The states should work with their vendors to report aggregate results in a way that is more uniform with other states.
6. First-time pass rates should be maintained and made available to the public. First-time pass rates are defined as the percentage of candidates who pass the whole test the first time.
7. In performing background checks, the use of an electronic process should be required whenever possible.
8. In those states requiring fingerprints, where possible, exam sites should have the capability to collect electronic fingerprints.

**Retesting or Notice of Failure**

A state licensing plan should include a method to facilitate prompt retesting of applicants who have failed a test. The “non-passing” notice should break scores out by each subject area. If the candidate requests to make another attempt, an examination should be made available within a reasonable time period.
### Producer Exam Content and Testing Administration Recommended Best Practices for Insurance Regulators

- The states should use accepted psychometric methods including job analysis to determine if the examination content falls within the content domain that a minimally competent candidate of that specific line of authority tested would be expected to know.
- The states should set passing scores (cut scores) and difficulty level using psychometric methods and appropriate SMEs based on what an entry-level producer needs to know.
- The states are encouraged to move to one-part exams to allow for more success among candidates without jeopardizing consumer protections.
- The states should require the test vendor (or other entity responsible for test development) to document the process for ensuring quality control and validity of the examination, including psychometric review and editing and analysis of item bias or cultural and gender sensitivity.
- To allow for meaningful comparison, all jurisdictions should define first-time pass rate as the percentage of candidates who pass the whole test the first time.
- At least annually, reports regarding exam pass rates, candidate demographics when collected and number of exams administered should be made available to the public. Reports should include first-time pass rate, success and average scoring by subject area. Whenever possible, the reports should be available by education provider and provided to them.
- A state advisory committee consisting of insurance regulators and the industry—including, where possible, recently licensed producers—should annually work with the testing vendor to review the questions on each examination form for substantive and psychometric requirements. If, during any other time, any examination results exhibit significant unexplained deviations, the examination should be reviewed.
- The states should work with testing vendors and approve CIBs that describe the examinations and examination policies and procedures, and provide sufficient examination content outline and study references for the candidate to prepare for the examination. Updated editions of the CIB/content outline should be provided to prelicensing education providers at least six (6) weeks in advance of implementation so that training materials can be updated.
- Testing should be made available at locations reasonably convenient to residents of all areas of the state, with registration available online or by telephone and the ability for a candidate to schedule testing within two to five business days of registration.
- Pass/fail notices should be issued at exam sites upon completion of the exam. The fail notice should break out scores by subject area. The state should provide a method to facilitate prompt retesting, while allowing a reasonable time for candidates to review and prepare for retest.
- The states should deliver exams in a secure test center network that employs qualified test proctors.
- The states should set clear performance standards for test vendors and require accountability.
Chapter 9

Lines of Insurance

The Major Lines

A line of authority is a general subject area of insurance that a producer can be licensed to sell. The PLMA identifies and defines seven lines of authority; however, the ULS set forth six lines that are considered major lines of authority, as well as certain core limited lines. Additionally, the ULS set forth standards for non-core limited lines. The states should review all other lines of insurance and consider eliminating them in an effort to become compliant with the ULS. Uniform adoption of the major lines is essential to fully implement NAIC licensing reforms.

The six major lines of authority are defined in the PLMA as follows:

1. Life – insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income.
2. Accident and health or sickness – insurance coverage for sickness, bodily injury or accidental death and may include benefits for disability income.
3. Property – insurance coverage for the direct or consequential loss or damage to property of every kind.
4. Casualty – insurance coverage against legal liability, including that for death, injury or disability, or damage to real or personal property.
5. Variable life and variable annuity – insurance coverage provided under variable life insurance contracts and variable annuities.
6. Personal lines – P/C insurance coverage sold to individuals and families for primarily noncommercial purposes.

Because the ULS also require that each major line be available individually, the states should provide individual examinations for each of the major lines except variable life and variable annuity. It is acceptable for a state also to offer combined exams. The ULS contemplate that each state will require an examination for residents to qualify for all major lines. The states should give examinations only to residents, not nonresidents.

While the ULS do not specifically prohibit an examination for variable life and variable annuity products, most states do not require an examination. This line of authority is usually granted if the applicant holds a life line of authority and has successfully completed the Financial Industry Regulatory Authority (FINRA), formerly known as the National Association of Securities Dealers (NASD), examinations necessary to obtain a state securities license in that state. In most cases, this means successful completion of the FINRA Series 6 and/or Series 7 (according to the specific state’s requirements) and/or Series 63 exams.

The Producer Licensing (EX) Working Group has not specifically stated that states should not require an active state securities license of residents or nonresidents as a condition of granting the variable life and variable annuity products line of authority. The ULS do contemplate that no such requirement shall be imposed. For nonresident applicants, it is not appropriate to pend a request for the variable life/annuity products line of authority to verify existence of the underlying life line of authority in the home state. If a proper request for licensure is received and the applicant is in good standing in the home state with the variable life and variable annuity line of authority, the nonresident license should be granted. If a state cannot verify through the SPLD that the applicant holds a variable authority, it is permissible to pend the application and contact the applicant’s home state to verify the variable authority.

Information regarding an applicant’s status as to securities registration and securities examinations passed currently are easily accessible on FINRA’s public Web site (under “Check Out Brokers & Advisors” at www.finra.org/InvestorInformation/index.htm). Information available includes: employment history; states where the individual is securities licensed; securities examinations passed; and formal and final disciplinary history. To obtain Central Registry Depository (CRD) information regarding pending complaints and unresolved cases, a state insurance department must contact its state’s securities regulator.

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1 The PLMA does not address title insurance, which is considered a major line by some of the states and a limited line by others.
Limited Lines

A limited line of insurance is a line of insurance that covers only a specific subject matter. Limited line licenses generally have simpler licensing requirements than required by the major lines. Some states require an examination for credit insurance. For the other limited lines, some states require an examination, while some require only a simplified application process. In some states, a business entity is permitted to maintain a limited lines license on behalf of individuals who make the limited line of insurance available to its customers. Often, a limited line is adopted by regulation and not by statute.

The PLMA contains a specific definition for credit insurance and allows states to define other limited lines. The Producer Licensing (EX) Working Group adopted definitions for specific “core” limited lines of insurance for producers, which have become part of the ULS. States are encouraged to adopt the definitions of those limited lines and to review and eliminate as many non-uniform limited lines as possible. The PLMA requires states to grant to a nonresident a nonresident limited line producer license with the same limited line of authority as the license issued by the home state. Many states have adopted a special licensing category to accommodate this type of situation.

The core limited lines are:

1. Car rental insurance.
2. Credit insurance.
3. Crop insurance.
4. Travel insurance.

The ULS provide that examinations are not generally required for limited lines, but that it is acceptable for examinations for areas such as crop and surety. The states should give examinations only to residents, not nonresidents. The ULS specifically state that CE is required for only the major lines of insurance. (See specifics for crop insurance.)

In 2009, the Producer Licensing (EX) Working Group was charged with reviewing limited line licensing issues, with particular focus on: 1) the establishment of a limited lines that encompasses several insurance products where the business of insurance is ancillary to the business of the person offering the product; 2) the licensing requirements of individuals selling limited line products; and 3) the fingerprinting of individuals selling limited line insurance products. Throughout the year, the Producer Licensing (EX) Working Group had discussions; however, no consensus was achieved. As a result, the Producer Licensing (EX) Working Group reported to the Producer Licensing (EX) Task Force and requested further guidance on its charge. For 2010, the Producer Licensing (EX) Working Group was asked to:

Finalize the review of limited-line licensing issues, with particular focus on the following: 1) individually review the licensing requirements for each core limited line; 2) review other limited lines, and determine what licensing requirements should apply to them; and 3) determine if another “catch all” limited line was needed to address licensing requirements for insurance products not already encompassed within the list of limited lines. Updates to the limited line charge may be obtained on the Producer Licensing (EX) Working Group’s web page on the NAIC website.

The NAIC has adopted a specific resolution rejecting a prior request by industry to adopt a new limited line for term life insurance. The full text of the resolution is in the Appendices.

As part of its 2010 charges, the Producer Licensing (EX) Working Group conducted a review of the ULS and adopted several amendments. Specifically related to this chapter, revisions were made to Standard 16 (Lines of Authority), Standard 33 (Definition of Core Limited Lines), Standard 34 (Travel) and Standard 37 (Non-Core Limited Lines).

Recommended Best Practices for Regulators

- Adopt the major lines and the definitions exactly as stated in the PLMA and provide separate testing for each line, except variable
- Allow combined examinations, as appropriate
A. Limited Line of Car Rental Insurance

Under the ULS, car rental insurance is defined as:

[I]nsurance offered, sold or solicited in connection with and incidental to the rental of rental cars for a period of [per state law], whether at the rental office or by pre-selection of coverage in master, corporate, group or individual agreements that (i) is non-transferable; (ii) applies only to the rental car that is the subject of the rental agreement; and (iii) is limited to the following kinds of insurance:

(a) personal accident insurance for renters and other rental car occupants, for accidental death or dismemberment, and for medical expenses resulting from an accident that occurs with the rental car during the rental period;

(b) liability insurance that provides protection to the renters and other authorized drivers of a rental car for liability arising from the operation or use of the rental car during the rental period;

(c) personal effects insurance that provides coverage to renters and other vehicle occupants for loss of, or damage to, personal effects in the rental car during the rental period;

(d) roadside assistance and emergency sickness protection insurance; or

(e) any other coverage designated by the insurance commissioner.

The states vary in their methods of supervising the sale of car rental insurance. In the states that require a license, there are generally three methods in use. The first is a registration requirement through submission of an application. The second is the successful completion of an exam and submission of an application. The states should give examinations only to residents, not nonresidents. Under the third method, a car rental company registers with the state insurance department. The company holds the license and is responsible for supervising the training and testing of its counter agents. The company reports to the department and pays all fees.

B. Limited Line of Credit Insurance

The PLMA defines limited lines credit insurance as:

Credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance or any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation and that is designated by the insurance commissioner as limited line credit insurance.

Credit insurance products are designed to protect the borrower against the risk of not being able to pay a debt. Credit life, disability and involuntary unemployment insurance are typical lines of coverage. These products are generally made available by the creditor at the time the loan transaction occurs. Because the insurance is purchased at the time the borrower completes the loan, policy and certificate forms, premium structures and underwriting conditions are generally simpler than other limited lines of insurance.

Credit insurance is issued under individual and group policies. This allows market flexibility for different distribution systems and variations in product design to insure the different types of credit risks. If an individual enrolls customers under a group insurance policy, the individual must obtain a limited lines license, if a commission is paid. Section 4(B)(2) of the PLMA provides an exception from licensing if no commission is paid to the enroller and the enroller does not engage in

Recommended Best Practices for Regulators

- Allow resident and nonresident limited lines license applications to be filed electronically.
- Eliminate state-specific applications.
- To further reciprocity, report all limited lines licensees to the SPLD.
- Adopt the applicable revisions to the ULS related to limited lines.
selling, soliciting or negotiating.

Section 6(D) of the PLMA provides that each insurer that sells, solicits or negotiates any form of limited line credit insurance shall provide its producers a program of instruction that may be approved by the insurance commissioner.

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C. Limited Line of Crop Insurance

Under the ULS, crop insurance is defined as:

Insurance providing protection against damage to crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease, or other yield-reducing conditions or perils provided by the private insurance market, or that is subsidized by the Federal Crop Insurance Corporation (FCIC), including multi-peril crop insurance.

There are two types of crop insurance: multiple peril crop insurance (MPCI) and crop hail insurance.

The federal government is involved with crop insurance because a single event (such as drought) often results in multiple losses. Automobile accidents or health problems generally are independent, random events that do not trigger multiple insurance losses. For crop insurance, multiple losses are the norm rather than the exception. For many years, capital requirements to maintain adequate reserves to cover widespread losses were so high that commercial development of MPCI policies by companies was unrealistic. As a result, the federal government created a federally subsidized risk management program.

Multiple Peril Crop Insurance

An MPCI policy provides protection against crop losses from nearly all natural disasters, including: adverse weather conditions; fire; insects, but not damage due to insufficient or improper application of pest control measures; plant disease, but not damage due to insufficient or improper application of disease control measures; wildlife; earthquake; volcanic eruption; or failure of the irrigation water supply if due to an unavoidable cause of loss occurring within the insurance period.

MPCI is subsidized by the federal government and delivered by private insurance companies. The insurer’s functions include hiring and training producers; paying for marketing and advertising; hiring and training loss adjusters; and carrying out loss adjustment activity, billing and collecting premiums, processing and verifying applications, conducting actual production history reviews, processing and verifying acreage reports, paying claims, auditing and verifying claims data, paying uncollected premiums, and maintaining the necessary automated data processing infrastructure to communicate data with the Risk Management Agency (RMA) on a routine basis for all MPCI policies.

The MPCI policy is a contract between the producer and the insurance company and not with the federal government. However, a farmer cannot receive the federal subsidy attached to the program unless the insurance policy followed the federal standards and rates. Like many insurance companies, crop insurance companies have reinsurance agreements to transfer risk to other private companies known as reinsurers. Unlike most other insurance lines, the private insurance companies also transfer some of the risk associated with the crop insurance program directly to the federal government.

There are many MPCI plan options available: yield-based, revenue-based or a combination of both. The basic policy provisions for all these plans, as well as the rates, are set by the FCIC. A combination of commodity markets results and the U.S. Department of Agriculture (USDA) establish the maximum price for each crop each year for insurance purposes (i.e., the value of each bushel in the event of loss).

While the RMA controls pricing and policy forms, producer licensing and enforcement of proper sales practices are left to the states.
Crop/Hail Insurance

Crop/hail insurance is offered through companies licensed by state insurance departments. A private market has existed for crop/hail insurance for more than a century. Companies have developed stand-alone full coverage and deductible crop hail policies, as well as companion policies that function very well in conjunction with the different MPCI plans that are offered at varying coverage levels. The premium rates for these crop/hail policies are determined by historical loss experience and are set by the companies.

Continuing Education

Subsequent to the adoption of the ULS, the Producer Licensing (EX) Working Group considered and agreed that a CE requirement for crop insurance shall not be a violation of the uniform standards. Under federal law, insurance producers selling MPCI are required to attend CE classes each year.

D. Limited Line of Surety

As part of the discussion of limited lines, the Producer Licensing (EX) Working Group made the determination to remove surety as a limited line. Although this determination was made, it is understood that surety is considered a major line by some of the states and a limited line by others.

E. Limited Line of Travel Insurance

Under the ULS (as revised Aug. 6, 2010), travel insurance is defined as:

Insurance coverage for personal risks incidental to planned travel, including, but not limited to:

1. Interruption or cancellation of trip or event.
2. Loss of baggage or personal effects.
3. Damages to accommodations or rental vehicles.
4. Sickness, accident, disability or death occurring during travel.

Travel insurance does not include major medical plans, which provide comprehensive medical protection for travelers with trips lasting six months or longer, including, for example, those working overseas as an ex-patriot or military personnel being deployed.

Standard 34 recognizes and sets the guidelines for the creation of an additional business entity licensing model under the travel limited line licensing structure. This structure creates the concept of a “travel retailer” in which the entity and a certain number of its employees may disseminate travel insurance under the direction of a responsible licensed producer. Said producer maintains responsibility for the training and conduct of any and all associated travel retailer(s).

F. Non-Core Limited Lines

After much discussion about the concept of “auxiliary” or “miscellaneous” lines, the Producer Licensing (EX) Working Group formally adopted Standard 37 as a basis for any future addition of other non-core limited line. The standard states, in part, that:

A state is not required to implement any non-core limited line of authority for which a state does not already require a license or which is already encompassed within a major line of authority; however, the states should consider products where the nature of the insurance offered is incidental to the product being sold to be limited line insurance products. If a state offers non-core limited lines (such as pet insurance or legal expense insurance), it shall do so in accordance with the following licensing requirements. Individuals who sell, solicit or negotiate insurance, or who receive commission or compensation that

Recommended Best Practices for Regulators

- A state adding the travel limited line should do so in accordance with applicable ULS.
is dependent on the placement of the insurance product, must obtain a limited line insurance producer license. The individual applicant must: 1) obtain the limited lines insurance producer license by submitting the appropriate application form and paying all applicable fees as set forth in applicable state law; and 2) receive a program of instruction or training subject to review by the insurance department.

No prelicensing or testing shall be required for the identified non-core limited lines insurance.
Surplus Lines Producer Licenses

In order to operate in a state, P/C insurance companies are generally categorized in one of two ways. An admitted company obtains a certificate of authority to operate in a given state and is fully subject to and regulated by the laws of the state. Its policyholders are protected, at least to some extent, by the state’s guaranty fund.

A nonadmitted company, otherwise known as a surplus lines company, has limited authority to operate in a state. These companies may be required to be eligible in a state but are subject to significantly less regulation. States allow surplus lines companies to operate because they recognize that certain types of insurance, or insurance at certain amounts, are not available from admitted companies. Generally, surplus lines companies are not subject to rate and policy form regulation, and their policyholders are not covered by state guaranty funds.

Under the ULS, a producer who wishes to engage in the sale of surplus lines insurance (SLI) must first obtain a surplus lines producer license. Under the ULS, this is considered a license type and not a line of authority; however, in some of the states, it is treated as a line of authority. The ULS require that a resident producer hold both property and casualty lines of authority before an SLI producer license can be issued. Under the previous reciprocity provisions of the GLBA, surplus lines producers were entitled to reciprocal licensing if they were licensed for surplus lines and in good standing in the producer’s home state. The NAIC uniform application is to be used for application as a surplus lines producer.

Some of the states also require a resident producer placing SLI to complete an examination or post a bond. However, to comply with the reciprocity provisions of Section 8 of the PLMA, these requirements cannot be imposed on nonresidents. States cannot impose an additional CE requirement on nonresident SLI producers.

The Nonadmitted and Reinsurance Reform Act

The federal Nonadmitted and Reinsurance Reform Act (NRRA) was signed into law by President Barack Obama on July 21, 2010, as part of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act, 12 U.S.C. § 5301. The NRRA set federal standards for the collection of surplus lines premium taxes, insurer eligibility, producer licensing and commercial purchaser exemptions. Most of the provisions of the NRRA went into effect on July 21, 2011.

For licensing of surplus lines brokers, the most significant change was to limit the licensing requirements to only the home state of the insured. Specifically, to place a surplus lines multistate risk policy, the broker needs only to be licensed as a surplus line broker in the insured’s home state, not in all of the states where the policy risk is located. The NRRA defines the home state of the insured as “(i) the state in which an insured maintains its principal place of business or, in the case of an individual, the individual’s principal residence; or (ii) if 100% of the premium of the insured risk is located out of the state referred to in clause (i), the state to which the greatest percentage of the insured’s taxable premium for that insurance contract is located.” The definition goes on to clarify that, with respect to affiliated groups, “[i]f more than one insured from an affiliated group are named insureds on a single non-admitted insurance contract, the term ‘home state’ means the home state, as determined pursuant to [clauses (i) and (ii) above], of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.”

The NRRA also prohibits a state from collecting fees relating to the licensing of a surplus lines broker unless the state participates in the NAIC’s national insurance producer database for surplus lines broker licensure by July 21, 2012. Currently, all states accept applications and renewals for surplus lines broker licenses for individuals through the NIPR and all but one state accept applications and renewals for surplus lines broker licenses for business entities.

Surplus Lines Distribution Systems

Surplus lines insurance is generally produced through one of two distribution systems. One, generally referred to as a retail distribution system, involves a single broker accessing the surplus lines company directly to place insurance. The second, generally referred to as a wholesale distribution system, involves a surplus lines broker that operates as an intermediary between a “retail agent” and a surplus lines company. In the retail distribution system, there is only one producer in a transaction, so that producer would need to conduct the diligent search of the admitted markets prior to accessing the surplus lines markets (unless there is some exception such as a large commercial purchaser or an export list). In the wholesale
distribution system, the diligent search is often conducted by the retail broker, who determines there is no admitted market prior to contacting the surplus lines wholesale broker; however, some of the states have different requirements.

The vast majority of the states take the position that a broker conducting a diligent search would need a P/C agent’s license because it is necessary to solicit insurance, take an application and make a submission to an admitted company. Many states do not require a retail producer to obtain a surplus lines broker’s license unless the broker is going to access the surplus lines companies directly. There are a couple of states that require a retailer to have a surplus lines license before using the services of a surplus lines wholesale broker.

Diligent Search Requirements

The vast majority of the states require a “diligent search” of the admitted market to determine if there is an admitted carrier willing to write the risk, prior to accessing the surplus lines markets. A couple of states have abolished the diligent search requirement. Many of the states require that brokers search those admitted companies that are actually writing the coverages sought. If there is no admitted carrier willing to write the risk, the risk can be placed in the surplus lines markets. Many of the states require an affidavit to be completed documenting that the diligent effort was completed. Recently, a number of the states have replaced the affidavit, which was sworn under penalty of perjury, with a report from the surplus lines licensee that the diligent search was conducted. Some of the states also have replaced the requirement that the affidavit (or report) be filed with the insurance department or Surplus Line Association (SLA) with a requirement that the report of the diligent search be maintained in the office of the broker and available for audit by the insurance department.

Many of the states specify that the diligent search can be conducted by the retail broker (commonly called producing broker), when a surplus lines wholesaler accesses the surplus lines markets. The retail broker has access to admitted markets. The retailer uses the services of a surplus lines wholesale broker only after the retail broker has determined that the admitted markets are not willing to underwrite the risk.

The most common diligent search standard requires declinations from three admitted carriers, but as many as five are required. Other states simply require the producing broker to make an effort, a reasonable effort or a good faith effort to place the coverage in the admitted markets. A couple of states require that the insurance not be procurable after a diligent effort has been made to place the coverage among a majority of insurers, but this standard has been called into question as unclear and impractical. A number of exceptions to the diligent search requirement exists in state law, and the NRRA implemented a national exception to the diligent search rules for insureds that qualify as exempt commercial purchasers. Twenty-two states have laws authorizing an “export list” of coverages that the insurance commissioner has determined are not generally available in the admitted markets. Coverages on the export list can be placed in the surplus lines market without a diligent search. In some of the states, the state insurance department is required to conduct an annual public hearing regarding the export list. The purpose of the hearing is to take testimony on the export list to determine whether any items should be added or removed.

The former NARAB (EX) Working Group updated the NAIC’s standard for determining compliance with the GLBA’s previous reciprocity provisions. In a report that was adopted by the NAIC in September 2009, the Working Group refined its approach to reciprocity relating to any underlying P/C licensing requirements for nonresident surplus lines producers. The Working Group determined that if a state requires the surplus lines producer to perform the diligent search of the admitted market, then the state may require the nonresident surplus lines producer to obtain an underlying nonresident P/C license in addition to a nonresident surplus lines license. However, the Working Group determined that a state may not require a nonresident surplus lines producer also to obtain a nonresident P/C license if they do not perform the diligent search. Many surplus lines producers do not perform diligent searches because the retailer has already conducted the diligent search, and the law does not require a second diligent search. In such instances, the surplus lines producer is not accessing the admitted market. Consequently, the Working Group determined that it was inconsistent with the previous GLBA reciprocity requirements to require an underlying P/C license for a surplus lines wholesale broker unless they are required by law to conduct a diligent search or conduct diligent searches in their agency.

The NRRA established a single “exempt commercial purchaser” exemption from state diligent search requirements that is applicable in every state. As of July 21, 2011, a diligent search in the admitted market is not required to place a policy for an exempt commercial purchaser if: 1) the broker has disclosed to the exempt commercial purchaser that coverage may be available from the admitted market, which may provide greater protection with more regulatory oversight; and 2) the exempt commercial purchaser has requested in writing that the broker procure/place such coverage with a surplus lines insurer.

An “exempt commercial purchaser” is defined in the NRRA as a purchaser of commercial insurance that:
1) employs or retains a qualified risk manager to negotiate insurance coverage; 2) has paid aggregate nationwide commercial P/C insurance premiums in excess of $100,000 in the immediately preceding 12 months; and 3) meets at least one of the following criteria: (i) possesses a net worth in excess of $20 million (as adjusted for inflation); (ii) generates annual revenues in excess of $50 million (as adjusted for inflation); (iii) employs more than 500 full-time employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate; (iv) is a not-for-profit organization or public entity generating annual budgeted expenditures of at least $30 million (as adjusted for inflation); or (v) is a municipality with a population of more than 50,000.

A number of the states elected to maintain their statutory exemptions from diligent search requirements, which were sometimes known as industrial insured exemptions. If the state’s industrial insured exemption was more liberal than the NRRA exempt commercial purchaser (ECP) exemption, then the state’s requirements were not in conflict with the NRRA, and the exemption in the NRRA would not apply.

SLI producers are routinely subject to additional state administrative requirements that are considered to be outside the scope of licensing reciprocity considerations or the ULS. The regulations regarding the administration of surplus lines are different from other types of insurance because the states typically require the licensed surplus lines producers to perform certain compliance activities that would usually be the responsibility of the licensed insurance company in a transaction in the admitted market. In a surplus lines transaction, the compliance obligations are imposed upon the producer because the producer is the licensed party. The surplus lines insurer is unlicensed and often referred to as a “nonadmitted insurer” in some of the states or “unauthorized insurers” in other states.

There are additional administrative requirements in some of the states for licensed surplus lines producers that apply once the coverage is placed. These may include:

1. Filing reports with state insurance departments or state stamping offices of placements made.
2. Collecting and paying surplus lines premium taxes.
3. Maintaining a record of all surplus lines placements made.
4. Providing the insured with a disclosure stating that the policy he or she has purchased is being issued by an insurer that is not licensed in the state, is not subject to the financial solvency regulation and enforcement that apply to the state’s licensed insurers, and does not participate in any of the insurance guarantee funds created by the state’s law.
5. Using a designated stamping office.
6. Including declaration or binder pages with the surplus lines tax filings.
7. Filing a report stating that no policies were written that are known as “zero reports” (as discussed later in this section).

In order for a producer to place business in the surplus lines market, the producer must first determine that the company is an eligible surplus lines company in a given state. Most of the states require that a surplus lines company be deemed “eligible” by meeting certain financial criteria or by having been designated as “eligible” on a state-maintained list. Prior to the enactment of the NRRA, state eligibility standards varied widely from state to state.

As of July 21, 2011, a surplus lines transaction is subject only to the eligibility requirements of the NRRA. The NRRA eligibility requirements are based on two provisions from the Nonadmitted Insurance Model Act (#870).

Specifically, the NRRA requires surplus lines carriers to comply with Section 5A(2) and Section 5C(2)(a) from Model #870, which require an insurer to be authorized in its domiciliary state to write the type of insurance that it writes as surplus lines coverage in the state where it is eligible and to have capital and surplus, or its equivalent, under the laws of its domiciliary jurisdiction, exceeding the greater of: 1) the minimum capital and surplus requirements under the law of the home state of the insured; or 2) $15 million. The insurance commissioner in the insured’s home state may reduce or waive the capital and surplus requirements (down to a minimum of $4.5 million) after the insurance commissioner makes a finding of eligibility based on several factors set out in Model #870, such as the quality of management, the surplus of a parent company and reputation within the industry.

In addition to eligibility requirements for U.S. domiciled insurers, the NRRA requires the states to permit the placement of surplus lines coverage with surplus lines companies organized in a foreign country (alien insurers) that are listed on the NAIC Quarterly Listing of Alien Insurers. The states cannot prohibit a broker from making a placement with an NAIC-listed
alien insurer. A state also may allow placement of coverage with alien insurers not on the NAIC list. A number of the states have authority to individually approve an alien carrier that is not listed on the Quarterly Listing of Alien Insurers.

The Quarterly Listing of Alien Insurers is available for reference and download on the NAIC Products – AVS, Data & Publications website at http://www.naic.org/prod_serv_alpha_listing.htm# (Quarterly Listing of Alien Insurers)

Premium Taxes

Surplus lines premium tax generally is the obligation of either the policyholder or the surplus lines producer, depending on the applicable state law. In all states, the producer or the insured, rather than the insurance company, remits the surplus lines tax. If the policy covers risks that are located entirely in one state, the tax is assessed at that state’s tax rate.

Under the NRRA, the home state of the insured has sole regulatory authority over the collection of surplus lines premium taxes. The NRRA prohibits any state other than the home state of the insured from requiring any premium tax payment for surplus lines insurance.

The NRRA permitted, but did not require, allocation of the surplus lines taxes among the states where the exposure was located. The states initially pursued three different approaches to allocation of taxes following the adoption of the NRRA: 1) the Nonadmitted Insurance Multi-State Agreement (NIMA); 2) the Surplus Lines Insurance Multi-State Compliance Compact (SLIMPACT); and 3) taxing and keeping 100% of surplus lines premium tax on policies in the home state of insureds. NIMA is no longer operational and SLIMPACT never became operational. The prevailing rule is that states are taxing and keeping 100% of the premium. The NRRA requires surplus lines brokers to adhere to the law of the home state of the insured to determine the amount of premium tax owed on a surplus lines transaction and for any other regulatory requirements the state may require in connection with the payment of the premium tax, such as the timing of tax payments and whether the state requires the submission of risk allocation information for multi-state transactions. The NRRA requires surplus lines brokers to submit the premium tax payment on a surplus lines transaction only to the insured’s home state. In the case of a state that has joined NIMA, the payment will be made to the clearinghouse in accordance with the home state’s law. Should SLIMPACT become operational, it also could elect to require multistate payments to be made to the clearinghouse.

Many of the states require brokers to submit documentation regarding allocation by state of the risks covered by a surplus lines transaction. If the home state of the insured is a state that has joined NIMA, the broker will be required to use the NIMA risk-allocation formula. If the home state is a state that has joined SLIMPACT, the broker will be required to use the SLIMPACT risk-allocation formula. As of May 2013, both NIMA and SLIMPACT have adopted the same allocation formula. Other states require the broker to submit allocation data in accordance with individual state laws and regulations, but the vast majority of states do not require allocation data because there are very few states allocating premium at this time. In some of the states, taxes are paid to a state agency other than the insurance department, such as the department of revenue.

Guaranty Fund Warning

Nearly all of the states require a disclosure regarding the unavailability of guaranty fund coverage for a surplus lines policyholder, even if the state represents a small portion of the risk. Prior to the NRRA, when a multistate risk was involved, the company would be required to include several pages of guaranty fund notices, many of which had nearly the same language with minor variations. Brokers may choose to continue to use this approach following the enactment of the NRRA, but the NRRA initiated a compliance system that requires compliance only with laws of the home state of the insured.
As an example, a typical disclosure statement is as follows:

NOTICE TO POLICYHOLDER

This contract is issued, pursuant to Section of the (State) Insurance Code, by a company not authorized and licensed to transact business in (State), and as such, is not covered by the (State) Insurance Guaranty Fund.

After review of this and other issues by a special NAIC subgroup in 2006, the Producer Licensing (EX) Working Group adopted its recommendation that, on a multistate risk, the home state’s disclosure should fulfill all other states’ disclosure requirements.

Stamping Offices

Stamping offices are entities that are not governmental agencies but whose existence is authorized by law. These offices act as the liaison between the surplus lines producer and the state insurance departments. The stamping offices have varied responsibilities, which may include evaluation of insurance companies for inclusion on a white list, review of surplus lines policies and education. Stamping offices also provide reports of premiums and taxes to the state insurance department.

Stamping offices are nonprofit and are funded by stamping fees assessed on each policy of surplus lines insurance written in the state. As of April 2017, there are stamping offices in 14 states.

Zero Reports

In some of the states, a producer is required to file a report, known as a “zero report,” stating that the producer has not placed any SLI business during a specified time period.

In 2006, a special NAIC study group documented that five states require this report monthly, 12 quarterly, seven semi-annually and 27 annually. The states also use the reports for different recording purposes, so it was not determined if it would be possible to eliminate these reports altogether. However, the study group concluded and recommended to the Producer Licensing (EX) Working Group that zero reports be eliminated. The group also recommended further study to determine feasibility of any other use of a zero report. As of January 2017, the Producer Licensing (EX) Working Group has not taken any formal action on this issue.
Chapter 11

Appointments

An appointment is a registration with the state insurance department that a producer is acting on behalf of an insurer. The PLMA contains several sections related to appointments. Section 14 of the PLMA establishes the requirement that a producer acting as an agent of an insurer must have an appointment. This is an optional provision and applies only in those states that require appointments. Section 15 of the PLMA establishes a procedure for the reporting of appointment terminations. The GLBA, as modified in 2015, prohibits any state other than a producer’s home state from imposing any appointment requirements upon a member of NARAB.

In 2002, the Producer Licensing (EX) Working Group adopted a uniform appointment process. The full text is included in the Appendices and is available on the Producer Licensing (EX) Working Group’s web page. This process is referred to in the ULS. The key elements include:

1. States should allow electronic filing of appointments and appointment terminations. Paper filings are discouraged.
2. States should establish a billing system for payment by insurers of initial appointments.
3. States shall allow insurers to select the effective date of the initial appointment.
4. States shall require insurers to follow a prescribed timeline to file appointments.
5. States shall require only one appointment or termination form or transaction per producer per company. (At this writing, appointments by company group are not available.)
6. States shall require insurance companies to submit terminations to the insurance department in accordance with the requirements of Section 15 of the PLMA.
7. States shall require that, if a producer is terminated for cause, the insurer must submit supporting documentation. Any information received by the insurance department must remain confidential in accordance with Section 15 of the PLMA.

In states that are required to renew appointments, the key elements include:

1. States shall provide or publish a pre-renewal notice to insurers informing them that appointment renewals are imminent.
2. At the time for renewal, a state will deliver an invoice. The invoice may not be altered, amended or used for appointing or terminating producers.
3. Insurers shall return the invoice and the payment to the department or its designee.
4. States shall establish a dispute resolution process to accommodate errors after the fact.

Appointment Terminations

Section 15 of the PLMA imposes a requirement on insurers to report terminations of producer appointments. Section 15 requires that the insurer report a termination within 30 days of its occurrence. If a termination is for any of the reasons listed in Section 12 (License Denial, Nonrenewal or Revocation) of the PLMA, insurers are required to submit a detailed report to the state and a copy of the report to the producer. Section 15 (E) grants immunity from civil liability for good-faith reporting to insurers and insurance regulators. Reports filed under Section 15 are considered confidential.
### Recommended Best Practices for Insurance Regulators

- Automatically terminate appointments if a license goes inactive for any reason.
- Eliminate fees for appointment terminations and instead assess all charges at the time of an appointment. This will eliminate delays in cancellations.
- Do not require an appointment as a condition of licensure. The PLMA and the ULS provide that a producer can hold a license without holding an active appointment.
- Require only one appointment or termination form or transaction for each company for each producer per state.
- Sub-appointments and Business Entity appointments are discouraged.
- Immediately accept terminations for cause and refer them for investigation. States should follow the procedures as outlined in the PLMA. No advance notice should be required to the producer or the state insurance department.
- Use electronic filing for appointments, terminations and renewals, to the extent possible, to eliminate delays and increase efficiency.
Chapter 12

Business Entities

Prior to the PLMA, most states used the term “insurance agency” to refer to the business structure used by insurance producers. Under the PLMA, the term “business entity” (BE) is used. This term is intended to cover a broad range of legal business operating structures. BEs are considered to be producers under the PLMA.

Section 2(A) of the PLMA defines a BE as a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

The Producer Licensing (EX) Working Group has adopted a uniform application form that is the standard for all states for resident and nonresident BE applications. Section 6(B) of the PLMA provides further guidance about the licensing of BEs:

A BE acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the Uniform Business Entity Application. Before approving the application, the insurance commissioner shall find that:

1. The BE has paid the fees set forth in [insert appropriate reference to state law]; and
2. The BE has designated a licensed producer responsible for the BE’s compliance with the insurance laws, rules and regulations of this state.

Since BEs are considered producers, the reciprocity issues discussed in other sections also apply to BEs. States should not require additional attachments to the application that might interfere with reciprocity.

A common issue that arises with resident and nonresident BE licensing is the role of the secretary of state (SOS) and the state corporation statutory requirements. Most states have adopted a Model Corporation Law that requires resident and nonresident businesses to register with the state corporation department. The issue for state licensing directors is whether the state insurance department should require some proof of registration with the SOS as a pre-condition to licensing. The NAIC legal department has studied this issue extensively and advised the Producer Licensing (EX) Working Group that states should not require items such as articles of incorporation or proof of registration with the SOS as a pre-condition to licensing for nonresident BEs.

The PLMA does require that all producers, including BEs, notify the insurance commissioner prior to using an assumed name. Section 10 of the PLMA states:

An insurance producer doing business under any name other than the producer’s legal name is required to notify the insurance commissioner prior to using the assumed name.

The uniform appointment process as adopted by the Producer Licensing (EX) Working Group does not specifically address BEs. Section 14 of the PLMA states that a producer acting as an agent of an insurance company must be appointed. States vary in the interpretation of these guidelines. This issue is one that the Producer Licensing (EX) Task Force considered in 2010 as part of its efforts to streamline BE licensing. In the absence of specific guidance from the Producer Licensing (EX) Working Group, the guidelines discussed in the paragraphs below are suggested.

Insurance regulators should balance the cost of a regulatory requirement with the benefit that requirement adds to consumer protection. If detailed information is collected, such as several levels of appointments, that information should be a meaningful part of the state insurance department’s consumer protection plan. If information is only rarely used in support of investigations, it may not be cost-effective to collect that information and require staff to compile it and process it. During a recent assessment of state insurance department licensing units, it was often found that information about affiliations and branch offices often required at the time of application was rarely used. Sub-appointments and BE appointments are discouraged.

Just as the uniform appointment process contemplates that only one appointment will be required for an individual producer no matter how many types of products that producer sells for a given company, if a state requires appointments for a BE, then
the state should require only one appointment per BE per company—no matter how many types of products that BE sells for a given company.

Section 6(B)(2) of the PLMA requires a BE to designate a licensed producer as responsible for compliance. This is commonly referred to as the designated responsible producer (DRP). There is no provision in the PLMA to require multiple DRPs if the BE chooses to write multiple lines of insurance. For example, if a DRP holds a life LOA only, and an affiliated producer is authorized to sell P/C products, it is not necessary for a DRP with a P/C LOA to be named as a second DRP.

The PLMA does not give specific guidance on appropriate action to take when a notification is received that the DRP has lost their home state license. A recommended practice is to send a notification to the BE and inform it that the BE license will go inactive unless a new DRP is named and approved within a reasonable number of days.

A BE has an ongoing responsibility to report misconduct of the BE or any of its affiliated producers. Section 12(c) of the PLMA states:

The license of a BE may be suspended, revoked or refused if the insurance commissioner finds, after hearing, that an individual licensee’s violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation and the violation was neither reported to the insurance commissioner nor corrective action taken.

<table>
<thead>
<tr>
<th>Recommended Best Practices for Insurance Regulators</th>
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<tbody>
<tr>
<td>• Use the NAIC uniform application for BEs, and eliminate all other state-specific forms.</td>
</tr>
<tr>
<td>• Review all state insurance laws and regulations, and amend any that require attachments that might violate reciprocity.</td>
</tr>
<tr>
<td>• Review the practical consumer protection value of all information collected, and collect only information that adds value.</td>
</tr>
<tr>
<td>• Require only one DRP per BE.</td>
</tr>
<tr>
<td>• If appointments are required for a BE, require only one appointment per state, and require no sub-appointments.</td>
</tr>
<tr>
<td>• Use electronic filings for more efficiency.</td>
</tr>
</tbody>
</table>
Chapter 13
Temporary Licenses

Section 11 of the PLMA contains a provision that allows a state insurance director to issue a temporary license to the survivor of a producer if the insurance commissioner deems it necessary for servicing the deceased producer’s customers.

The license is limited to 180 days and also may be limited in scope by the insurance commissioner. The intent of this section is to wind up the business affairs of the producer and not to indefinitely continue the decedent’s insurance business.

The PLMA gives three examples of persons eligible for a temporary license:

1. The surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the producer, or for the recovery or return of the producer to the business, or to provide for the training and licensing of new personnel to operate the producer’s business.
2. A member or employee of a BE licensed as an insurance producer, upon the death or disability of an individual designated in the BE application or the license.
3. The designee of a licensed insurance producer entering active service in the armed forces of the U.S.

The insurance commissioner also is given discretion to grant a temporary license in any other circumstance where the insurance commissioner deems that the public interest will best be served by the issuance of this license. The insurance commissioner also may require the temporary licensee to have a licensed producer as a sponsor.
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Chapter 14
Continuing Education

The completion of CE is the method used by state insurance regulators to ensure continued competence of producers. Under the previous GLBA reciprocity requirements, a state had to recognize a producer’s completion of a CE requirement in the producer’s home state as satisfying the other state’s CE requirement for license renewal. The only exception was if the producer’s home state refused to provide reciprocity to another state.

Some states have adopted special training requirements for specific lines of insurance. When such a requirement exists, it is typically imposed on resident and nonresident producers selling a specific insurance product. A specific CE standard, which is derived from federal mandates, may be imposed on nonresidents such as for long-term care insurance (LTCI), annuity, flood or crop insurance and would not violate the ULS.

Section 16(B) of the PLMA specifically states:

A nonresident producer’s satisfaction of his or her home state’s CE requirements for licensed insurance producers shall constitute satisfaction of this state’s CE requirements if the nonresident producer’s home state recognizes the satisfaction of its CE requirements imposed upon producers from this state on the same basis.

Under the ULS, producers are to complete 24 credits of CE for each biennial compliance period. Three of the 24 credits must be in ethics. Fifty minutes is equal to one credit hour of CE. If applicable, the CE compliance period should coincide with the license renewal. The ULS indicate that the license term should be tied to the birth date or birth month. Calculation of one credit hour of CE should be based on the NAIC Guidelines for CE. If applicable, the CE compliance period should coincide with the license renewal. The ULS indicate that the license term should be tied to the birth date or birth month.

CE is required if the producer holds one of the six major lines of authority contained in the PLMA, but it is not required for each line of authority. For example, if a producer holds a life and a property line of authority, the requirement for renewal is 24 credits. If a producer holds only the life line of authority, the requirement for renewal is 24 credits. States may limit the subject area requirements for CE. Some states prohibit CE credit for training on sales techniques. Generally, CE is not required for limited lines. Under the ULS, producers may repeat CE courses for credit in successive renewal terms but are not permitted to take a course for credit more than once in the same license continuation period. States must accept both classroom study and verifiable self-study. States should not impose a limit on the use of self-study courses.

Producers and CE providers must submit evidence of course completion in the method specified by the insurance commissioner. Some states require the producer to present a certificate of completion at the time of license renewal. Many states require the CE provider to report attendance. Under this system, a producer is required to present only the attendance certificates if there is a discrepancy. Another option is to require producers to self-certify completion and then verify compliance by random desk audits.

The PLMA and the ULS contain two exemptions from CE requirements. The exemptions are an inability to comply due to military service and/or a demonstration of an extenuating circumstance, such as medical disability. States with waivers for professional designations should consider allowing CE credits for filed and approved courses used to obtain and maintain professional designations.

Some states grant an extension instead of an exemption. This decision is left to each state to decide.

Course Approvals

The Producer Licensing (EX) Working Group has adopted standards for course approval and reciprocity in filing of courses. States are to follow the standards set forth in the Continuing Education Reciprocity (CER) process as adopted by the Producer Licensing (EX) Working Group. Under a reciprocity filing, states are to accept the number of credits awarded by another state and treat a request for reciprocity as a registration. Only the home state of the CE provider is to perform a content review of the course filing. The Appendices contain information on CER and the current filing forms. The most current information on CER can be found on the Producer Licensing (EX) Working Group web page.
States vary in their method for course content approval. Some states use outside vendors, and others do the course reviews internally. The Producer Licensing (EX) Working Group has not adopted any guidelines on methods for approving classroom courses.

The Producer Licensing (EX) Working Group has adopted guidelines for approval of online and self-study courses. The goal of these standards is to deliver functional computer-based Internet courses that offer quality insurance and/or risk management material in a password-protected online environment.

The key elements are:

1. Material that is current, relevant and accurate, and includes valid reference materials, graphics and interactivity.
2. Clearly defined objectives and course completion criteria.
3. Specific instructions to register, navigate and complete the coursework.
4. Technical support or provider representative available during business hours.
5. A process to authenticate student identity.
6. A method for measuring the student’s successful completion of course material and for evaluating the learning experience.
7. A process for requesting and receiving CE course-completion certificates.

The standards call for an examination that is proctored by a disinterested third party. The standards also provide several methods to compute the number of credits that should be awarded. The standards also recommend acceptance of courses that are part of a program that is part of a nationally recognized professional designation. For designation courses, the course should receive credit hours equivalent to hours assigned to the same classroom course material.

The Continuing Education Recommended Guidelines on Online and Self-Study is included in the Appendices.

The ULS prohibit CE providers from advertising CE programs until state course approval is received.

The Appendices contain a sample list of questions and answers frequently asked by insurance producers about CE requirements.

**Continuing Education Providers**

A state should have a process for registering and qualifying persons who wish to be recognized as CE providers. The process should include duties, responsibilities and performance standards for CE providers. An aspiring CE provider should demonstrate an ability to deliver quality instruction and to comply with all reporting and course supervision requirements. These standards should also contain the conditions under which a CE provider may be removed from the state’s approved provider list.

The Appendices contain a sample outline of instructions to CE providers.

### Recommended Best Practices for Insurance Regulators

- Require CE providers to electronically report class attendance to the state insurance department or its designated vendor.
- Set a reasonable deadline for CE providers to deliver electronic reports.
- Require CE providers to promptly issue attendance certificates (or certificate of completion for self-study courses) and require producers to retain them. The certificates should be sent only to the state insurance department in the event of a dispute.
- Provide access for producers and insurers to department records to monitor CE credits on file.
- Implement an audit program to observe and evaluate CE providers and instructors.
- Participate in the NAIC Personalized Information Capture System (PICS) to receive alerts or monitor actions against existing licensees.
Chapter 15

Reporting of Actions and Compensation Disclosure

Reporting of Actions

Section 17 of the PLMA requires a producer to report, to all states in which the producer is licensed, any administrative action taken against the producer in another jurisdiction or by another governmental agency in this state within thirty (30) days of the final disposition of the matter. Producers also are required to report any criminal prosecution of the producer taken in any jurisdiction within 30 days of the initial pretrial hearing date.

The challenge for producers is that it can be difficult to ensure that all relevant states received the report. NIPR has created an electronic solution, called Reporting of Actions (ROA), to facilitate distribution of one report to multiple states. States should encourage the use of this electronic process to save time and create an electronic record of timely submission.

State licensing directors should have a method to receive these reports and refer them for investigation. The director should consider giving staff limited authority to review and clear reports that include violations such as traffic citations or certain misdemeanors.

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<tr>
<td>• Use the Attachment Warehouse/Reporting of Action system to receive electronic notifications to alert a state when an individual or business entity producer has added information into the Attachment Warehouse since their initial entry regarding administrative, criminal or civil actions.</td>
</tr>
</tbody>
</table>

Compensation Disclosure

Section 18 of the PLMA requires disclosure where the producer receives any compensation from the customer for the placement of insurance or represents the customer with respect to that placement. This section contains several specific definitions and exceptions to the disclosure requirement. The Producer Licensing (EX) Working Group has not developed any formal guidance on the implementation of Section 18, but the NAIC issued an FAQ document to give additional guidance. This FAQ is in the Appendices. State licensing directors should confer with their legal counsel as to appropriate methods for implementing this section.
Chapter 16

License Renewal and Reinstatement

License Renewal

Under the PLMA, the general rule is that a producer license remains in effect unless suspended, cancelled or revoked. All states have a procedure for individual producers to verify compliance with CE requirements. In states that renew licenses, the CE compliance period should coincide with the license renewal.

The Producer Licensing (EX) Working Group has adopted a uniform license renewal application that is recommended for use by states that renew producer licenses. The current version of the application can be found on the Producer Licensing (EX) Working Group web page. States should use the data elements from the uniform renewal application, whether renewal is done via paper application or electronically.

The previous reciprocity provisions of the GLBA also applied to license renewal of nonresidents. The process should be similar to initial licensing:

1. The proper application and fee are submitted.
2. If the answers to any of the questions on the renewal application indicate conduct prohibited by Section 12 of the PLMA, a state can require additional documentation.
3. No other attachments should be required.

A number of states use the electronic license renewal process. This process automatically checks the NAIC and NIPR databases to verify the producer’s standing in the home/resident state. The NIPR process uses the data elements from the uniform renewal application.

The PLMA contains a special process for producers who cannot comply with CE requirements due to military service or other extenuating circumstances.

Reinstatement

The PLMA allows a producer to reinstate a lapsed license within 12 months of expiration. No examination is required as long as the producer was otherwise eligible to renew. The PLMA also provides that a penalty fee can be assessed.
Chapter 17

Post Licensing Producer Conduct Reviews

Section 12 of the PLMA contains a list of 14 reasons a producer may be disciplined. The insurance commissioner is given authority to take administrative action against a producer who commits any of these acts. Disciplinary action may include suspension, revocation or refusal to renew the producer license. Some states have added additional provisions to this list. For example, if a state does not align the CE compliance term with license renewal, it may be necessary to commence an administrative action to suspend the producer’s license for failure to timely complete CE. In some states, insurance departments are required to suspend the license of any individual who fails to pay student loans on a timely basis.

States should use caution in adding additional disciplinary reasons and should carefully review the requirements of the ULS. The full text of the PLMA can be found in the Appendices.

After a license is issued, an insurance regulator may become aware of potential violations of Section 12 in several ways:

1. A licensed producer notifies the insurance regulator of pending criminal charges.
2. The insurance regulator receives a notice from PICS indicating that a nonresident producer failed to disclose criminal charges.
3. A PICS Notice is received of previously unreported administrative action.
4. A letter is received from the producer informing of an administrative sanction by another state or FINRA.
5. The insurance regulator receives subsequent arrest or conviction information from the state’s department of justice (DOJ).

The following considerations should be taken into account:

1. If the producer is a nonresident, the insurance regulator should consider what, if any, action was taken by the producer’s resident state or FINRA.
2. Whether the criminal charge or administrative action indicates that the producer is or may be a danger to consumers.
3. Whether the charge involves theft or other financial fraud, or involves an activity that threatens the safety of consumers, such that action should be taken immediately to revoke or suspend the producer’s license.
4. Whether it is appropriate to contact the producer and request a voluntarily surrender of the license.
5. If the producer failed to report an action, the insurance regulator should consider contacting the producer and request an explanation from the producer. Technical violations (e.g., bad address, failure to timely report) generally do not merit formal action. However, the failure to report an action in itself can be cause for administrative penalty or a warning letter, depending on the particular state’s statutes and regulations.
6. Whether the individual did not disclose previous criminal or administrative actions taken in response to the answers to the background questions on any application.

License Reinstatement or Reissuance After Disciplinary Action

Reinstatement of a producer license means the producer’s previous license is re-activated and will expire at the end of the license term. Reissuance of a license means the issuance of a new license with a full license term.

Reinstatement or reissuance of a license after disciplinary action usually is not automatic. A producer whose license has been revoked or suspended by order, or who forfeited a license in connection with a disciplinary matter, should be required to make a written request to the insurance commissioner for reconsideration of the action taken on the license whether it be reinstatement or reissuance in accordance with the terms of the order of revocation or suspension or the order accepting the forfeiture.

When a producer’s license has been suspended for a period of time that extends beyond the producer’s license expiration date, reinstatement is not an option. The producer must request reissuance of a license and should not be allowed merely to apply for a new license by passing an examination and submitting a new application.

The producer’s request for reinstatement or reissuance must include sufficient information to allow the insurance department to determine whether the basis of the revocation, suspension or forfeiture of the applicant’s license no longer exists and whether it will be in the public interest to grant the request for a new or reinstated license. The burden of proof to establish such facts is on the producer. In most states, the producer will have a right to an administrative hearing if the reinstatement request is denied.
Some states allow a license to be voluntarily forfeited in lieu of compliance with an order of the insurance commissioner. In this scenario, a request for voluntary forfeiture of a license should be made in writing to the insurance commissioner. The written consent of the insurance commissioner usually is required.

Forfeiture of a license is effective upon submission of the request, unless a contested case proceeding is pending at the time the request is submitted. If a contested case proceeding is pending at the time of the request, the forfeiture becomes effective when and upon such conditions as required by order of the insurance commissioner. A forfeiture made during the pendency of a contested case proceeding is usually considered a disciplinary action subject to reporting to RIRS.

**Collaboration and Referrals Among Insurance Regulators**

There are several NAIC tools to facilitate communication about enforcement actions among insurance regulators.

The NAIC’s Market Actions (D) Working Group (MAWG) identifies and reviews insurance companies that are exhibiting or may exhibit characteristics indicating a current or potential market regulatory issue that may affect multiple jurisdictions. The Working Group determines if regulatory action should be taken and supports collaborative actions in addressing problems identified.

The NAIC has adopted the *Market Regulation Handbook* to guide state insurance regulators in the conduct of investigations and enforcement activities. The *Market Regulation Handbook* also gives guidance to market conduct examiners on some licensing issues. The Producer Licensing (EX) Working Group has advised examiners that insurers should not be required to keep a hard copy of each individual producer license. Under the PLMA and the *Market Regulation Handbook*, insurers and insurance regulators are directed to rely on the SPLD to verify license status.

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<tr>
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<td>• Report all formal final administrative actions to RIRS regardless of the voluntary forfeiture, fine or penalty amount.</td>
</tr>
<tr>
<td>• Use CRD, SPLD, RIRS, 1033 Application, PICS and state court records to verify information submitted by applicants. State court records databases may be available online to analysts.</td>
</tr>
<tr>
<td>• Check the producer’s resident or home state’s website or other licensing records to verify actions reported or taken by that state. The NAIC website has a map with links to each state insurance department website.</td>
</tr>
<tr>
<td>• Develop form letters or consent order templates pre-approved by legal staff to be used by experienced licensing staff to propose settlement of minor violations without need to involve legal staff.</td>
</tr>
<tr>
<td>• Adopt an administrative rule that if an order of revocation or suspension does not contain terms regarding reissuance or reinstatement, an application for reinstatement or reissuance may not be made until at least one year has elapsed from the date of the order or acceptance of the forfeiture of a license.</td>
</tr>
<tr>
<td>• Maintain a record tickler system of all special conditions imposed on any producer licenses so that the compliance with the conditions can be reviewed as the end of any special supervision term nears.</td>
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Part II

Miscellaneous Licenses

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Chapter 19  Bail Bond Agents
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Chapter 18

Adjusters

An adjuster is a person who investigates claims, determines coverage, examines relevant documents and inspects property damage. An adjuster also may determine the amount of a claim, loss or damage payable under an insurance contract or plan. An adjuster often settles or negotiates settlement of the claim. In some states, the adjuster’s authority is limited to a specialty area such as auto, homeowner, workers’ compensation or crop insurance.

There are three-four kinds of adjusters: 1) public; 2) independent including crop; and 3) company (sometimes called staff adjusters). Public adjusters represent the insured, while independent and staff adjusters represent the insurer. More than 30 states require licensure of one or more of these types of adjusters.

Public adjusters directly contract with the person who is seeking coverage or benefits under an insurance policy or other kind of insurance plan. The role of a public adjuster is to represent an insured or claimant in the settlement of a claim. The NAIC has adopted the Public Adjuster Licensing Model Act (#228).

Under the model, a public adjuster is defined as:

“Public adjuster” means any person who, for compensation or any other thing of value, acts on behalf of an insured by doing any of the following:

1. Acting for or aiding an insured in negotiating for or in effecting the settlement of a first-party claim for loss or damage to real or personal property of the insured.
2. Advertising for employment as a public adjuster of first-party claims or otherwise soliciting business or representing to the public that the person is a public adjuster of first-party claims for loss or damage to real or personal property of an insured.
3. Directly or indirectly soliciting the business of investigating or adjusting losses, or of advising an insured about first-party claims for loss or damage to real or personal property of the insured.

Staff adjusters are typically salaried employees of an insurer or an insurer’s affiliates and do not adjust claims for entities other than their employer or its affiliates. Independent adjusters are self-employed or associated with or employed by an independent firm. Independent adjusters may adjust claims on behalf of many insurers. The NAIC has adopted model guidelines for Independent Adjuster Licensing Guideline adjusters that states are encouraged to adopt. The Appendices contain the model guideline.

Most states recognize one or more of the following exemptions to adjuster licensing:

1. Attorneys-at-law admitted to practice in this state, when acting in their professional capacity as an attorney.
2. A catastrophe situation officially declared by the insurance commissioner or governor (according to state law). Registration may be required, but no permanent license should be required of a nonresident adjuster who is sent on behalf of an insurer for the purpose of investigating or adjusting a loss or a series of losses resulting from a catastrophe.
3. A person employed solely to obtain facts surrounding a claim or to furnish technical assistance to a licensed independent adjuster.
4. An individual who is employed to investigate suspected fraudulent insurance claims but who does not adjust losses or determine claims payments.
5. A person who solely performs executive, administrative, managerial or clerical duties, or any combination thereof, and who does not investigate, negotiate or settle claims with policyholders, claimants or their legal representatives.
6. A licensed health care provider or its employee who provides managed care services as long as the services do not include the determination of compensability.
7. A managed care organization or any of its employees or an employee of any organization providing managed care services as long as the services do not include the determination of compensability.
8. A person who settles only reinsurancce subrogation claims.
9. An officer, director, manager or employee of an authorized insurer, surplus lines insurer, a risk retention group (RRG) or an attorney-in-fact of a reciprocal insurer.
10. A U.S. manager of the U.S. branch of an alien insurer.
11. A person who investigates, negotiates or settles life, accident and health, annuity, or disability insurance claims.
12. An individual employee, under a self-insured arrangement, who adjusts claims on behalf of his or her employer.
13. A licensed insurance producer to whom claim authority has been granted by the insurer.
14. A person authorized to adjust workers’ compensation or disability claims under the authority of a third-party administrator (TPA) license pursuant to [applicable licensing statute].

Drafting Note: This guideline is drafted to eliminate redundant licensure requirements with respect to the activities engaged in by a licensee. If licensed as an independent adjuster, TPA or similar business entity, licensees should not be required to obtain separate independent adjuster licenses, provided that the types of claims adjusted do not include life, health, annuity or disability insurance claims.

**Qualifications of an Adjuster**

States that do require licensure assess the qualifications of potential adjusters in various ways. States use one or more of the following methods to determine that a person has the requisite knowledge to properly adjust claims:

1. Specialized or related education prior to licensure, i.e., prelicensing coursework.
2. A specified amount of experience that is relevant to the kind of adjusting work the applicant will be doing (i.e., P/C, workers’ compensation or life/health).
3. A license examination.
4. Relevant professional designation such as the Chartered Property Casualty Underwriter (CPCU) or Associate in Claims (AIC).
5. Prior similar licensure in another state.

For states implementing a new regulatory scheme for adjusters, it is common practice to waive the initial exam for applicants with appropriate credentials and experience.

**Fitness and Character Considerations**

Like insurance producers, many states also evaluate an applicant’s fitness, character and trustworthiness to engage in this aspect of the insurance business. Insurance regulators typically consider:

1. Criminal history.
2. Administrative actions taken by other state insurance regulators.
3. Civil judgments that may shed light on an applicant’s character or fiscal integrity.

In some states, an adjuster must apply for a license by line of insurance, or line of authority, similar to the manner in which producers are licensed. Other states require adjuster licenses by categories such as motor vehicle physical damage, workers’ compensation or crop.

States are encouraged to implement a fingerprint requirement for public and independent adjusters, similar to what is required of producers. Additionally, if a state permits a nonresident adjuster to designate that state as its home state, fingerprinting of that nonresident should be required. States are encouraged to adopt the Authorization for Criminal History Record Check Model Act (#222) when evaluating and considering whether an applicant or licensee has met the character and trustworthiness requirements to obtain, maintain or renew a license.

**Reciprocity**

In almost every jurisdiction where licensure is required, it is the “home state” insurance regulator who assesses the qualifications of his or her resident adjusters. Based upon securing a license in one’s home state, many states will grant a comparable or similar nonresident license to such an individual. This is not the case in all states, and varying lines of authority, qualification standards and license types have created barriers to nonresident licensure. In addition, an adjuster based in a state that does not license adjusters may be required to take exams in multiple states.

The **New NAIC Public Adjuster Model Act** defines home state as:

“Home state” means the District of Columbia and any state or territory of the U.S. in which the public adjuster’s principal place of residence or principal place of business is located. If neither the state in which the public adjuster maintains the principal place of residence nor the state in which the public adjuster maintains the principal place of business has a substantially similar law governing public adjusters, the public adjuster may declare another state in which it becomes licensed and acts as a public adjuster to be the “home state.”
The NAIC Independent Adjuster Guidelines defines home state as:

“Home state” means the District of Columbia and any state or territory of the U.S. in which an independent adjuster maintains his, her or its principal place of residence or business and is licensed to act as a resident independent adjuster. If the resident state does not license independent adjusters for the line of authority sought, the independent adjuster shall designate as his, her or its home state any state in which the independent adjuster is licensed and in good standing.

There are a few states that will not grant nonresident licensure based upon a person having qualified and passed a license exam in the applicant’s home state. Instead, these states require the nonresident applicant to take an exam in the nonresident state even though the person has taken and passed the license exam in the home state.

Adjuster licensing processes were modeled on producer licensing processes and in 2011, the NAIC adopted the Independent Adjuster Reciprocity Best Practices Guidelines paper, which provides jurisdictions with a model to meet reciprocity requirements, as well as take major steps toward reaching uniformity. The NAIC uniform licensing forms are designed to be used by applicants for adjuster licenses. Producer licensing for nonresidents is predicated on the producer satisfying the requirements for a home state license. Those producer requirements often include prelicensing education and examination. Since, at this writing, 40 states license public adjusters, 33 states license independent adjuster licenses and only 15 states require company adjusters to be licensed, obtaining nonresident adjuster licenses becomes more complex because adjusters often do not have an underlying resident license. Until states adopt the provision that allows an individual to qualify for licensure by designating another state as the person’s home state or to designate the state in which the application is filed as the person’s home state, obtaining a nonresident adjuster license becomes more complex because adjusters often do not have an underlying resident license.

Some states do not license adjusters. In order for the use of electronic licensing systems, adjusters residing in states that do not license adjusters can select an Adjuster Designated Home State (ADHS). The ADHS is the state in which the adjuster does not maintain his, her or its principal place of residence or business, and the adjuster qualifies for the license as if the person were a resident.

A state whose laws permit a nonresident adjuster to designate that state as its home state will require the nonresident to qualify as if the person were a resident (exam requirements; fingerprinting, if required; and CE). Once the individual has met the qualifications, the designated home state will issue a nonresident license. The PDB and designated home state will list the record as nonresident, designated home state.

If the resident state of the adjuster does not require an adjuster license, adjusters cannot use the NIPR ADHS module unless they declare another state to be the home state. NIPR has recently added a new Nonresident Adjuster Licensing (NRAL) application that allows an individual to designate a state other than the resident state as the home state. NIPR contains functionality to allow adjusters that have designated another state as the home state to renew online. Adjusters with any license can update contact information through the NIPR CCR.

Continuing Education

Approximately 18 states have CE requirements for their resident adjusters. Reciprocity exists among a majority of these states but not all, in part as a result of the inconsistency among lines of authority granted within each state’s adjuster licensing scheme. It also becomes problematic when the resident adjuster’s home state does not have any CE requirements.

Model #228 and the Independent Adjuster Licensing Guideline contain a CE requirement that the home state shall require 24 hours of CE every two years, with three of the 24 hours covering ethics. It is recommended that a state accept an adjuster’s satisfaction of its home state’s CE requirements as satisfying that state’s CE requirements, provided that the home state recognizes CE satisfaction on a reciprocal basis. For a state that permits a nonresident adjuster to designate that state as its home state, the home state will require and track CE compliance for that adjuster.

Emergency/Catastrophic Adjusters

A state that offers temporary licensure or registration for emergency/catastrophic adjusters are encouraged to follow the Independent Adjuster Licensing Guideline and develop an automated notification or registration procedure that allows for an immediate, streamlined and efficient filing process for adjusters who are seeking authority to adjust claims in the event an emergency or catastrophe is declared.
Non-U.S. Adjusters for Limited Lines Portable Electronics Insurance Products

Many states license, or are considering licensure for, limited lines portable electronics insurance producers. Because some major portable electronics insurance companies provide claims adjustment services via non-U.S. entities, the issue of licensing adjusters who do not reside in the U.S. has gained increased prominence. The Independent Adjuster Licensing Guideline and Model #228 are silent on the licensing of non-U.S. citizens beyond the requirement to designate a home state. Some states, however, have tax laws or other laws that require licensees and applicants for licenses to submit and maintain a Social Security number (SSN). State license laws that allow for the licensing of non-U.S. adjusters must take this possible barrier to licensure into consideration. States also should require non-U.S. citizens to comply with all necessary qualification requirements, such as passing the resident license examination (if applicable).

Recommended Best Practices for Regulators

- Adopt the NAIC Model Act for Public Adjusters.
- Adopt the NAIC Independent Adjuster Licensing Guideline.
- Use the NAIC uniform applications and develop a mechanism for electronic submission and electronic bulk submissions.
- Use the definition of “home state” as defined in the NAIC Public Adjuster Model Act as the basis of reciprocity.
- Provide resident and nonresident adjuster licensing requirements on forms and Web sites and on the SPLD.
- Allow electronic payment for residents and nonresidents for authorized submitters as well as individual adjusters.
- Post applications and license status information on Web sites and on the SPLD.
- Eliminate perpetual licenses, eliminate the word “perpetual” from issued licenses, and adopt a biennial renewal process tied to the uniformity standards.
- Adopt the NAIC Independent Adjuster Reciprocity Best Practices Guidelines.
- Use the definition of “home state” as defined in the NAIC Independent Adjuster Licensing Guideline (#1224)
- Participate in the NIPR ADHS application.
- Participate in the NAIC Personalized Information Capture System (PICS) to receive alerts or monitor actions against existing licensees.
- Use the Attachments Warehouse/Reporting of Action system to receive electronic notifications to alert a state when an adjuster has added information into the Attachments Warehouse since their initial entry regarding administrative, criminal or civil actions. For nonresidents that designate your state as the “home state”, a nonresident license should be issued.
- For nonresidents that designate your state as the “home state”, develop internal data fields that will allow the tracking of CE compliance.
- Include a provision in law that prohibits simultaneous licensure as both an Independent Adjuster and a Public Adjuster.
- If your state requires a license examination, require applicants for a resident license to pass your own state’s examination, not simply use passing results from another’s state’s examination. However, recognition of an exam taken in another state may be given where a nonresident license is being requested.
- Grant an exemption from the license examination requirement to applicants for the crop line of authority who have satisfactorily completed the National Crop Insurance Services Crop Adjuster Proficiency Program or the loss adjustment training curriculum and competency testing required by the Federal Crop Insurance Corporation Standard Reinsurance Agreement.
- If your state allows non-U.S. citizens to receive a license, ensure that other laws in your state (such as tax laws) do not require every licensee or applicant for a license to submit a Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN).
Chapter 19

Bail Bond Agents

A bail bond is one method used to obtain the release of a defendant awaiting trial upon criminal charges from the custody of law enforcement officials. A bail bond can be based on an insurance product or collateral. The defendant, the defendant’s family and friends, or a professional bail bond agent executes a document that promises to forfeit the sum of money determined by the court to be commensurate with the gravity of the alleged offense if the defendant fails to return for the trial date. A bail bond is considered a three-part contract between the defendant, the government and the insurance company.

Some states regulate bail bonds through the insurance department, and others leave the administration to the discretion of the court system. It is usually required that a bail bond insurer file a power of attorney with the local court authority. This power of attorney is proof to the court that the bail agent is authorized to write bonds for that insurer up to a certain dollar amount.

State insurance departments vary in the manner in which bail bond activities are regulated. There is no NAIC model to guide state licensing directors for bail bond agents. A number of states use the surety line of authority to regulate only the bonds that are insurance-based. In other states, a more comprehensive system has been developed that includes examinations, background checks and personal integrity bonds. The majority of bail bond transactions are executed by resident bail bond agents. Some states prohibit nonresident bail bond agents. In many states, the state court system and local county sheriff may also have a process for approval of bail bond agents.

States that regulate bail bond agents should consider including the following elements in their regulatory scheme:

1. Minimum content and disclosure requirements for the bail bond contract.
2. Detailed record-keeping.
3. Requirement that bail funds be segregated in a trust account.
4. Appointments for all bail bond agents.
5. Written examination.
6. Background check, including fingerprints.
7. P relicensing education on state laws and bond procedures.
8. Completion of CE.
9. Laws that clearly place liability on insurers’ appointed bail bond agents who fail to comply with state law on bail bonds and return of collateral.
10. Cross reference the PLMA and the state’s unfair trade practices act to apply penalties for misconduct.
11. Laws that create a fiduciary relationship between the bail bond agent and the criminal defendant.
12. Dialogue with the appropriate state court and law enforcement officials to coordinate efforts at regulating bail bond agents.
13. Adoption of a specific list of prohibited activities by bail bond agents.

Bond Forfeiture

Forfeiture enforcement may or may not be the responsibility of the state insurance department. In some states, enforcement is left to the court system. This may result in a bail agent’s bond privileges being revoked in a particular county. If enforcement is the responsibility of the state insurance department, the state likely will have authority to suspend or revoke the license of a bail agent.

Prohibited Activities

The following list contains excerpts from several states’ laws and regulations regarding bail bond agent licenses. This is a suggested starting point for states to draft a list of prohibited activities for bail bond agents and insurers:

1. Pay, rebate, give or promise anything of value to a jailer, peace officer, magistrate or any other person who has power to arrest or hold a person in custody, or to any public official or public employee for the purpose of securing a settlement, compromise, remission or reduction of the amount of bail bond, or to secure delay or other advantage. This section does not prohibit public reward paid for the return of a fugitive.
2. Pay, rebate, give or promise anything of value to an attorney in a bail bond matter, except in defense of an action on a bail bond, collateral or indemnification agreement.
3. Pay, rebate, give or promise anything of value to a defendant or anyone acting on the defendant’s behalf in exchange for a referral of bail bond business.
4. Recommend a particular attorney to represent a defendant.
5. Solicit business where a prisoner is confined in or near a courtroom if otherwise prohibited by court order or law.
6. Sign or countersign a bail bond that the licensee did not execute.

**Immigration Bonds**

An immigration bond guarantees the Immigration and Naturalization Service (INS) that an alien will comply with one of several obligations under U.S. immigration laws. Most often, an immigration bond guarantees the alien while released from U.S. custody during the pendency of the government’s case for unlawful entry into the country. An immigration bond can be in the form of a surety product or collateral. (See INS Form I-352.) With respect to surety products, the underlying guarantee is an insurance product permitted to be issued solely by a licensed insurer. Consequently, an individual selling, soliciting or negotiating an immigration bond must maintain a resident or nonresident producer license in order to legally sell the bond in a state.

States should recognize that immigration bonds are a form of insurance required to be issued by a licensed insurer and that the sale, solicitation and negotiation of immigration bonds constitute activities for which an individual must maintain a license as a resident or nonresident producer under the respective states’ licensing laws. New Jersey Bulletin No. 09-09 contains an example of notification regarding appropriate treatment of immigration bonds.
Chapter 20

Charitable Gift Annuities

A charitable gift annuity (CGA) is a transfer by a donor to a charitable organization. In return, the donor receives an annuity payable over one or two lives. If the actuarial value of the annuity is less than the value of the property transferred, then the difference in value constitutes a charitable deduction for federal tax purposes. CGAs are not investments. Annuity payments are tax-free partial returns of the donor’s gift based on actuarial tables of life expectancy.

To qualify as a charitable organization under the federal law, the entity must be one described in either Section 501(c)(3) or Section 170(c) of the Internal Revenue Code (IRC).

The maximum rates of return that are typically paid on these uninsured annuities are established by the American Council on Gift Annuities (ACGA).

Gift annuity payments are fixed. They never go down or up. CGAs are not insured. A charity could become insolvent and be unable to make annuity payments. Most gift annuities are not protected by any state guaranty fund.

Chapter 21

Fraternals and Small Mutuals

Fraternal Benefit Societies

A fraternal benefit society is a membership organization that is legally required to offer life, health and related insurance products to its members, be not-for-profit, and carry out charitable and other programs for the benefit of its members and the public. It must be composed of members having a common bond and be organized into lodges or chapters (local membership groups). A fraternal benefit society exists solely for the benefit of its members and their beneficiaries. Fraternal benefit societies must have a representative form of governance.

Federal law allows a fraternal to offer life and health insurance products. Section 501(c)(8) of the IRC defines a fraternal beneficiary society as:

(a) a nonprofit mutual aid organization;
(b) operating under the lodge system or for the exclusive benefit of the members of a fraternity itself operating under the lodge system; and
(c) providing for the payment of life, sick, accident or other benefits to the members of such society, order or association, or their dependents.

Fraternal benefit societies offer insurance products, are chartered and licensed according to state insurance laws, and are regulated and examined by state insurance departments. Individuals who sell, solicit or negotiate insurance products for a fraternal benefit society are required to obtain a state insurance producer license.

The NAIC has adopted the Uniform Fraternal Code (#675). However, this model is not widely in use. At this writing, 45 states had adopted a version of the Model Fraternal Code as drafted by the National Fraternal Congress of America (NFCA). Both the NAIC model and the NFCA model contain a section about producer licensing that pre-dates the PLMA. States should check the fraternal law that has been adopted in their state and update it to reference the PLMA.

Small Mutual Insurers

Small mutual insurers are risk-bearing entities that historically formed around common interests of farmers, householders, and ethnic and religious groups. Small mutuals, commonly known as farm mutuals, may also be called “town” or “county” or “state” mutuals.

Small mutuals provide, with only a few exceptions, property insurance for homes, farmsteads, crops and some small businesses. They do not, except for the legal liability associated with those risks, write casualty insurance. In some states, small mutuals are allowed to offer liability coverage through an affiliation with an insurer. State laws usually limit small mutuals to either a certain premium volume or geographic area or both. Most states also impose a lighter regulatory burden than that applied to larger mutual and investor-owned insurers.

Mutual insurers are owned and operated by the policyholders. Unlike a stock company, a mutual policyholder has an indivisible interest in the enterprise that, in general, cannot be bought or sold like a share of stock. Policyholders often are referred to as “members.” In some cases, a dividend or return of premium is paid when the mutual’s board of directors judges it has sufficient capital. Members of the board also are policyholders.

Individuals who sell products for small mutuals should be licensed as producers as outlined in the PLMA and the ULS.
Chapter 22

Insurance Consultants

An insurance consultant is a person who charges a fee for giving advice about insurance products. Not all states require a separate consultant license. In those states, the individual can obtain a producer license and abide by the disclosure provisions for insurance consultants. In states that do require a special license, the applicant usually is required to pass an examination. The exam may be either one of the same subject-matter examinations that insurance producers must pass or an examination specific to consultants. In states that require an examination, a waiver may be granted if the applicant can demonstrate a specified amount of insurance experience.

States usually adopt exemptions from the consultant licensing requirement. The exemptions are available as long as the person is acting in his or her professional capacity or in the normal course of business. Common exemptions are:

1. A licensed attorney.
2. A trust officer of a bank.
3. An actuary or certified public accountant.
4. A risk manager who consults for his or her employer only.

If a state requires appointments for insurance producers, appointments should not be required of insurance consultants. The consultant represents the insured and is not an agent of the insurance company. Some states prohibit an individual from holding both an insurance producer license and an insurance consultant license. Other states allow an insurance producer to function in either capacity with full disclosure. In all cases where an individual is acting as an insurance consultant, a written contract should be used to clearly explain the terms of the consultant arrangement.

In states that have a separate insurance consultant license, it is a common practice to have a CE requirement that mirrors the CE requirement for insurance producers.
Chapter 23

Managed Care Providers

Health Maintenance Organizations

A health maintenance organization (HMO) is a type of managed care organization that provides a form of health care coverage that is fulfilled through hospitals, doctors and other providers with which the HMO has a contract. Unlike traditional health insurance, an HMO sets out guidelines under which doctors can operate. On average, an HMO costs less than comparable traditional health insurance, with a trade-off of limitations on the range of treatments available. Unlike many traditional insurers, HMOs do not merely provide financing for medical care. The HMO actually delivers the treatment as well. Doctors, hospitals and insurers all participate in the HMO business arrangement.

The NAIC has adopted a model law and regulation that governs the licensure of HMOs: Health Maintenance Organization Model Act (¶430) and Model Regulation to Implement Rules Regarding Contracts and Services of Health Maintenance Organization (¶432). In most cases, access to an HMO is only available to employer group plans.

Preferred Provider Organizations

A preferred provider organization (PPO) is a group of doctors and/or hospitals that provides medical service only to a specific group or association. The PPO may be sponsored by a particular insurance company, by one or more employers, or by some other type of organization. PPO physicians provide medical services to the policyholders, employees or members of the sponsor(s) at discounted rates and may set up utilization review programs to help control the cost of medical care.

In some states, managed care providers may be licensed by an agency outside the insurance department.
Chapter 24

Managing General Agents

A managing general agent (MGA) is an insurance producer authorized by an insurance company to manage all or part of the insurer’s business in a specific geographic territory. Activities on behalf of the insurer may include marketing, underwriting, issuing policies, collecting premiums, appointing and supervising other agents, paying claims, and negotiating reinsurance. Many states regulate the activities and contracts of MGAs.

The NAIC has adopted the Managing General Agents Act (Model #225) to guide states in regulating MGAs. Under the model, an MGA is defined as any person who engages in all of the following:

1. Negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer—including the management of a separate division, department or underwriting office—and who acts as an agent for such insurer whether known as a managing general agent, manager or other similar term or title.
2. With or without authority and either separately or together with affiliates, directly or indirectly produces and underwrites an amount of gross direct written premium equal to or greater than 5% of the policyholder surplus in any one quarter or year, as reported in the last annual statement of the insurer.
3. Engages in either or both of the following:
   (a) Adjusts or pays claims in excess of an amount determined by the insurance commissioner.
   (b) Negotiates reinsurance on behalf of the insurer.

Under the model, an MGA does not include any of the following:

1. An employee of the insurer.
2. A manager of a U.S. branch of an alien insurer who resides in this country.
3. An underwriting manager who, pursuant to contract, manages all insurance operations of the insurer, who is under common control with the insurer, subject to [cite to state law] relating to the regulation of insurance holding company systems, and who is not compensated based upon the volume of premiums written.
4. An insurance company, in connection with the acceptance or rejection of reinsurance on a block of business.
5. The attorney-in-fact authorized by or acting for the subscribers of a reciprocal insurer or interinsurance exchange under a power of attorney.

In most states, MGAs must be licensed as producers and are not allowed to place business until a written contract exists among all parties. Under the Model #225, insurers are required to monitor the financial stability of MGAs under contract.
Chapter 25

Multiple Employer Welfare Arrangements

Multiple employer welfare arrangements (MEWAs) are arrangements that allow a group of employers collectively to offer health insurance coverage to their employees. MEWAs are most often found among employer groups belonging to a common trade, industry or professional association.

MEWA plans are generally available to the employees (and sometimes their dependents) of the employers who are part of the arrangement. People who do not have an employment connection to the group cannot obtain coverage through the MEWA plan. MEWA plans cannot be sold to the public.

To qualify as an MEWA, the organization must be nonprofit, in existence for at least five years and created for purposes other than that of obtaining health insurance coverage. In other words, employers cannot group together solely for the purpose of offering health insurance. However, employers that already have grouped together for another common purpose (for example, a trade association) may also offer health insurance coverage to their member employers.

States and the federal government coordinate the regulation of MEWAs pursuant to a 1982 amendment to the federal Employee Retirement Income Security Act (ERISA). This dual jurisdiction gives states primary responsibility for overseeing the financial soundness of MEWAs and the licensing of MEWA operators. The U.S. Department of Labor (DOL) enforces the fiduciary provisions of ERISA against MEWA operators to the extent a MEWA is an ERISA plan or is holding plan assets. State insurance laws that set standards requiring specified levels of reserves or contributions are applicable to MEWAs even if they also are covered by ERISA.

The NAIC has adopted a model regulation, Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation (#220), to give guidance to states in the supervision of MEWAs.
Chapter 26

Reinsurance Intermediaries

A reinsurance intermediary acts as a broker in soliciting, negotiating or procuring the writing of any reinsurance contract or binder. Reinsurance intermediaries act as insurance producers in accepting any reinsurance contract or binder on behalf of an insurer.

The NAIC has adopted the Reinsurance Intermediary Model Act (#790), which contains a simplified registration process for nonresident reinsurance intermediaries. Nonresident reinsurance intermediaries verify that they are licensed in their home states under similar laws as in the nonresident states, i.e., the NAIC Model, and the nonresident reinsurance intermediaries are granted reciprocity.
Chapter 27

Risk Retention Groups and Risk Purchasing Groups

Risk Retention Groups

Congress enacted the federal Risk Retention Act (RRA) in 1981. This federal law enabled product sellers to form RRGs to provide group self-insurance. RRGs are insurers licensed and fully regulated in one state pursuant to that state’s laws. In the mid-1980s, general liability insurance premiums skyrocketed, and certain lines were unavailable. Coverage for some classes of businesses was typically either unavailable or extremely expensive for the desired limits and coverages. Congress intervened again in 1986, this time expanding the RRA to permit RRGs to cover broader liability risks. The RRA is now referred to as the federal Liability Risk Retention Act (LRRA).

Under the Model Risk Retention Act (#705), an RRG “registers” in non-domicile states and is then exempt from most insurance laws in non-domicile states. RRGs are limited to providing non-workers’ compensation commercial lines liability insurance to its members. All owners of an RRG must be insureds, and all insureds must be owners.

RRGs can be required by states to:

1. Comply with the unfair claim settlement practices law.
2. Pay applicable premium and other taxes that are levied on admitted insurers and surplus lines insurers, brokers or policyholders.
3. Participate in residual market mechanisms.
4. Register and designate the insurance commissioner as agent for service.
5. Submit to a financial examination in any state in which the group is doing business if:
   a. The domiciliary insurance commissioner has not begun or refused to initiate an examination.
   b. Any examination shall be coordinated to avoid unjustified duplication and repetition.
6. Comply with a lawful order issued in a delinquency proceeding commenced by the insurance commissioner if there has been a finding of financial impairment or in a voluntary dissolution proceeding.
7. Comply with deceptive, false or fraudulent acts or practices laws, except that if the state seeks an injunction regarding the conduct, it must be from a court of competent jurisdiction.
8. Comply with an injunction issued by a court of competent jurisdiction, upon a petition by the state insurance commissioner alleging that the group is in hazardous financial condition or is financially impaired.
9. Provide the following notice, in 10-point type, in any insurance policy:

   NOTICE

   This policy is issued by your risk retention group (RRG). Your RRG may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your RRG.

A state may require that a person acting, or offering to act, as a producer or broker for an RRG obtain a license from that state, except that a state may not impose any qualification or requirement that discriminates against a nonresident producer or broker.

Risk Purchasing Groups

The second type of entity allowed to operate under the RRA is a risk purchasing group (RPG). RPGs are vehicles for any insurer to market on a group basis, with the ability to discriminate as to rates for those groups. But as with RRGs, RPGs are only allowed to place liability coverage. RPGs are formed so that similar risks may pool purchasing power. RPGs are purchasing entities, not insurers, and are not generally subject to state insurance laws.

Insurance departments generally do not actively regulate RPGs. The insurer writing for an RPG is subject to all insurance laws, with few exceptions. The transaction of insurance for an RPG in a state generally follows a traditional transaction based on the form of the insurer in relation to that state. Hence, if the insurer is licensed in the state, then producer licensing and, if applicable, appointment procedures apply. If the insurer is a writer of surplus lines, then the traditional surplus lines producer
licensing rules apply. As with RRGs, a state may require that a person acting, or offering to act, as a producer or broker for a purchasing group obtain a license from that state. A state may not impose any qualification or requirement that discriminates against a nonresident producer or broker.
Chapter 28

Third-Party Administrators

A TPA is an entity that directly or indirectly underwrites, collects charges or premium from, or adjusts or settles claims on residents of a state, in connection with life, annuity or health coverage offered or provided by an insurer, unless accepted by statute.

When an employer offers its employees a self-funded health care plan (the employer helps finance the health care costs of its employees), the employer often contracts with a TPA to administer the plan. The employer also may contract with a reinsurer to pay amounts in excess of a certain threshold in order to share the risk for potential catastrophic claims experience.

In most states, a TPA is required to register with the state. Some states require a bond. The TPA is required to answer inquiries from the state insurance department, but, if the TPA is working for a self-funded ERISA plan, a state has limited authority to take enforcement action against the TPA. An insurer also may act as a TPA for certain customers. This can be confusing to a consumer who has an identification card that has a name similar to a well-known health insurance company. The consumer often thinks coverage is provided by that insurance company instead of the employer plan.
Title Insurance Agents

Title insurance is insurance indemnifying against financial loss from defects in title of real property arising from conditions of title that exist on the date of issuance of the policy. While most insurance coverage indemnifies insureds against loss caused by future events, title insurance is unique as it focuses on the elimination of risk before the policy is issued. Title insurance policies are typically purchased when real property is conveyed or financed. Insureds pay one premium for coverage that has no expiration. In many states, title insurance has essentially replaced abstracts of title, and it is often required as a condition for obtaining a loan secured by a lien on real property.

Title insurance policies commonly guarantee or indemnify the fee title of owners or the lien priority of a lender from losses or damages from liens, encumbrances, defects or unmarketability of title, or adverse claims to title in the real property, and defects in the authorization, execution or delivery of an encumbrance on the real estate. Coverage is subject to standard exceptions, as well as specific exclusions listed on a schedule attached to the policy limiting the extent of the insurer’s liability. Coverage is often expanded or amended through endorsements attached to the policy.

Two types of title insurance policies are commonly issued: the owner’s policy and the lender’s loan policy. The owner’s policy ensures that the title to the real property is vested as described in the policy, that the title is marketable, that there is a right of access to the property, and against defects in or lien or encumbrances on the title. Title insurance does not require a written application. Policies often are ordered by real estate agents or lenders. The title insurance agent issues a commitment or binder basically revealing the current state of title to the property and agreeing to insure the property, provided that the requirements in the commitment are met to the satisfaction of the title insurer. Typically, even though the buyer/borrower pays for the loan policy, only the lender is covered by the loan policy.

The effective date of the policy is typically the date that transactional documents (deed, deed of trust, etc.) are recorded in the public real estate records. Losses under the policy are subject to the limits listed on Schedule A of the Policy, plus any costs of defense. The policy limit of an owner’s policy is generally the purchase price of the real property, and the policy limit of a lender’s loan policy is generally the original amount of the loan. Losses from title defects are rare, and loss ratios for insurers are relatively low. The goal of a title insurer is to find defects in title prior to issuing a policy; consequently, expense ratios are fairly high due to the cost of title research.

Most states place monoline restrictions on title insurers. Monoline restrictions prohibit title insurers from issuing any line of insurance other than title insurance. Rates and rate setting processes vary by state. Some states regulate only the risk premium, while other states regulate an all-inclusive premium, which generally includes all costs of issuing the policy, search expenses and the risk premium.

Functions of title insurance agents include conducting title searches, performing underwriting functions, preparing and issuing title insurance commitments and policies, maintaining policy records, and receiving premiums. In addition, many title agents perform real estate closings, and provide settlement and escrow services.

Many activities of state licensing divisions with regard to title insurance are the same as in other lines of insurance. In most states, agents are required to pass a licensing exam and fulfill ongoing (CE) requirements. In some states, the licensing division also will be responsible for receiving and filing agency appointments with insurers, bonds or letters of credit (LOCs), proof of errors and omissions (E&O) coverage, and forms disclosing controlled and affiliated business relationships. The NAIC has adopted the Title Insurance Agent Model Act (#230) to give guidance to state licensing directors.

Title insurance creates some unique regulatory issues, primarily due to the risk elimination nature of the insurance coverage, and the business relationships between title insurance agents and those who refer title insurance business. The entity referring the title insurance business often is viewed as the customer rather than the insured due to the nature of real estate transactions. Entities that regularly refer title insurance business—such as mortgage brokers, lenders, realtors and attorneys—are referred to as producers of title insurance business. Note that “producer of title insurance” as used in this context carries a very different meaning from “insurance producer.”

Controlled and affiliated business relationships refer to business relationships between title insurance agents and producers of title insurance business. Many states require that controlled and affiliated business relationships be disclosed both to the insured and to the insurance department in writing. Many states also prohibit title insurance agents from providing rebates, referral fees, inducements or financial incentives to producers of title insurance business. In addition to state laws, rebates and referrals related to most residential real estate transactions are prohibited under the federal Real Estate Settlement Procedures Act (RESPA).
Chapter 30
Viatical and Life Settlement Providers and Brokers

The Viatical Settlements Model Act (#697) defines a viatical settlement as a transaction in which the owner of a life insurance policy sells the right to receive the death payment due under the policy to a third party. Typically, the owner/insured receives a cash payment, and the buyer agrees to make any remaining premium payments on the policy.

In 1993, the NAIC adopted the Viatical Settlements Model Regulation (#698) and Model #697 to provide a regulatory structure to protect consumers involved in viatical settlements. The Model #697 was revised in 2003 and 2004 to address the issue of healthy consumers who might want to sell their insurance policy on the secondary market, better known as “life settlements.”

Licensing requirements vary as a result of the several versions of Model #697. Under the 1993 version of Model #697, a viatical settlement broker was required to have an underlying life producer license before being able to apply for and receive a viatical settlement broker license. This provision was not uniformly adopted.

The 2003 version of Model #697 provided for licensing procedures of individuals who were not licensed life insurance producers by requiring CE to maintain the license. The 2003 version was modified in 2004 to allow for licensed life insurance producers to notify or register with the insurance regulator as prescribed by the insurance commissioner if they were engaging in the business of settlements, and exempted life insurance producers from the viatical settlement brokers’ examination and the CE requirements.

The 2003 and 2004 versions of Model #697 also required the viatical settlement broker to maintain financial responsibility in the form of an errors and omissions policy, surety bond or cash deposit, or a combination of any of the three. It also placed fiduciary responsibility requirements on the broker. The 2003 and 2004 versions of Model #697 required brokers to disclose the method by which compensation was calculated and the amount of compensation. It is essential the viatical broker meet the licensing requirements of the state where the transaction occurs.

The 2003 version of Model #697 also provided for licensing procedures for viatical settlement providers.

Model #697 was revised in 2007 to address, among other things, transactions that have been called stranger-originated life insurance (STOLI) or investor-originated life insurance (IOLI). These transactions are related to a life insurance policy exhibiting any one of three characteristics prior to or within two years of policy issue:

1. Non-recourse premium financing.
2. Guarantee of settlement.
3. Settlement evaluation.

Settlement of such policies is prohibited for five years.

Other key revisions include:

1. New consumer disclosures related to viatical settlement compensation.
2. A new consumer disclosure requiring a statement that the viatical settlement broker represents exclusively the viator and owes a fiduciary duty to the viator, including a duty to act in the best interest of the viator.
3. Allowing life agents to sell without a viatical license, but special conditions apply.
Additional revisions include:

Under specified circumstances, a life insurance producer may operate as a viatical settlement broker. The life insurance producer is deemed to meet the viatical settlement broker licensing requirements. The revisions also permit a person licensed as an attorney, certified public accountant (CPA) or financial planner accredited by a national recognized accrediting agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider, to negotiate viatical settlement contracts on behalf of a viator without having to obtain a viatical settlement broker’s license.

To receive and maintain a license, the 2007 revisions require a viatical settlement provider or broker to demonstrate evidence of financial responsibility through a surety bond or a deposit of cash, certificates of deposit or securities, or any combination thereof in the amount of $250,000. The surety bond must be issued in the favor of the state and must specifically authorize recovery by the insurance commissioner on behalf of any person in the state who sustained damages as the result of erroneous acts, failure to act, conviction of fraud or conviction of unfair practices by the provider or broker. The insurance commissioner may ask for evidence of financial responsibility at any time the insurance commissioner deems necessary. The revisions make clear that a provider or broker that is licensed in more than one state is not required to file multiple bonds in each state. Some problems have arisen with implementing the bonding requirements of the Model #697. Regulated entities argue that it is impossible to obtain a bond as described by Model #697.

The revisions also require an individual licensed as a viatical settlement broker to complete, on a biennial basis, 15 hours of training related to viatical settlements and viatical settlement transactions. A life insurance producer who is operating as a viatical settlement broker is not subject to this requirement.
CONTINUING EDUCATION
COURSE GUIDELINES
Declaration / Classroom & Online / Formula / Webinar & Webcast

NAIC CONTINUING EDUCATION RECIPROCITY AGREEMENT – 2019 VERSION UNIFORM DECLARATION – CE RECIPROCITY COURSE APPROVAL GUIDELINES

Whereas, the Commissioners find that it is in the best interest of each of their States and their insurance producers to simplify the continuing education (CE) reciprocity course approval process and reduce barriers to non-resident CE providers that reside in a State.

Whereas, the undersigned Insurance Commissioners of the National Association of Insurance Commissioners, hereafter the Commissioners, have determined that it is redundant unnecessary for each State to perform a substantive review of continuing education courses or individual instructors that have previously been approved by another State.

Whereas, the Commissioners find that it is in the best interest of each of their States and their insurance producers to simplify the continuing education (CE) reciprocity course approval process and reduce barriers to non-resident CE providers that reside in a State.

Definitions

Home State: the state in which the CE provider organization maintains his, her, or its principal place of residence or principal place of business.

Home State Course Approval: approval of a course that has had a substantive review in a home state.

Reciprocal State: state other than the home state and a party to of this continuing education reciprocity agreement.

Substantive Review: a thorough review of the course to confirm compliance with the home State’s applicable laws and regulations for the approval of insurance continuing education. The review includes a determination whether the:

i. Subject matter meets the criteria for insurance education, to include approvable and non-approvable topic guidelines;

ii. Provider has procedures for reviewing course material in order to keep it up to date and timely;

iii. Course design and instructional strategies are appropriate for the method of delivery;

iv. Credit hours are properly calculated based on instruction method;

v. Criteria for completing the course meets the standards applicable to the instruction method.

The Commissioners agree as follows:

1. Each state will conduct a substantive review of continuing education courses submitted for home state approval. Once When a CE provider residing in a State has received a home state course approval initial approval to offer courses in its home State, that a reciprocal State will not conduct a substantive review of that same course as a condition of approval. not require that CE provider to file courses for substantive review that have been awarded credit by the CE provider’s home state. A CE Provider’s Home state means the state in which the CE pProvider’s Home state Organization maintains his, her, or its principal place of residence or principal place of business. However, If the laws or regulations of the CE Provider’s home state restrict or limit the minimum or maximum number of credit hours for which a national course may be approved for in that state, or restricts certain course topics, the CE pProvider may elect to recognize another home state in order to obtain a home state course approval for the filing of its national courses in order to obtain the maximum credits allowed. A CE Provider that elects another home state in which to file its national courses shall elect a state that conducts a substantive review of its courses.

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2. Unless specifically limited by State law and regulations, a reciprocal State will award a course the same number of credits and will accept all course topics as approved by the CE provider’s home State.

3. A **reciprocal** State will agrees to approve a course submission within 30- days of receipt, provided that the review and approval process for a course that is filed using the NAIC Uniform Continuing-Education Reciprocity Course Filing Form (Appendix A) or an equivalent electronic submission method, and contains a **home state course approval**, A CE provider who wishes to offer topics that are not approvable by the home State may still file a course directly with a State by completing a specific State’s course approval form.

4. Each State will accept the NAIC Uniform Continuing-Education Reciprocity Course Filing Form (Appendix A), or a substantially similar form; including an equivalent the delivery by electronic submission method, and the required attachment(s) a **home state course approval document** as the sole form requirements required by for a reciprocal course submission non-resident CE provider.

5. Each State accepts and will use the following standards for substantive course review approval:
   
   a. For classroom and webinar courses, one credit will be awarded for each 50 minutes of contact instruction. Each State will use its own method to award credit for self-study courses.
   
   b. For self-study/online courses, credit will be awarded based on the NAIC’s Recommended Guidelines for Online Courses (Appendix B).

   c. The minimum number of credits that will be awarded is one credit, no partial credits will be awarded and there is no maximum number of credits.

   d. Credits will only be awarded for courses whose subject matter will increase technical knowledge of insurance principles, coverages, ethics, laws or regulations and will not be awarded for topics such as personal improvement, motivation, time management, supportive office skills or other matters not related to technical insurance knowledge. If any credits are awarded for sales and/or marketing those credits will be separately noted on the course approval document. Credits for sales and/or marketing will only be awarded in States that are permitted by law or regulation to accept credit for those topics. **Additional guidance can be found in the NAIC’s Recommended Approved/Not Approved Course Topics (Appendix C).**

**NAIC UNIFORM DECLARATION—(CONT’D)**

4. Each State will use its own method to determine if an instructor is qualified and no instructor will be approved unless the CE provider has provided sufficient information to demonstrate that the instructor is qualified, according to that State’s laws and regulations, to teach the topics covered in the outline.

5. A reciprocal State will not review an instructor’s qualifications once that instructor’s qualifications have been reviewed and approved by the CE provider’s home State.

6. A State’s course approval document or approved course application will include, at a minimum, the following information: course name, whether the method of instruction is self-study, whether a course is part of a national or professional designation program and the contact person. A National Course is defined as an approved program of instruction in insurance related topics including a course leading to a National Professional Designation or an insurance course at an institution offered as part of a degree conferring curriculum, presented by an approved CE Provider organization title, credit hours, credit category, method of instruction, and clearly indicate if it is a **home state approval**.

7. Each State reserves the right to disapprove individual instructors or CE providers who have been the subject of disciplinary proceedings or who have otherwise failed to comply with a State’s laws and regulations.

8. Each State agrees that it will notify other States when a CE provider or instructor has been the subject of a formal administrative action or other disciplinary action by that State.
Drafting Note: The Producer Licensing Working Group needs to make a formal request to NAIC staff to ensure the proper programming and electronic systems are in place through which a provider/instructor is assigned a unique identifier number and notification can be made through the use of electronic means. Can this become part of the NAIC’s Regulatory Information Retrieval Systems and the Personalized Information Capture System.


Drafting Note: The Producer Licensing Working Group needs to discuss how to proceed with getting these changes officially agreed upon by states and replacing the existing Midwest Zone Guidelines and Filing Form. The working group also needs to discuss the impact these changes will have for the Uniform Regulation Through Technology.
**UNIFORM CONTINUING EDUCATION RECIPROCITY COURSE FILING FORM**

Please clearly print or type information on this form. Thank you for helping us promptly process your application.

<table>
<thead>
<tr>
<th><strong>Provider Information</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Provider Name</strong></td>
</tr>
<tr>
<td><strong>Contact Person</strong></td>
</tr>
<tr>
<td><strong>Phone Number ( ) - ext.</strong></td>
</tr>
<tr>
<td><strong>Home State</strong></td>
</tr>
<tr>
<td><strong>Reciprocal State</strong></td>
</tr>
<tr>
<td><strong>Mailing Address</strong></td>
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<tr>
<td><strong>Submitter Name (if different from provider contact person above)</strong></td>
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<tr>
<td><strong>Submitter Phone Number</strong></td>
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<tr>
<th><strong>Course Information</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Course Title</strong></td>
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<tr>
<td><strong>Date of Course Offering (if applicable)</strong></td>
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</table>

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<tr>
<th><strong>Method of Instruction</strong></th>
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<tbody>
<tr>
<td><strong>Non-Contact / Asynchronous</strong></td>
</tr>
<tr>
<td><strong>Self – Study</strong></td>
</tr>
<tr>
<td>☐ Correspondence</td>
</tr>
<tr>
<td>☐ On-Line Training (Self-Study)</td>
</tr>
<tr>
<td>☐ Recorded Media</td>
</tr>
<tr>
<td>☐ Other __________________</td>
</tr>
<tr>
<td>Word Count __________________</td>
</tr>
<tr>
<td>Mandatory Run-time __________________ (Interactive Components of Course)</td>
</tr>
<tr>
<td><strong>Contact / Synchronous</strong></td>
</tr>
<tr>
<td><strong>Classroom</strong></td>
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<tr>
<td>☐ Seminar/Workshop</td>
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<tr>
<td>☐ Other __________________</td>
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<tr>
<td><strong>Webinar</strong></td>
</tr>
<tr>
<td>☐ Virtual Class/Webinar/Video Conference</td>
</tr>
<tr>
<td>☐ Other __________________</td>
</tr>
</tbody>
</table>

| **Measurement used for successful completion:** | ☐ Attendance | ☐ Final Exam | ☐ Other __________________ |
| **Is this course open to the public?** | ☐ Yes | ☐ No |
| **National Designation?** | ☐ Yes | ☐ No |
| **If yes, Designation Type:** |

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**Credit Hours Requested and Course/Hours Decision**

<table>
<thead>
<tr>
<th>Course Concentration</th>
<th>Hrs Requested by Provider</th>
<th>Hrs Approved by Home State</th>
<th>Hrs Approved by Reciprocal State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sales/Mktg</td>
<td>Insurance</td>
<td>Sales/Mktg</td>
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<tr>
<td><strong>A. Producer Topics:</strong></td>
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<td></td>
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<tr>
<td>(Circle Appropriate Course Concentration)</td>
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<tr>
<td>Life / Health</td>
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<tr>
<td>Property / Casualty/Personal Lines</td>
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<tr>
<td>Ethics</td>
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<td></td>
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<tr>
<td>General (Applies to all lines)</td>
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<tr>
<td>Insurance Laws</td>
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<tr>
<td>Other (LTC, NFIP, Viotics, Annuities, etc.)</td>
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<tr>
<td><strong>Total Hours</strong></td>
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<tr>
<td><strong>B. Adjuster Topics</strong></td>
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<tr>
<td>(Circle Appropriate Course Concentration)</td>
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<tr>
<td>General</td>
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<td>Workers Comp</td>
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<td>Ethics</td>
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<tr>
<td>Other</td>
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<tr>
<td><strong>Total Hours</strong></td>
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<tr>
<td><strong>C. Public Adjuster</strong></td>
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<tr>
<td>(Circle Appropriate Course Concentration)</td>
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<tr>
<td>General</td>
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<td>Other</td>
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<tr>
<td><strong>Total Hours</strong></td>
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**Information Below is for Regulator Use Only**

- Approval Date
- Course Number assigned
- Course approval expiration date
- Signature of Home State Regulator/Representative
- OR ATTACH Provider Home State Approval Form
- Signature of Reciprocal State Regulator/Representative
- OR ATTACH Reciprocal State Approval Form
INSTRUCTION SHEET

NOTE: This course may NOT be advertised or offered as approved in the state to which application has been made until approval has been received from the insurance department.

1. If you are a PROVIDER filing for approval from the Home State:
   1.1 Complete all the fields in the “Provider Information” section except “Reciprocal State” and the adjacent “Provider #” fields.
   1.2 Complete the Course Information Section.
   1.3 In the “Credit Hours Requested and Course/Hours Decision” section, complete the “Hrs. Requested by Provider” columns, detailing in the respective columns the number of hours for sales – and marketing-related instruction and the number of hours for other insurance-related instruction. Please note the following:
      1.3.1 When using this application, which is governed by the NAIC CE Reciprocity Agreement in conjunction with ‘states’ laws, only whole numbers of credit hours will be approved – partial hours will be eliminated.
      1.3.2 States that approve sales/marketing topics will consider the hours in the “sales/Mktg” column and the hours in the “Insurance” column when deciding the number of hours to approve. States that do not permit sales/marketing topics as part of continuing education credit hours will only consider the hours shown in the “Insurance” column when making their credit-hour approval decisions.
      1.3.3 Contact the individual state to determine whether there are any state specific requirements for submitting courses.
   1.4 Submit the application form along with required course materials, a detailed course outline, instructor information, if required, and the required course application fee.

2. If you are a PROVIDER filing for approval from a Reciprocal State:
   2.1 Make a sufficient number of photocopies of the Home State approval form to enable you to submit a copy of this application to each of the Reciprocal States where you are seeking credit.
   2.2 On each application, write the Reciprocal State and the provider number assigned to you by that state in the “Reciprocal State” and adjacent “Provider #” fields.
   2.3 Send the CER application, home state approval, if home state issues one, a detailed course outline, and the required fee to the reciprocal state. If this is a National Course *, the Providers will be allowed to submit an agenda that must include date, time, each topic and event location in lieu of a detailed course outline.
   2.4 Subsequent national course offerings should only be reported for events that are conducted in the “home” state.

* National Course is defined as an approved program of instruction in insurance related topics, offered by an approved provider, and leads to a national professional designation or a course offered to individuals who must update their designation once it is earned.

3. If you are the HOME STATE or designated representative of the Home State:
   3.1 After reviewing the course materials, complete the “Hrs Approved by Home State” column.
   3.1.1 Multiple types of credit and delivery methods can be approved using one CER Form.
   3.2 Enter the date of approval, course # assigned, course approval expiration date. Sign the CER Form OR attach the home state approval form.
   3.3 If the course is not approved, note it on the bottom of the CER Form.

4. If you are the RECIPROCAL STATE or designated representative of the Reciprocal State:
   4.1 After reviewing “Hrs approved by Home State” complete the “Hrs Approved by Reciprocal State”.
      4.1.1 It is unnecessary for each State to perform a substantive review of continuing education courses that have previously been approved by the Home State.
      4.1.2 Reciprocal states cannot award different credits than the home state unless certain aspects are not allowed by state law.
   4.2 Enter the date of approval, course number assigned, course approval expiration date. Sign the CER Form OR attach the reciprocal state approval form.
   4.3 If the course is not approved, note it on the bottom of the CER Form.
   4.4 The reciprocal state agrees to approve the CER submission within 30 days of receipt.

Substantive Review – A thorough review of the course to confirm compliance with the home state’s applicable laws and regulations for the approval of insurance continuing education. The review includes a determination whether the:

1. Subject matter meets the criteria for insurance education, to include approveable and non-approvable topic guidelines;
2. Provider has procedures for reviewing course material in order to keep it up to date and timely;
3. Course design and instructional strategies are appropriate for the method of delivery;
4. Credit hours are properly calculated based on instruction method;
5. Criteria for completing the course meets the standards applicable to the instruction method.

*Drafting Note: The instructor information matrix was eliminated in 2018 as this information should be readily available on individual state/jurisdiction websites.
Continuing Education Recommended Guidelines for Online Courses

Adopted by NAIC Membership March 18, 2015

**Goal:** To deliver functional computer-based internet courses that offer quality insurance and/or risk management material in a password-protected online environment.

**Key Components:**
- Material that is current, relevant, accurate, and that includes valid reference materials, graphics and interactivity.
- Clearly defined objectives and course completion criteria
- Specific instructions to register, navigate and complete the course work
- Technical support/provider representative should be available during business hours and response provided within 24 hours of initial contact.
- Instructors/subject matter experts must be available to answer student questions during provider business hours
- Process to authenticate student identity such as passwords and security prompts
- Method for measuring the student’s successful completion of course which includes the material, exam and any proctor requirements.
- Process for requesting and receiving CE course-completion certificate and reporting student results to the appropriate regulator
- Require each agent to enroll for the course before having access to course material.
- Prevent access to the course exam before review of the course materials.
- Prevent downloading of any course exam.
- Provide review questions at the end of each unit/chapter and prevent access to the final exam until each set of questions are answered at a 70% rate.
- Provide final exam questions that do not duplicate unit/chapter questions.
- Prevent alternately accessing course materials and course exams. This does not apply if the state allows for “open book” exams.
- Have monitor affidavit containing specific monitor duties and responsibilities printed for monitor’s use to direct the taking of the final exam. Monitor will complete the affidavit after the exam is completed. (This only for states that require a monitored exam).

**Final Assessment (exam) Criteria:**
- Minimum of 10 questions for 1 credit hour course with additional 5 questions for each subsequent credit hour and a score of 70% or greater
- At least enough questions to fashion a minimum of 2 versions with a least 50% of questions being new/different in each subsequent version
- Inability to print the exam or to view the exam prior to reviewing material
- Proctor, if required by the state, who verifies identity by photo identification and processes affidavit testifying the student received no outside assistance

**Procedures to determine Appropriate Number of Credit Hours:**

**Word Count/Difficulty Level**
- Divide total number of words by 180 (documented average reading time) = number of minutes to read material
- Divide number of minutes by 50 = credit hours
- Course difficulty level is identified by the CE provider on the CER form and should be based on the NAIC CE Standardized Terms-Definitions for basic, intermediate and advanced course difficulty levels.
- Multiply number of hours by 1.00 for a basic level course; 1.25 for an intermediate level; 1.50 for an advanced course for additional study time = total number of credit hours (fractional hours rounded up if .50 or above and rounded down if .49 or less)
Interactive Course Content

- Elements included in the online course, in addition to text, such as video, animation, interactive exercises, quizzes, case studies, games, and simulations.
- Interactive elements should be applicable to course material and facilitate student learning.
- Only mandatory interactive elements should be included in the calculation of CE credit hours.
- Calculation of CE hour credits should be based on the run time of the interactive elements.
- CE providers will indicate run time of the interactive elements in the course content and upon request provide access to the state for review of the course.

Professional Designation Course

- Course that is part of a nationally recognized professional designation
- Credit hours equivalent to hours assigned to the same classroom course material

Final Assessment

- Time spent completing the final assessment should not be used in calculation of CE credit hours.

Adopted by the NAIC Membership 2015
COURSE GUIDELINES FOR CLASSROOM WEBINAR/WEBCAST DELIVERY
Adopted by the NAIC Membership August 2014

- These guidelines are intended to apply to courses conducted and viewed in real time (live) in all locations and are not intended to apply when courses have been recorded and are viewed at a later time or to other online courses.

- Each student will be required to log in to the webinar using a distinct username, password and/or email. Students that view webinars in group settings which is two or more individuals should alternatively verify their participation in the form of sign-in and sign-out sheets submitted by a monitor with an attestation or verification code.

- The provider will verify the identity and license number, or National Producer Number (NPN), of all students.

- A provider representative, using computer-based attendance-monitoring technology, must monitor attendance throughout the course.

- The provider must have a process to determine when a participant is inactive or not fully participating, such as when the screen is minimized, or the participant does not answer the polling questions and/or verification codes.

- For webinars not given in a group setting, no less than two polling questions and/or attendance verification codes must be asked, with appropriate response provided, at unannounced intervals during each one-hour webinar session to determine participant attentiveness.

- The provider will maintain an electronic roster to include records for each participant’s log-in/log-out times. If required by states chat history and polling responses should be captured as part of the electronic record.

- When a student is deemed inactive or not fully participating in the course by the course monitor of failure to enter appropriate polling question response or verification codes, continuing education (CE) credit is denied.

- All students and the instructor do not need to be in the same location.

- Students in all locations must be able to interact in real time with the instructor. Students should be able to submit questions or comments at any point during the webinar session.

- The course pace must be set by the instructor and does not allow for independent completion.

- Instruction time is considered the amount of time devoted to the actual course instruction and does not include breaks, lunch, dinner or introductions of speakers.

- One credit will be awarded for each 50 minutes of webinar/webcast instruction, and the minimum number of credits that will be awarded for webinar/webcast courses is one credit.

- The provider must have a procedure that informs each student in advance of course participation requirements and consequences for failing to actively participate in the course.

- A comprehensive final examination is not required.
**Approved Topics**

1. Actuarial mathematics, statistics and probability – in relation to insurance
2. Assigned risk – in relation to insurance
3. Claims adjusting
4. Courses leading to and maintaining insurance designations
5. Employee benefit plans – in relation to insurance
6. Errors and omissions – in relation to insurance
7. Estate planning/taxation – in relation to insurance
8. Ethics
9. Fundamentals/principles of insurance (including but not limited to: annuities, crop and hail, life, accident and health, property/casualty [P/C], etc.)
10. Insurance accounting/actuarial considerations
11. Insurance contract/policy comparison and analysis
12. Insurance fraud
13. Insurance laws, rules, regulations and regulatory updates
14. Insurance policy provisions
15. Insurance product-specific knowledge
16. Insurance rating/underwriting/claims
17. Insurance tax laws
18. Legal principles – in relation to insurance
19. Long-term care/partnership
20. Loss prevention, control and mitigation – in relation to insurance
21. Managed care
22. Principles of risk management – in relation to insurance
23. Proper uses of insurance products
24. Real Estate Settlement Procedures Act (RESPA) – in relation to insurance
25. Restoration – addresses claims, loss control issues and mitigation – in relation to insurance
26. Retirement planning – in relation to insurance
27. Securities – in relation to insurance
28. Suitability in insurance products
29. Surety bail bond
30. Underwriting principles – in relation to insurance
31. Viatical/slife settlements – in relation to insurance

Other topics approved that contribute substantive knowledge relating to the field of insurance and expands competence of the licensee.
RECOMMENDED APPROVED/NOT APPROVED TOPICS FOR CE CREDIT

Adopted by the Uniform Education (D) Working Group 12.20.17
Adopted by the Producer Licensing (D) Task Force 3.25.18

Not Approved Topics

1. Automation
2. Clerical functions
3. Computer science
4. Computer training/skills or software presentations
5. Courses on investments – stocks, bonds, mutual funds, Financial Industry Regulatory Authority (FINRA)/U.S. Securities and Exchange Commission (SEC) compliance (National Association of Securities Dealers [NASD]/SEC), etc.
6. Courses that are primarily intended to impart knowledge of specific products of specific insurers
7. Customer service
8. General management training
9. Goal-setting
10. Health/stress/exercise management
11. Marketing/telemarketing
12. Motivational training
13. Company and vendor-specific product launches
14. Office skills or equipment or procedures
15. Organizational procedures and internal policies of an individual insurer
16. Personal improvement
17. Prospecting
18. Psychology
19. Relationship building
20. Restoration – promoting products or services
21. Sales training
22. Service standards or service vendors
23. Time management

Other topics or courses not related to insurance knowledge or competence of the licensee.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Austin, TX, Dec. 8, 2019. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Ryan James and Suzanne Tipton (AR); Maria Ailor (AZ); Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Frank Pyle (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); LeAnn Crow (KS); Jeff Zewe (LA); Christopher Joyce (MA); Nour Benchaaboun (MD); Timothy Schott (ME); Michele Riddering (MI); Cynthia Amann and Stewart Freilich (MO); Paul Hanson (MN); Troy Smith (MT); Laura Arp (NE); Philip Gennace (NJ); Paige Duhamel (NM); Stephanie McGee (NV); Angela Dingus (OH); Cuc Nguyen (OK); Katie Dzurec and Gary Jones (PA); Michael Bailes (SC); Tracy Klausmeier (UT); Julie Blauvelt (VA); Christina Rouleau (VT); Erin K. Hunter and Tonya Gillespie (WV).

1. **Adopted its Nov. 21 Minutes**

The Working Group met Nov. 21 and took the following action: 1) adopted its Oct. 31 minutes; 2) adopted “other health” as a line of business in the Market Conduct Annual Statement (MCAS); and 3) discussed a uniform process for addressing MCAS extension requests.

Ms. Dzurec said she was concerned about the lack of clarity around the term “other health” and the possibility of insurance companies avoiding reporting by finding loopholes in what constitutes “other health.”

Mr. Haworth said the Market Conduct Annual Statement Blanks (D) Working Group will be developing the blank and working out the details and definitions. He said the health MCAS blank took five years to complete.

Ms. Dzurec said the development of the other health blank needs to be done carefully, due to the activity in the marketplace, including the combining of products to compete with qualified plans.

Ms. Arp said the short-term limited duration (STLD) data call focused on products with coverage periods less than 365 days. She asked if the other health MCAS would apply to more than STLD. She noted there are many insurers with many types of products.

Mr. Haworth said it would apply to more than STLD. He said the health MCAS took five years to develop, but for the other health MCAS, the Market Conduct Annual Statement Blanks (D) Working Group will have both the health MCAS and the STLD data call to use as templates.

Ms. Ailor said the Market Conduct Annual Statement Blanks (D) Working Group is aware that there are many products, and it may consider segmenting the other health MCAS blank. She said all variables will be considered, and the Working Group will develop a blank that is useful to state insurance regulators.

Ms. Amann made a motion, seconded by Mr. Pyle, to adopt the Working Group’s Nov. 21 minutes (Attachment Six-A). The motion passed unanimously.

2. **Heard an Update on the STLD Medical Data Call Template**

Ms. Rebholz said the STLD data call is due Dec. 13 and, as of Dec. 8, there is only one STLD submission. She said there have, however, been 29 users that requested and obtained the necessary role permission to submit data to the NAIC and that may represent more than 29 companies, because some users may work with multiple cocodes.

Ms. Rebholz said a reminder email was sent Dec. 5 to all the initial recipients of the call letter. Immediately after the reminder, numerous emails were received from companies that do not write STLD. She said more than 600 emails from companies and groups of companies have been received advising that they do not write STLD business and have nothing to report.
Ms. Rebholz reminded the Working Group and interested parties that this is a mandatory data call and each participating state may take any actions that they would normally pursue whenever a company fails to report or does not file timely. She encouraged all the company representatives to check to be sure that their company has either completed an STLD filing or has sent an email to the NAIC advising that you do not write STLD business. She said she anticipates a flood of filings close to the Dec. 13 deadline, but she encouraged the states to consider what actions they can take in response to companies that fail to file or who say that they have no STLD products when, in fact, they do. She said Wisconsin is already considering its response to companies that file late or fail to file.

Ms. Dingus asked how soon the participating states will: 1) get a list of companies that did not file or said they had no STLD business to report; and 2) how soon the reported data will be available to them.

Randy Helder (NAIC) said the list of companies should be ready within one week of the due date and the data itself should also be available within one week.

3. Discussed Revisions to the MCAS Best Practices Guide

Ms. Rebholz said that during the Nov. 21 conference call, she asked for additional volunteers to form a small group to review and make suggested revisions to the MCAS Best Practices Guide. She said five volunteers are on the group, and she welcomes anyone else who is interested. She asked interested volunteers to send a note to Mr. Helder.

Ms. Rebholz said that in the first week of January 2020, she plans to send a list of the materials the small group needs to look at and potentially update. She will then schedule the group’s first conference call for mid- to late January 2020.

Ms. Rebholz said the topics that the group will look at as part of the update process include: 1) identifying threshold issues, such as the number of extension requests that a company has made in recent years and the reasons the company cites; 2) specifying the length of the extensions allowed in order to try to bring consistency in the states’ responses to company extension requests; 3) mapping out a generic process that the states can use as a template; and 4) developing templates for extension request response letters and orders to be available to the states.

Ms. Rebholz said the materials to be reviewed are the MCAS Best Practice Guide; the MCAS web page; the MCAS Frequently Asked Questions (FAQs); the MCAS Industry User Guide; the MCAS data call letters; and all MCAS training materials.

Finally, Ms. Rebholz said the small group will explore what type of extension request report the NAIC can provide on an annual basis to help the states determine where threshold issues are triggered. She said that as part of the State Ahead strategic plan, the NAIC market regulation staff will be developing a Tableau report that will be able to track historical extension and waiver requests. She said the work of the Best Practices small group will be to provide input into what should be included in this tool and its design.

4. Discussed its 2020 Proposed Charges

Mr. Haworth said there are no changes to the charges from 2019.

Mr. Haworth said the Working Group’s first charge is to “[r]ecommend changes to the market analysis framework based on results over the past five years, including the current set of Level 1 and Level 2 questions.” He said the Working Group is to provide recommendations to the Market Regulation and Consumer Affairs (D) Committee by the 2020 Fall National Meeting. He said the current framework used by most market analysts on the state departments is described in chapter 7 of the Market Regulation Handbook. He suggested that the Working Group review chapter 7 in light of the experiences of its members as analysts to see if any improvements on the methodology can be made. He said it would be helpful to determine how well the process works and what can be done to improve the abilities of analysts to identify concerns and make recommendations to the insurance department leadership.

Mr. Haworth said the Working Group’s second charge is to “[d]iscuss other market data-collection issues and make recommendations as needed.” He said Working Group continues to do a good job of identifying new data-collection needs, such as the STLD data call, and it is also working this year on the MCAS Best Practices Guide.
Mr. Haworth said the third charge is to recommend new lines of business in the MCAS. He encouraged everyone to be thinking of which lines need to be added to the MCAS throughout 2020. He said the Working Group should be considering at least one line of business per year, but preferably two or three.

5. **Discussed Other Matters**

Charles Piacentini (American Council of Life Insurers—ACLI) said the consideration of “other health” as the next line of business in the MCAS was tabled in 2018, but when it was reintroduced, there was a lack of discussion before adopting it. He said the industry can assist in defining health plans that are alternatives to qualified federal Affordable Care Act (ACA) plans and welcome the possibility of participating. He said if the other health line is not properly defined, the reporting could be misleading and disruptive. He said much of the best data comes from consumer complaints.

Mr. Haworth said carriers are welcome to participate in the process, as well as the industry representatives. He said the Market Conduct Annual Statement Blanks (D) Working Group spends a lot of time in the development of MCAS blanks.

Ms. Dzurec said complaints are helpful, but consumers are often not aware that they can complain or that there is any issue.

Mr. Haworth said all the analytics, including reported complaints, will be considered in the development of the blank.

Heather Jerbi (America’s Health Insurance Plans—AHIP) agreed with Mr. Piacentini, and she said AHIP is concerned with the lack of specificity about what is being considered for this line of business. She said she wants the industry and state insurance regulators to work together with a robust discussion.

Birny Birnbaum (Center for Economic Justice—CEJ) said the Market Analysis Procedures (D) Working Group only identifies lines of business; it is the Market Conduct Annual Statement Blanks (D) Working Group’s job to develop the blank. He said industry is always invited to participate in the creation of the blank.

Ms. Dzurec said the Market Conduct Annual Statement Blanks (D) Working Group must be very clear on what is to be reported to make the blank most effective.

Ms. Ailor said the Working Group recognizes that the term “other health” is broad, but she said the term is taken from the annual financial statement’s Supplemental Health Care Exhibit. She said definitions may be able to be found in the *Annual Statement Instructions*. She said the ACLI and AHIP will be invited to participate in the development of the blank.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
Market Analysis Procedures (D) Working Group
Conference Call
November 21, 2019

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Nov. 21, 2019. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Melissa Grisham (AR); Maria Ailor and Cheryl Hawley (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Frank Pyle (DE); Scott Woods (FL); Patrick Tallman (IL); Tate Flott (KS); Lori Cunningham (KY); Jeff Zewe (LA); Mary Lou Moran (MA); Salama Camara (MD); Connie Mayette (ME); Jill Huiskens (MI); Teresa Kroll (MO); Paul Hanson (MN); Troy Smith (MT); Robert McCullough (NE); Douglas Rees (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Larry Wertel (NY); Angela Dingus (OH); Landon Hubbart (OK); Jeffrey Arnold (PA); Rachel Moore (SC); Tanji Northrup (UT); Wil Felvey (VA); Christina Rouleau (VT); and Tom Whitener (WV).

1. Adopted its Oct. 31 Minutes

The Working Group met Oct. 31 and took the following action: 1) adopted its Aug. 27 minutes; 2) discussed analysis of lender-placed insurance Market Conduct Annual Statement (MCAS) data; 3) discussed the uniform process for addressing MCAS extension requests; 4) discussed the inclusion of fraternals in the MCAS; and 5) discussed adding “other health” as the next line of insurance in the MCAS.

Ms. Northrup made a motion, seconded by Ms. Moran, to adopt the Working Group’s Oct. 31 minutes (Attachment Six-A1). The motion passed unanimously.

2. Heard an Update on the STLD Medical Data Call Template

Ms. Rebholz said the call letters were sent to all companies licensed in the 40 participating jurisdictions, or about 6,400 companies. She said the due date for responses is Dec. 13, and there will be no opportunity to submit data through the Regulatory Data Collection (RDC) tool after that date. Any late submissions allowed by any of the participating jurisdictions will have to be submitted outside of the tool directly to the jurisdiction. Ms. Rebholz said no submissions have been received yet, and only 24 people have requested the short-term limited duration (STLD) role necessary to submit reports. She said 262 emails have been received from companies advising that they have no STLD data to report. She estimated that this equates to more than 300 companies, because some of the emails came from groups on behalf of multiple companies.

3. Adopted “Other Health” as a Line of Business in the MCAS

Mr. Haworth said the discussion to add “other health” as a line of business in the MCAS is being considered in order to collect market data regarding medical plans that are not required to be compliant with the federal Affordable Care Act (ACA). He said the discussion began last year, but it was put on hold while the Working Group developed the STLD data call.

Katie Keith (Out2Enroll) said the NAIC-funded consumer representatives support the addition of the “Other Health” line of business in the MCAS. She agreed with the original proposals identification of gaps in the current health MCAS blank.

Ms. Ailor made a motion, seconded by Ms. Rouleau, to add the “other health” line of business to the MCAS. The motion passed unanimously.

4. Discussed the Uniform Process for Addressing MCAS Extension Requests

Ms. Rebholz said the best way to address how to consistently handle extension requests is to review and update the MCAS Best Practices Guide developed by the Working Group in 2014. She said three state insurance regulators have volunteered to assist her in reviewing and updating the MCAS Best Practices Guide. She asked others interested in volunteering to contact Randy Helder (NAIC).

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Oct. 31, 2019. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Melissa Grisham (AR); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Robin David (DE); Scott Woods (FL); Tate Flott (KS); Russell Hamblen (KY); Jeff Zewe (LA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huiskens (MI); Cynthia Amann and Teresa Kroll (MO); Reva Vandevoorde (NE); Douglas Rees (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Larry Wertel (NY); Angela Dingus (OH); Landon Hubbard (OK); Gary Jones and Katie Dzurec (PA); Michael Bailes (SC); Julie Fairbanks (VA); and Christina Rouleau (VT). Also participating was: October Nickel (ID).

1. **Adopted its Aug. 27 Minutes**

The Working Group met Aug. 27 and took the following action: 1) adopted its Summer National Meeting Minutes; 2) adopted the disability insurance Market Conduct Annual Statement (MCAS) scorecard ratios; and 3) agreed to post a 2018 national health MCAS scorecard.

Ms. Dingus made a motion, seconded by Ms. Amann, to adopt the Working Group’s Aug. 27 minutes (Attachment Six-A1a). The motion passed unanimously.

2. **Heard an Update on the STLD Medical Data Call Template**

Ms. Rebholz said the call letters were sent to all companies licensed in the 40 participating jurisdictions. She said the due date for responses is Dec. 13 and there will be no opportunity to submit data through the Regulatory Data Collection (RDC) tool after that date. Any late submissions allowed by any of the participating jurisdictions will have to be submitted outside of the tool directly to the jurisdiction, and they will not be in the aggregated totals.

Ms. Rebholz said an NAIC web page has been set up for the short-term limited duration (STLD) data call with the RDC tool, the data call, instructions, a frequently asked questions (FAQ) document and other assistance for companies. She said the RDC only provides form and format validations. Data quality and accuracy will need to be determined by each jurisdiction.

Ms. Rebholz said the NAIC will compile a list of all companies receiving the call. The list will include whether the company indicated on their Accident and Health Policy Experience Exhibit that it collected premium for Short-Term Medical products and whether the company filed any STLD products in the System for Electronic Rate and Form Filing (SERFF). Companies that do not have any STLD products to report are being instructed to send an email to the NAIC stating that they have no data to report.

Ms. Rebholz said after Dec. 13, the participating jurisdiction will be provided lists of companies that provided no response. The participating jurisdictions will follow up with the companies.

3. **Discussed an Analysis of LPI MCAS Data**

Mr. Haworth said the first submission of lender-placed insurance (LPI) was received earlier in the year. He said comments were received from Tom Keepers (Consumer Credit Industry Association—CCIA) about reporting concerns for blanket vehicle single-interest (VSI) insurance.

Mr. Keepers said blanket VSI provides protection only for the lender’s financial interest. A commercial insurance policy is issued to the lender that covers all eligible property. He said no certificates are issued to individuals. He said the MCAS blank has 17 underwriting data elements requesting certificate information for the blanket VSI business which companies have answered with zeroes. He said some participating MCAS states are insisting on responses for these data elements. He wanted to bring this issue to the attention of the Working Group so that analysts would understand why zeroes are being reported.
Mr. Keepers questioned whether blanket VSI belongs in the MCAS, because it is a commercial product protecting commercial lenders. Mr. Haworth asked what the size of the marketplace is. He said there are six to 10 insurers writing about $10 million each in premium. He said it is a small market.

Birny Birnbaum (Center for Economic Justice—CEJ) agreed with the description of blanket VSI, but he said all single-interest LPI is commercial in that it protects the lender. Blanket VSI is still LPI. He said because there are no certificates or reporting on an individual basis, it creates problems for analysts because the companies still report on claims, complaint, canceled policies, and other underwriting and claims information. He said this can skew the ratios in comparison to other LPI coverages. He suggested, however, that blanket VSI does not need to be excluded in the MCAS, but it could be broken out into a separate coverage. He recommended a special data call on blanket VSI and then creation of the separate MCAS blank.

Ms. Ailor agreed and said the issue should be referred to the Market Conduct Annual Statement (D) Working Group for consideration. She recommended that companies use the comments to explain their data if they expect that their data will create questions.

4. Discussed the Uniform Process for Addressing MCAS Extension Requests

Ms. Rebholz said the best way to address how to consistently handle extension requests is to review and update the MCAS Best Practices Guide developed by the Working Group in 2014. She asked for volunteers to review and update the MCAS Best Practices Guide.

Mr. Haworth volunteered and asked other volunteers to contact Randy Helder (NAIC).

5. Discussed the Reporting of Phantom Claims in the MCAS

Mr. Haworth said there seemed to be no concerns by any of the members about the reporting of phantom claims, and he said he would take this item off the agenda for the next meeting.

6. Discussed the Inclusion of Fraternals in the MCAS

Mr. Haworth said several states have expressed opposition to adding fraternals to the MCAS because they operate differently in different states. Additionally, he said many of the fraternals are small companies. Ms. Vandevoorde said Nebraska strongly opposes adding fraternals to the MCAS.

Ms. Huisken said that while many fraternals are small, there are a number of large fraternals for which MCAS data would be helpful. She said small fraternals could be eliminated by the premium threshold for reporting.

Mr. Birnbaum agreed with Ms. Huisken and noted that reporting from large fraternals should not be excluded just to protect small fraternals.

Mr. Haworth said there is no proposal one way or the other concerning the inclusion of fraternals. He solicited a proposal before considering this further.

7. Discussed Adding “Other Health” as a Line of Business in the MCAS

Mr. Haworth said the discussion to add “other health” as a line of business in the MCAS is being considered in order to collect market data regarding medical plans that are not required to be compliant with the federal Affordable Care Act (ACA).

Ms. Ailor supported adding the “other health” line of business to the MCAS. She noted that the line of business was never disapproved by the Working Group, but only put on hold. She said the STLD data call will provide some necessary data for analysts, but work should begin on the “other health” line of business.

Ms. Nickel and Ms. Rebholz also supported adding the “other health” line of business.

Ms. Ailor said now that the STLD template has been developed and the first collection of data will occur soon, the STLD data call can be used as a pilot for the development of an “other health” line of business blank for the MCAS.
Ms. Rebholz and Mr. Pyle said they support including “other health” in the MCAS.

Mr. Haworth said the Working Group would accept comments until Nov. 15 and would consider adoption of “other health” as the next line of business in the MCAS during the Working Group’s Nov. 21 conference call.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
Market Analysis Procedures (D) Working Group
Conference Call
August 27, 2019

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Aug. 27, 2019. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Melissa Grisham (AR); Maria Ailor and Cheryl Hawley (AZ); Pam O’Connell (CA); Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Frank Pyle (DE); Pamela Lovell (FL); Susan Lamb and Matthew Ryan (IL); Tate Flott (KS); Russell Hamblen (KY); Jeff Zewe (LA); Mary Lou Moran (MA); Raymond Guzman (MD); Timothy Schott (ME); Jill Huiskens (MI); Paul Hanson (MN); Cynthia Amann and Teresa Kroll (MO); Jeannie Keller (MT); Reva Vandevoorde (NE); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Sylvia Lawson (NY); Angela Dingus (OH); Joel Sander (OK); Jeffrey Arnold (PA); Michael Bailes (SC); Julie Fairbanks (VA); and Theresa Miller (WV).

1. **Adopted its Summer National Meeting Minutes**

Ms. Amann made a motion, seconded by Mr. Hanson, to adopt the Working Group’s Aug. 4 minutes (*see NAIC Proceedings – Summer 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Three*). The motion passed unanimously.

2. **Heard an Update on the STLD Medical Data Call Template**

Ms. Rebholz said the confidentiality agreement was sent to the participating states on Aug. 15, and responses have been received from around 25 jurisdictions.

Randy Helder (NAIC) said the confidentiality agreement indicated the data call would cover the period of September 2018 to March 2019. Because it was decided to possibly conduct the short-term, limited duration (STLD) data call multiple times, the NAIC Legal Division will send an email to the participating states asking for their agreement to leave the data call period open and not limited to just the September 2018 to March 2019 period. He also said the date the Regulatory Data Collection (RDC) tool will be ready was pushed to Oct. 1.

3. **Adopted Disability Insurance MCAS Proposed Scorecard Ratios**

Mr. Haworth said that during the Summer National Meeting, he asked for technical comments regarding the proposed disability insurance Market Conduct Annual Statement (MCAS) scorecard ratios. He said comments were received from the American Council of Life Insurers (ACLI), America’s Health Insurance Plans (AHIP) and the Center for Economic Justice (CEJ).

Michael Lovendusky (ACLI) said his comments concerned ambiguities in the definitions of paid and denied claims within the definitions of the MCAS blank, as well as technical comments on six of the ratios.

Mr. Haworth told Mr. Lovendusky to limit with comments to the ratios because data element and definitional matters belong to the Market Conduct Annual Statement Blanks (D) Working Group.

Mr. Lovendusky said ratio 1, “Percentage of claims denied,” would be improved by making the denominator the sum of claims denied and new paid claim determinations. He said ratio 6, “The number of complaints relating to group policies to the average number of group policies in force during the reporting period,” could produce false positives because the denominator is the average number of policies, but the number of members in group policies can vary substantially from company to company. He also noted that ratio 4, ratio 5 and ratio 6 refer to “complaints from consumers” but should read “complaints from insureds.”

Mr. Lovendusky said ratio 7, “The percentage of lawsuits closed with consideration for the consumer,” does not actually measure any wrong-doing or fault on the part of the insurer because some litigation results in good-will settlements by the insurer. He also cautioned that it could be exploited by the plaintiff bar. He was also unsure if the impact of class action lawsuits were considered.

Mr. Arnold said he would like a better understanding of the ratio.
Mr. Haworth said class action lawsuits were considered and noted this was just one data point that needed to be reviewed in addition to the raw data.

Mr. Birnbaum said the definition of a lawsuit closed with consideration to the consumer states that the settlement has to be larger than the last offer of the company before the lawsuit was brought. A company with a higher ratio may be making offers that more often compel litigation. He noted that if a data element is adopted, the assumption is it has value to market analysts.

Mr. Lovendusky said the titles of ratio 8, “Non-renewals and cancellations to average policies in-force,” and ratio 9, “Covered lives affected by non-renewals to average policies in-force,” should specify that the cancellations and non-renewals are by the insurer, not the insured. He said ratio 9 has the same confusion as ratio 6 in that the number of members in a group can vary significantly. Mr. Lovendusky said the purpose of ratio 10, “Average pending benefit determinations to claims received,” is unclear. He said if claims are handled appropriately by being processed within the standards set for timely claim handling, then there is no significance to average pending determinations.

Ms. Ailor made a motion, seconded by Ms. Amann, to revise ratio 4, ratio 5 and ratio 6 to change the word “consumer” to the actual terminology in the blank, “any entity other than the DOI,” and to clarify the titles of ratio 8 and ratio 9 to make it clear they refer to insurer non-renewals and cancellations. The motion passed unanimously.

Ms. Ailor made a motion, seconded by Ms. Amann, to adopt the proposed disability insurance MCAS scorecard ratios (Attachment Six-A1a1). The motion passed unanimously.

4. **Agreed to Post a 2018 National Health MCAS Scorecard**

Mr. Haworth said that for the 2017 data year, it was decided that the public health MCAS scorecards would not be posted. He said there was a concern of having only one or two companies writing health business within a jurisdiction. He said that at the Summer National Meeting, it was agreed again not to post the state by state scorecards for the 2018 data year. He said a proposal was made to post a single national scorecard instead.

Mr. Zewe noted there were no comments in opposition to a national scorecard.

Demetria Tittle (Blue Cross and Blue Shield Association—BCBSA) said since the national scorecard was only introduced at the last meeting, it would be helpful for all state insurance regulators and interested parties to see it prior to posting it as the 2018 health scorecard.

Mr. Haworth noted that whether it was publicly exposed as a working document or if it was posted as the scorecard, it would be publicly viewable.

Joseph Zolecki (BCBSA) said there was some confusion regarding how the scorecard ratios would be calculated.

Mr. Helder explained that for each numerator and denominator, the total of all reported data by all companies would be calculated regardless of which state or states it was reported to. It will not be an average.

Mr. Zolecki asked that the statement regarding the methodology employed be included on the scorecard.

Mr. Zewe made a motion, seconded by Ms. Amann, to post a 2018 data year national health MCAS scorecard. The motion passed unanimously. Mr. Haworth said a statement regarding the methodology for the calculation will be included.

5. **Discussed Uniform Process for Addressing MCAS Extension Requests**

Ms. Rebholz said there was interest by the Working Group for a uniform process and what would and would not be in that process. She said, for example, that many states are not interested in fines, but many states do want a template letter that can be sent if a company meets a trigger, such as two or three consecutive years of requesting an extension. She volunteered to draft a process to begin the discussions.
6. Discussed the Reporting of Phantom Claims in the MCAS

Ms. Kroll said she brought this issue up at the Summer National Meeting. She said she understands the property/casualty (P/C) insurers were originally given latitude on the reporting of claims in the MCAS. She said, however, that after 15 years, they should be able to report accurate claims numbers without including claims setup for precautionary reasons only or set up just to address an inquiry of coverage and closed without payment. She suggested the participating MCAS states need to make a firm stand on this issue.

Ms. Ailor noted the Market Conduct Annual Statement Blanks (D) Working Group made revisions in 2017 to the P/C MCAS definitions to address claims reported for informational reasons only.

Mr. Haworth asked state insurance regulators to let the Working Group and Ms. Kroll know if they are seeing the same issues.

7. Discussed Inclusion of Fraternals in the MCAS

Mr. Haworth said fraternals are currently not required to file an MCAS because the MCAS submission tool is only available to companies that file their annual financial statements on the life, property and health statement types. He said because fraternals used to file their financial statements on a fraternal statement type, they were unable to access the MCAS submission tool. He said beginning with the 2019 data year, fraternals will no longer submit on the fraternal financial statements; instead, they will be reporting on the life, health and P/C financial statements. He noted that this means fraternals could now be required to file an MCAS if the Working Group decides it would be useful to have them submit MCAS filings.

Ms. Vandever said there are only a few fraternals that account for most of the premium generated by fraternals. She said for most fraternals, submitting an MCAS would be a cost burden. She said Nebraska does not support requiring fraternals to report an MCAS.

Ms. Rebholz said, in Wisconsin, there are not many complaints relating to fraternals. She suggested adding a line to the MCAS that has more issues that need addressing.

Ms. Huisken asked if the consideration was to add an MCAS blank specifically for fraternals or to require fraternals to file on the already established MCAS blanks.

Mr. Haworth said the consideration was for fraternals to report on already established MCAS blanks.

Ms. Huisken said that was not too much of a burden and that the consumers of products provided by fraternals are subject to the same issues as consumers of products offered by other types of insurance companies.

Mr. Arnold said a stand-alone fraternal MCAS blank is not necessary. He said the top six fraternals in Pennsylvania account for 90% of the premium written by fraternals.

Mr. Birnbaum said it would be helpful to quantify the cost burden to fraternals for comparison to the qualitative benefits of adding fraternals.

Mr. Haworth noted that fraternals are regulated differently from other companies in Washington. He said the Working Group would continue the discussion.

8. Discussed Adding “Other Health” as a Line of Business in MCAS

Mr. Haworth said the discussion to add “other health” as a line of business in MCAS was tabled last year while the Working Group developed the STLD data call. He said interest was expressed in reopening the discussion.

Ms. Ailor said that now that the STLD template has been developed and the first collection of data will occur soon, the STLD data call can be used as a pilot for the development of an “other health” line of business blank for the MCAS.

Ms. Rebholz and Mr. Pyle said they support including “other health” in the MCAS.

Mr. Haworth said this agenda item will remain on the Working Group agenda.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
2019 Market Conduct Annual Statement Ratios

Disability Income

**Ratio 1**  Percentage of claims denied

\[
\frac{\text{Number of claims denied during reporting period (21)}}{\text{Number of paid claims closed during reporting period (22)}}
\]

**Ratio 2**  Percentage of claims processed with initial decision after 45 days

*Short-Term Only*

\[
\frac{\text{Number of claims processed with initial claim decision over 45 days (28)}}{\text{Number of claims processed with initial claim decision within 1-14 days (25)} + \text{Number of claims processed with initial claim decision within 15-30 days (26)} + \text{Number of claims processed with initial claim decision within 31-45 days (27)}}
\]

**Ratio 3**  Percentage of claims processed with initial decision after 90 days

*Long-Term Only*

\[
\frac{\text{Number of claims processed with initial claim decision over 90 days (33)}}{\text{Number of claims processed with initial claim decision within 1-30 days (30)} + \text{Number of claims processed with initial claim decision within 31-60 days (31)} + \text{Number of claims processed with initial claim decision within 61-90 days (32)}}
\]

Commented [HR1]: Replaced Benefit Determinations with Claims Decisions
2019 Market Conduct Annual Statement Ratios

**Ratio 4** The number of complaints received directly from consumers per 1,000 individual policies in force during the reporting period

\[
\frac{[\text{Number of complaints received from consumers (83)}]}{([\text{Number of policies beginning of the reporting period (67)}] + [\text{Number of policies at the end of the reporting period (75)}] + 2) \div 1000}
\]

**Ratio 5** The number of complaints received directly from consumers per 1,000 lives covered on group policies

\[
\frac{[\text{Number of complaints received from consumers (83)}]}{([\text{Number of lives covered at the beginning of the reporting period (76)}] + [\text{Number of lives covered at the end of the reporting period (82)}] + 2) \div 1000}
\]

**Ratio 6** The number of complaints relating to group policies to average number of group policies in force during the reporting period

\[
\frac{[\text{Number of complaints received from consumers (83)}]}{([\text{Number of policies in force at beginning of reporting period (67)}] + [\text{Number of policies in force at end of the reporting period (75)}] + 2)}
\]

**Ratio 7** The percentage of lawsuits closed with consideration for the consumer

\[
\frac{[\text{Number of lawsuits closed with consideration for consumer (87)}]}{[\text{Total number of lawsuits closed during the period (86)}]}
\]

Commented [HR2]: Ratio 4 was split into three ratios in order to separately measure complaints on individual policies and complaints on group policies.
2019 Market Conduct Annual Statement Ratios

**Ratio 8  Non-renewals and cancellations to average policies in force**

\[
\left( \frac{\text{Number of insurer non-renewals (71) + Number of insurer cancellations (72)}}{\text{\(\frac{\text{Number of policies in force at the beginning of the reporting period (67) + Number of policies in force at the end of the reporting period (75)}}{2}\)}} \right)
\]

**Ratio 9  Covered lives affected by non-renewals to average policies in force**

Group only

\[
\left( \frac{\text{Number of lives covered under insurer non-renewals (79) + Number of lives covered under insurer cancellations (80)}}{\text{\(\frac{\text{Number of lives covered under policies in force at the beginning of the reporting period (76) + Number of lives covered under policies in force at the end of the reporting period (82)}}{2}\)}} \right)
\]

**Ratio 10  Average pending benefit determinations to claims received**

\[
\left( \frac{\text{\(\frac{\text{Number of pending benefit determinations, beginning of reporting period (17) + Number of pending benefit determinations, end of reporting period (23)}}{2}\)}}{\text{Number of claims received during the reporting period (19)}} \right)
\]

**Ratio 11  Rescissions after two years from issuance to total rescissions**

\[
\left( \frac{\text{Number of rescissions after two years from policy issue (74) + Number of rescissions within two years from policy issue (73)}}{\text{Number of rescissions after two years from policy issue (74)}} \right)
\]
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Nov. 21, 2019. The following Working Group members participated: Maria Ailor, Chair (AZ); Angela Dingus, Vice Chair (OH); Melissa Grisham (AR); Kurt Swan (CT); Scott Woods (FL); October Nickel (ID); Lori Cunningham (KY); Teresa Fischer (MN); Teresa Kroll and Cynthia Amann (MO); Katie Dzurec (PA); Ned Gaines and John Haworth (WA); Jo LeDuc (WI); and Letha Tate (WV). Also participating were: Laura Arp and Martin Swanson (NE).

1. **Adopted its Oct. 23 Minutes**

The Working Group met Oct. 23 and took the following action: 1) adopted its May 2 minutes; 2) heard an update on the Life and Annuity Market Conduct Annual Statement (MCAS) Data Element Review Project; 3) heard an update on the Other MCAS Lines of Business Data Element Review Project; and 4) heard an update on the health MCAS industry questions meetings.

Ms. Dingus made a motion, seconded by Mr. Haworth to adopt the Working Group’s Oct. 23 minutes (Attachment Seven-A). The motion passed.

2. **Agreed to Change MCAS Due Dates Occurring on Weekends and Federal Holidays**

Ms. Ailor advised concerns were expressed to the Working Group related to when an MCAS due date falls on the weekend. It was asked if the due date could be moved to a weekday. The Working Group discussed this concern and agreed that if the due date falls on a weekend or a federal holiday, the due date will be moved to the next business day.

3. **Extended the Health MCAS Filing Deadline for 2020, 2021 and 2022**

Ms. Ailor advised a letter was received requesting the health MCAS filing due date be permanently changed from April 30 to June 30. The letter is attached to the minutes for reference (Attachment Seven-B).

Joseph Zolecki (Blue Cross and Blue Shield Association—BCBSA) provided the Working Group with a summary of the request. He went through the points outlined in the letter and explained that one of the concerns health carriers have with an April 30 filing deadline instead of a June 30 deadline is that certain health MCAS data may not be complete or entirely reliable due to the numerous health claim adjustments that occur in the beginning of the year and the year-end claim submissions in the first and second quarters. He advised that based on carrier experiences in the first two years of health MCAS filings, a June 30 filing date will allow for adequate time to pull and process this information and will result in more accurate and useful health MCAS filings. He advised the amount of external data required for health MCAS reporting compared to the life and property/casualty MCAS reporting is disproportionate, yet the filing dates are similar. He explained there is not currently an automated way to compile the data into the health MCAS because health data is received from so many different sources, and, as a result, health carriers are required to manually compile the data. He advised it would likely be several years before full automation is possible, noting that a June 30 filing date should minimize and/or eliminate extension requests. He stated that unless there are extraordinary circumstances, June 30 would be the firm due date.

Prior to requesting comments and/or questions from the Working Group, Ms. Ailor explained that any decision by the Working Group to amend the due date would need to be considered and approved by the Market Regulation and Consumer Affairs (D) Committee at the Fall National Meeting.

Ms. Nickel expressed concern with getting corrections from health carriers made within the next data year for Idaho. She said Idaho has a small department and a small market conduct section. She explained that getting all carriers and lines of business together at once to evaluate the MCAS data in a consistent manner and have enough time to analyze those carriers and provide companies with letters and/or contact information when irregularities/outliers are seen is already going into the next year. Then, after adding in time for responses and re-evaluations, many times the next data year is already underway. To review if there are violations going on, the department would like to cure that as soon as possible.

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Mr. Gaines said Washington has the same issue as Idaho, noting that the department is required to review all domestic companies. Most of the domestic companies that must report happen to be health carriers, and, with a June 30 date, the department cannot even start reviews until August at the earliest, which puts staff in a bind to get everything completed by the end of the year. If reviewing data at the end of the year, it makes it difficult to go back to the carrier and try to get any corrections, as so much time has passed and the carrier is already looking at submitting new data for the next year.

Ms. Dingus advised she understands the issues with companies trying to get data and she is not opposed to extending the deadline but not on a permanent basis. She advised a period of three years would be acceptable, with the understanding the due date would be reevaluated.

Mr. Haworth asked for clarification on what would be considered extraordinary circumstances. He advised that Washington often gets requests for extension the day of or day before the due date, claiming the carrier was unable to get data from a third-party vendor and wants to know if this would qualify.

Ms. Dingus added the example of carriers requesting extensions because the person who was handling the data left the company and did not think this should qualify as an extraordinary circumstance.

Ms. Arp said she believes three years is fair, with the understanding that this due date will be reevaluated in three years.

Mr. Swanson said he envisions that an extraordinary circumstance would be a fire or an “Act of God,” not a staffing issue. Ms. Arp said changes in personnel should be excluded.

Ms. Nickel suggested a May 30 deadline, explaining the Working Group cannot really define “extraordinary” and, if an extension is requested, trying to qualify “extraordinary” could become problematic.

Ms. Ailor asked Mr. Zolecki what he considers to be “extraordinary,” and he agreed it would not be a change of personnel. He asked if he could go back to the carriers and send some examples for consideration, but said he agrees something like an Act of God is a reasonable parameter.

Birny Birnbaum (Center for Economic Justice—CEJ) asked that the deadline be kept at April 30 and enforced because the purpose is not to be aligned with other reporting dates, but to provide data to regulators in a timely fashion. He advised that routine reporting requirements enables insurers to develop procedures for timely reporting. He advised the annual financial statement is far more complex than the health MCAS and insurers are able to report just two months following the end of the experience period, as insurers have developed the tools and resources to meet this reporting deadline despite the complexity, noting that regulators have confirmed the importance of this data for regulatory purposes.

Ms. Ailor expressed her understanding of the concerns presented from all parties and advised she supports extending the deadline to June 30 or May 30 with a reevaluation date in the future, such as three years as previously discussed. She asked how the Working Group would like to move forward with this request.

Ms. Dingus made a motion, seconded by Ms. Dzurec, to extend the health MCAS deadline to June 30 for three reporting periods of 2020, 2021 and 2022, to be reevaluated in 2022, only if companies request the reevaluation. If companies do not request reevaluation of the due date in 2022, the due date will roll back to April 30. The motion passed.

Tressa Smith (NAIC) confirmed with the Working Group that this motion is for the 2019 data to be reported in 2020, the 2020 data to be reported in 2021, and the 2021 data to be reported in 2022.

4. Discussed Other Matters

Ms. Amann advised that regarding the life MCAS, there was not enough desire from the small group to expand the life and annuity MCAS due to time and staff limitations. Mr. Haworth advised the State Ahead initiative is taking a lot of NAIC resources and adding extra data fields may not be feasible at this time.

Teresa Cooper (NAIC) advised that while the State Ahead initiative is taking a lot of resources, the Working Group should not let that be a factor in this decision and to make changes as needed.
Mr. Birnbaum asked who the members of the small group are, noting that such information is not readily available. He then asked if the NAIC was specifically asked if this request would be a burden or conflict with the State Ahead initiative, and Ms. Amann confirmed the NAIC was not asked that question.

Mr. Birnbaum then asked for clarification on why this would be difficult for regulators.

Ms. Amann advised the difficulty is collecting data they are not able to analyze because they either do not have the time or they have limitations on the data being accurate. Mr. Birnbaum then asked that a more robust report be provided from the small group and that a discussion take place about it.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Oct. 23, 2019. The following Working Group members participated: Maria Ailor, Chair (AZ); Angela Dingus, Vice Chair (OH); Melissa Grisham (AR); Kurt Swan represented by Steve DeAngelis (CT); Scott Woods (FL); Paul Hanson (MN); Teresa Kroll and Cynthia Amann (MO); Michael Bailes (SC); Ned Gaines and John Haworth (WA); Jo LeDuc (WI); and Letha Tate (WV).

1. **Adopted its May 2 Minutes**

The Working Group met May 2 and took the following action: 1) adopted its March 28 minutes; 2) adopted the private flood Market Conduct Annual Statement (MCAS) Data Call and Definitions; 3) adopted items from its Jan. 23-24 meeting; and 4) made a motion to add a health MCAS blank for the “number of member months for policies terminated during the period.”

(Editor’s Note: Item #4 regarding the health MCAS blank was adopted unanimously by the Working Group. It was subsequently adopted by the Market Regulation and Consumer Affairs (D) Committee during its July 15 conference call, and it will be added to the 2020 health MCAS blank, which will be reported in 2021.)

Mr. Haworth made a motion, seconded by Ms. Kroll to adopt the Working Group’s May 2 minutes (see NAIC Proceedings – Summer 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Four). The motion passed.

2. **Heard an Update on the Life and Annuity MCAS Data Element Review Project**

Ms. Amann said there was a previous survey generated regarding product category expansion/modification for life and annuity data elements. The smaller review group is currently reviewing the comments and survey responses, and it will provide a written update to the Working Group by the end of the month.

Birny Birnbaum (Center for Economic Justice—CEJ) said he recently submitted supplemental survey comments referring to changes in the annual financial statement. The changes to the annual financial statement provide for the recording of more categories, so he suggested that the Working Group consider tracking these changes because they break life and annuity into more product categories. The comments he submitted will be reviewed.

Michael Lovendusky (American Council of Life Insurers—ACLI) asked that Ms. Amann include him on the distribution list for the written update on this subject matter, and she confirmed that she would. He asked when the 2019 MCAS User Guide would be posted because disability income is being reported for the first time, and Teresa Cooper (NAIC) said it should be posted by the end of the month.

3. **Heard an Update on the Other MCAS Lines of Business Data Element Review Project**

Ms. Ailor said the Working Group needs to review the other lines of business for MCAS. She suggested that a survey be sent out to see if there is any interest in updating or changing data elements for homeowners and private passenger auto to begin the reviews for other lines of business. The survey would be similar to the one generated for the pending life and annuity data element review. Depending on the results of the survey, subject-matter expert (SME) groups can be formed to review the data elements.

4. **Heard an Update on the Health MCAS Industry Questions Meetings**

Ms. Ailor said comment letters were received yesterday from health insurance industry interested parties regarding the MCAS submission process and filing deadline. A Working Group meeting is being arranged for Nov. 21 to further discuss these details after Working Group members have had an opportunity to review these letters, which will soon be generated with the meeting notice.
Joseph E. Zolecki (Blue Cross and Blue Shield Association—BCBSA) asked if there would be time to get this reviewed before the Market Regulation and Consumer Affairs (D) Committee meets in December.

Ms. Cooper explained that system changes related to validations and attestations do not have to go through the Working Group.

Ms. Ailor explained that, if needed, there may need to be separate handling of these matters between scheduled meetings.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
Ms. Maria Ailor  
Chair, Market Conduct Annual Statement Blanks (D) Working Group  
National Association of Insurance Commissioners

Ms. Angela Dingus  
Vice Chair, Market Conduct Annual Statement Blanks (D) Working Group  
National Association of Insurance Commissioners

c/o RHelder@naic.org

RE: Health Industry Interested Parties Proposed Health Market Conduct Annual Statement Blank (MCAS) Filing Date

Dear Ms. Ailor and Ms. Dingus:

The Health Industry Interested Parties (“HIIP”) group is comprised of single and multi-state licensed health insurers and administrators representing comprehensive major medical and managed care health insurance carriers of all sizes located throughout the United States. On behalf of the HIIP group, we continue to be concerned about the due date for filing the Health Market Conduct Annual Statement (Health MCAS) in 2020 and thereafter, and we request that the Market Conduct Annual Statement Blanks Working Group (Working Group) consider making June 30 the permanent annual filing deadline for the Health MCAS beginning in 2020.

As the due date for health insurers to file their 2019 Health MCAS Reports is scheduled to shift forward in 2020 to April 30, the HIIP group recognizes and understands the Working Group’s desire to align the due dates for MCAS filings across all lines of business. During Health MCAS implementation, the HIIP group has appreciated the Working Group’s flexibility in allowing health insurers to submit their MCAS reports on a different timetable in 2018 and 2019. However, based on their experiences from these first two years of Health MCAS reporting, the HIIP group members firmly believe that the April 30 deadline is problematic and impracticable as it pertains to the reporting of health insurance data. Based on the HIIP group members’ experiences compiling and reporting Health MCAS data over the past two years, the group believes that a June 30 deadline is more suitable going forward and more constructive toward the NAIC’s goal of collecting complete, useful and fully-adjusted health insurance market data. External administrators also support a filing date for health carriers that is later in the second quarter in order to support and manage the capacity and growing number of reporting client needs and expectations during their peak reporting season.

As discussed more fully below, we believe that the rationale for requiring uniform deadlines for all MCAS data should not outweigh the need for ensuring that the Health MCAS produces complete, carefully compiled and validated health data that regulators can rely upon in performing their regulatory oversight goals.
Complexity of Health Data and the Health MCAS

It is important to recognize the complexity and nature of Health MCAS data being reported compared to data reported for other MCAS lines of business, as well as the manner in which data must be collected and compiled for the Health MCAS report.

As compared to MCAS blanks used to collect data on other lines of business, which are more straightforward and involve relatively few data elements, the Health MCAS is substantially more complex, requiring significantly more data elements to collect and validate through quality assurance processes necessary to produce complete, consistent and verifiable information. Without counting Interrogatories, the Health MCAS calls for more than 140 lines (or elements) of policy and claim data - over four times more than the MCAS for Homeowners and over six times more than that for Private Passenger Auto. Moreover, each of these lines or data elements requires dozens of individual, potentially unique, or overlapping substratifications that require various programming, querying, aggregating, or cross-referencing processes to identify and compile, not to mention validate and attest. These various sub-elements and substratifications, which generally are not otherwise tracked and maintained throughout an insurer’s systems in the Health MCAS format include:

- On Exchange vs. Off Exchange;
- Single State vs. Multi-State;
- Grandfathered vs. NonGrandfathered;
- Individual vs. Group;
- Small Group vs. Large Group;
- Catastrophic vs. Non-Catastrophic;
- Student vs. Non-Student;
- Bronze, Silver, Gold or Platinum;
- In-Network vs. Out of Network;
- Pharmacy vs. Non-Pharmacy; and
- Behavioral Health vs. Non-Behavioral Health

There is nothing comparable in the other Life or Property and Casualty MCAS filings. Moreover, much of the data reported in the Health MCAS must be obtained from multiple internal and external sources or systems, further complicating the effort necessary to compile accurate data for the Health MCAS report. These sources include finance, membership, claims, customer service, health care services, care management, and pharmacy, and typically involve data maintained by numerous vendors or third-party administrators.

The amount of external data required for Health MCAS reporting compared to Life and Property and Casualty MCAS reporting is disproportionate, yet the filing dates are similar. For example, there are products like behavioral health, where this sensitive data is extensively controlled and restricted by regulation. For these reasons, carriers' behavioral health data is often held outside of the reporting database. Data processing is extremely complex and time-consuming to initially retrieve the data from external sources and match it to members and policies that exist on internal reporting databases, followed by multiple iterations of testing and validation to ensure accurate presentation of data in Health MCAS filings.

Nor is there currently an automated way to compile the data into the Health MCAS, since health data is received from so many different sources. Therefore, health carriers are required to manually compile the data to ensure quality and accuracy. A Health MCAS filing could have millions of associated underlying lines of administrative data that requires health carriers to perform multiple manual steps in their comprehensive review of the data. Life and property and casualty carriers do not have the volume of manual data input and analysis that health carriers are required to perform.
The Working Group has indicated that it expects health carriers to eventually automate the process for data retrieval required for the annual Health MCAS report; however, this expectation is several years from realization and will require a substantial outlay of healthcare resources to achieve. Considering the vast quantity of data elements and sub-strata mandated by the Health MCAS blank, not to mention the changes or additions to those elements from year to year and the evolving state of definitions and instructions applicable to them, it will likely be several years to come before full automation is possible.

Until full automation is achieved, carriers must go through a series of cumbersome and manual processes for Health MCAS reporting. Carriers can have a significant volume of underlying lines of administrative data associated with the data elements required for Health MCAS reporting. The underlying administrative data can be subject to a manual multi-step validation process. A key step in this validation process is to model claims, which can encompass 200+ data elements that are extracted from administrative systems and data warehouses. Each associated line of administrative data must have a specific designation (i.e. “be modeled”) to allow for changes due to any number of internal variables, such as place of service code or line of business changes.

Data Readiness
One of the primary concerns that health carriers have with an April 30 filing deadline instead of June 30 is that certain data needed for compiling the Health MCAS report may not be fully adjusted or complete, which could result in MCAS reports that are not entirely reliable. Health carriers have numerous adjustments that occur in the first few months of the year, as well as the processing of year-end claim submissions in the 1st and 2nd quarters. Based on carrier experiences in the first two years of Health MCAS filings, a June 30 filing date will allow for adequate time to pull and process this information and will result in more accurate and useful Health MCAS filings.

For example, if a carrier pulls claims data at the beginning of the year (in January or February), the carrier would not catch certain active member validations related to unpaid December premiums, given that members would be in a 90 day grace period during this data pull. In this example, the member would be counted as having active coverage through year-end instead of having inactive coverage for non-payment. However, if the same data is pulled in April, the member would be accurately counted as having inactive coverage since the retroactive adjustment back to November 30 would have been processed.

Furthermore, there is national recognition that health claim reporting requires a significant amount of time after year-end to complete and test the accuracy of data. An example of complex state reporting is the All-Payer Claims Databases (APCD) report, which typically has a nine-month timeline as the minimum standard concerning new or modified reporting requirements in recognition of the need for data accuracy. This guide has proved effective for carriers to reconfigure inclusions and exclusions rules, schedule and execute data workloads and outputs and finally to run all of the data edits and investigate any variances.

In order for carriers to provide carefully compiled and validated Health MCAS filings by June 30, the HIIP group recommends that all Health MCAS reporting requirements be released as final by the NAIC no later than August 31 of the data year. Any new Health MCAS reporting requirement requires significant analysis and a complete re-look at all of the required modeling to ensure that there is not a relationship issue or other issues in the data. This form of analysis requires sufficient time for necessary programming and modeling in order to process through all of the data quality edits and to investigate and re-test the correction of variances.

Other Mandatory Filing Requirements
The health insurance industry is unique compared to other lines of insurance in that since the passage of the Affordable Care Act, the vast majority of health policies follow a strict annual calendar-year cycle. This means that, while other insurance policies are underwritten and issued throughout the
year, the annual policies offered by health insurers are predominately marketed, sold and issued only during a brief open enrollment period each year. Accordingly, product development, rating, approval, and marketing cycles for health insurance products also follow a strict annual cycle. As a result, during the first quarter of each year substantial resources and focus of health insurers are devoted toward enrollment validation and processing for new and renewing plan members for the current policy year (including distribution of member ID cards and coverage information), as well as the planning and development of the next year’s product offerings so that they can be submitted for regulatory approval in time to be brought to market. Under an April 30 filing deadline, the need to pull Health MCAS data hits health insurers at a time when their data systems and personnel are already intensely focused on the enrollment process and product development aspects of the health insurance cycle.

In addition to the burdens created by this annual cycle and the array of mandatory NAIC financial, actuarial and solvency reporting requirements for all carriers in the 1st and 2nd quarters, the health industry is further unique in having several other mandatory health insurance data filing requirements during the 1st and 2nd quarters that the other line of business carriers do not have. These mandatory filing requirements are uniquely applicable to health carriers only include the following:

- Medicare Supplement Insurance Experience Exhibit;
- Medicare Part D Coverage Supplement;
- Accident & Health Policy Experience Exhibit;
- Supplemental Health Care Exhibit; and
- Long-Term Care Experience Exhibit

Many health insurers are also required to make mandatory federal and state rate and form filings for their Affordable Care Act (ACA) products. Given the delays in receiving the Notice of Benefit and Payment Parameters (NBPP) information from the federal government, the period for these filings is greatly condensed, adding to the stress on carriers’ resources and systems during this period. In addition to the filing requirements imposed by state regulators, most health insurers are in various ways subject to an added layer of federal regulation, which differentiates them from companies reporting other MCAS lines of business and enhances the challenges imposed by an April 30th deadline.

On behalf of the Health Industry Interested Parties group, we would like to thank you for your consideration of our concerns and related comments regarding an April 30 filing deadline, and we look forward to working with you on a feasible alternative date that is satisfactory for both regulators and health carriers. Please contact us if you have any questions.

Sincerely,

Joseph E. Zolecki
BCBSA

Samantha Burns
AHIP

Cc: Demetria Tittle, BCBSA
The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Nov. 20, 2019. The following Working Group members participated: Bruce R. Ramge, Chair, Martin Swanson and Reva Vandevoorde (NE); Russell Hamblen, Vice Chair (KY); Melissa Grisham and Mel Heaps (AR); Damion Hughes (CO); Kurt Swan (CT); Frank Pyle (DE); Sarah Crittenden (GA); Lindsay Bates and Kim Cross (IA); Mary Lou Moran (MA); Jill Huiskens and Gloria Mason (MI); Cynthia Amann, Stewart Freilich and Win Nickens (MO); Edwin Pugsley (NH); Ralph Boeckman (NJ); Sylvia Lawson (NY); Rodney Beech and Angela Dingus (OH); Landon Hubbart and Joel Sander (OK); Scott Martin (OR); Katie Dzurec and Christopher Monahan (PA); Julia Fairbanks and Yolanda Tennyson (VA); Marcia Violette (VT); John Haworth and Jeanette Plitt (WA); Barbara Belling, Sue Ezalarab, Darcy Paskey, Rebecca Rebolz and Mary Kay Rodriguez (WI); and Desiree Mauller (WV).

1. **Adopted its Oct. 9 Minutes**

The Working Group met Oct. 9 and took the following action: 1) adopted its Aug. 29 minutes; 2) discussed revisions made to the draft travel insurance examination standards subsequent to comments received in September from Nebraska, the U.S. Travel Insurance Association (USTiA) and the American Property Casualty Insurance Association (APCIA); and 3) adopted the travel insurance-related examination standards for inclusion in the Market Regulation Handbook (Handbook).

Mr. Swan made a motion, seconded by Ms. Plitt, to adopt the Working Group’s Oct. 9 minutes (Attachment Eight-A). The motion passed unanimously.


Director Ramge said that a new draft farmowners in force standardized data request (SDR) and a new draft farmowners claims SDR were developed by regulator subject matter experts (SMEs) for the Working Group’s review, discussion and consideration of adoption, for inclusion in the reference documents of the Handbook. The drafts were exposed Oct. 29 for a public comment period ending Dec. 2.

Ms. Vandevoorde said the field name CanTerRs (reason for cancellation/termination of coverage) in the farmowners in force SDR duplicates the data that is obtained by field name CanTer (who cancelled the coverage); Ms. Vandevoorde will submit revised language for the field name CanTerRs, and Petra Wallace (NAIC staff) will circulate a revised draft farmowners in force SDR prior to the Working Group’s next conference call. Director Ramge encouraged state insurance regulators and interested parties to submit comments on the draft SDRs by the comments due date so that the Working Group can discuss the comments during its next conference call, which is scheduled for Dec. 18.

3. **Discussed New Draft Limited LTC Chapter, Oct. 29 Draft, for Inclusion in the Handbook**

Director Ramge said that new draft limited long-term care (LTC) exam standards were developed by regulator SMEs for the Working Group’s review, discussion and consideration of adoption, for inclusion as a new market conduct examination standards chapter in the Handbook. The drafts were exposed Oct. 29 for a public comment period ending Dec. 2.

Ms. Moran said there is language in 1) Marketing and Sales Standard 1 and 2) Standard 1 Appeal of Benefit Trigger Adverse Determination of the draft that may not be relevant. Ms. Moran said that she will provide revisions to these areas and that Ms. Wallace will circulate revised draft standards prior to the Working Group’s next conference call. Director Ramge encouraged state insurance regulators and interested parties to submit comments on the draft standards by the comments due date so that the Working Group can discuss the comments during its Dec. 18 conference call.

4. **Discussed Other Matters**

Director Ramge said NAIC staff will provide advance email notice of the Working Group’s Dec. 18 conference call.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.

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Market Conduct Examination Standards (D) Working Group
Conference Call
October 9, 2019

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Oct. 9, 2019. The following Working Group members participated: Bruce R. Ramge, Chair, and Reva Vandevoorde (NE); Russell Hamblen, Vice Chair (KY); Mel Heaps (AR); Maria Ailor (AZ); Damion Hughes (CO); Kurt Swan (CT); Frank Pyle (DE); Sarah Crittenden (GA); Lindsay Bates (IA); Mary Lou Moran (MA); Jill Huisken and Gloria Mason (MI); Paul Hanson (MN); Win Nickens (MO); Ralph Boeckman (NJ); Otis Phillips (NM); Peggy Willard-Ross (NV); Sylvia Lawson (NY); Rodney Beetch and Angela Dingus (OH); Kevin Foor, Landon Hubbart, Joel Sander and Shelly Scott (OK); Scott Martin (OR); Gary Jones (PA); Joy Morton and Yolanda Tennyson (VA); Christina Rouleau (VT); Jeanette Plitt (WA); Barbara Belling, Darcy Paskey, Rebecca Rebholz and Mary Kay Rodriguez (WI); and Desiree Mauller (WV).

1. Adopted its Aug. 29 Minutes

The Working Group met Aug. 29 and took the following action: 1) adopted a new workers’ compensation standardized data request for inclusion in the Market Regulation Handbook (Handbook) reference documents; and 2) continued its discussion of new travel insurance-related examination standards for inclusion in the Handbook.

Ms. Plitt made a motion, seconded by Ms. Dingus, to adopt the Working Group’s Aug. 29 minutes (Attachment Eight-A1). The motion passed unanimously.


Director Ramge said the draft travel insurance exam standards were developed by state insurance regulator volunteers Ms. Morton and Rebecca Nichols (VA). The draft was first circulated May 22, and the Working Group discussed the draft during its May 30, June 18, July 18 and Aug. 29 conference calls.

Director Ramge said the draft being discussed during today’s conference call was circulated Oct. 3 and contains revisions made by Ms. Morton and Ms. Nichols after they reviewed the following comments: 1) Sept. 20 comments received from Ms. Vandevoorde; 2) Sept. 27 comments received from John P. Fielding and LeeAnn Goheen (Steptoe & Johnson LLP) on behalf of the U.S. Travel Insurance Association (UStiA); and 3) Sept. 30 comments received from Angela Gleason (American Property Casualty Insurance Association—APCIA).

Director Ramge said the Oct. 3 draft was circulated in a redlined version and a “clean” version with the redlines accepted. Additionally, a summary of changes made to the document was also provided to the Working Group, interested state insurance regulators and interested parties.

Ms. Morton presented the changes made to the draft. Ms. Vandevoorde said that the first sentence in the first review procedures and criteria paragraph in Marketing and Sales Standard 1 should be replaced with: “Examiners should request a listing of all marketing materials and select a sample according to the jurisdiction’s sampling protocols.”

Ms. Plitt made a motion, seconded by Ms. Lawson, that in Marketing and Sales Standard 1, in the next to last bullet point in the “Materials should …” review procedures and criteria section, the bullet should be changed from “… indicate that the travel protection plan being marketed includes insurance” to “… indicate that the travel protection plan being marketed is insurance.” A voice vote was held, and a majority of the Working Group agreed to the change. Ms. Morton and Ms. Vandevoorde opposed this change.

Mr. Hamblen made a motion, seconded by Mr. Pyle, to adopt the new travel insurance-related examination standards draft, including all revisions made during the conference call, for inclusion in the Handbook (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Three). The motion passed unanimously.

Director Ramge said NAIC staff will provide advance email notice of the Working Group’s next conference call, which is scheduled for Nov. 20.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.
Market Conduct Examination Standards (D) Working Group
Conference Call
August 29, 2019

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Aug. 29, 2019. The following Working Group members participated: Bruce R. Ramge, Chair (NE); Russell Hamblen, Vice Chair (KY); Melissa Grisham and Mel Heaps (AR); Sarah Borunda and Maria Ailor (AZ); Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Frank Pyle (DE); Sarah Crittenden (GA); Lindsay Bates (IA); Mary Lou Moran (MA); Jill Huisken (MI); Win Nickens (MO); Paul Hanson (MN); Edwin Pugsley and Maureen Belanger (NH); Ralph Boekeeman (NJ); Bogdanka Kurahovic and Otis Phillips (NM); Peggy Willard-Ross (NV); Sylvia Lawson (NY); Rodney Beetch and Angela Dingus (OH); Kevin Foor, Landon Hubbard, Joel Sander and Shelly Scott (OK); Scott Martin (OR); Christopher Monahan (PA); Joy Morton, Rebecca Nichols and Yolanda Tennyson (VA); Christina Rouleau (VT); Jeanette Plitt (WA); Barbara Belling, Darcy Paskey, Diane Dambach and Rebecca Rebholz (WI); and Desiree Mauller (WV).


Director Ramge said Ms. Nichols and Ms. Morton developed draft travel insurance-related examination standards and a high-level summary of the draft standards for the Working Group’s review and discussion, based on the Travel Insurance Model Act (#632) and to be incorporated into the Market Regulation Handbook (Handbook). He said the draft examination standards were exposed May 22 for a public comment period ending June 24, and the comment period was subsequently extended to July 10 and then to Aug. 15.

Ms. Morton said a revised draft was circulated Aug. 26 for the conference call, and the draft included revisions she and Ms. Nichols made in response to comments received in July from John P. Fielding (Steptoe & Johnson LLP) on behalf of the U.S. Travel Insurance Association (UStiA) and Angela Gleason (American Property Casualty Insurance Association—APCIA).

Ms. Morton presented the redlined changes made to the draft. Ms. Plitt suggested that in Marketing and Sales Exam Standard 1 in the sentence “Indicate that the travel protection plan being marketed is insurance,” that “is” be changed to “can include.” Ms. Gleason and Mr. Fielding said they would both be submitting additional comments on the draft.

Director Ramge extended the comment due date to Oct. 2, and Ms. Gleason and Mr. Fielding said they would both be submitting additional comments on the draft by that date. Director Ramge asked for comments by Oct. 2, so Ms. Nichols and Ms. Morton can review any comments received and provide a revised draft for discussion during the next Working Group conference call, which is scheduled for Oct. 9. Director Ramge said NAIC staff will provide advance email notice of the conference call.


Director Ramge said the new workers’ compensation in force standardized data request (SDR) was circulated July 15. It was discussed during the Working Group’s July 18 conference call and exposed for a public comment period ending Aug. 15. He said it was developed by state insurance regulator subject-matter experts (SMEs) for the Working Group’s review, discussion and consideration of adoption.

Mr. Hamblen made a motion, seconded by Ms. Nichols, to adopt the new workers’ compensation standardized data request (see NAIC Proceedings – Market Regulation and Consumer Affairs (D) Committee, Attachment Two). The motion passed unanimously.

3. Discussed Other Matters

Director Ramge welcomed Oregon’s new representatives, TK Keen and Mr. Martin, to the Working Group.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.

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The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Nov. 20, 2019. The following Working Group members participated: John Haworth, Chair (WA); Melissa Grisham (AR); Lindsay Bates (IA); Holly Williams-Lambert (IN); Mary Lou Moran (MA); Jason Decker (MD); Chlora Lindley-Myers and Cynthia Amann (MO); Tracy Biehn (NC); Reva Vandevoorde (NE); Edwin Pugsley (NH); Angela Dingus (OH); Brian Fordham (OR); Christopher Monahan (PA); Rachel Moore (SC); Julie Fairbanks (VA); Christina Rouleau (VT); and Theresa Miller (WV). Also participating were Pam O’Connell (CA); Sarah Crittenden (GA); and Russell Hamblen (KY).

1. Discussed Suggestions of the Certification Pilot Volunteers

Mr. Haworth said the pilot of the Voluntary Market Regulation Certification Program took place during 2017 and 2018 and included 18 states. He noted there have been previous attempts to develop an accreditation program for market regulation that, for a variety of reasons, never got off the ground. He said because the insurance industry is growing and changes are happening faster with the advent of new tools leveraging big data, there is an obvious benefit to a certification program so the states can rely on the market regulation efforts of other states.

Mr. Haworth said the certification program is written broadly and maintains flexibility for each state’s specific needs. Each state has its own authorities for the protection of its consumers. He said the certification program recognizes that domestic deference does not work well for market conduct regulation. Additionally, he said the market certification program is designed to be independent of financial accreditation.

Mr. Haworth said that based on their experiences with attempting to comply with the requirements of the program, the volunteer states revised the certification program. He said the most obvious change is the reorganization of the program document to combine the requirements, guidelines and checklists by requirement such that for each requirement, the guidelines and checklists are immediately below the description of the requirement.

Mr. Haworth said the certification program is divided into 12 requirements that fall into five general categories: 1) the statutory authority for the department to conduct market regulation; 2) use of the Market Regulation Handbook; 3) staffing; 4) timely, accurate and complete use of shared market information systems; and 5) collaboration.

Mr. Haworth provided an overview of the suggested revisions to the 12 requirements, guidelines and checklists.

Ms. O’Connell asked if there would be time allowed for state insurance regulators and interested parties to review and comment. Mr. Haworth asked that comments be sent to Randy Helder (NAIC) by Dec. 18.

Ms. Crittenden asked whether the comments should be in the form of redlines to the current certification program document or simply reference the document. Mr. Haworth asked that comments not be made as redline in order to maintain version control.

Mr. Hamblen asked if the goal is to turn the program into a mandatory program or keep it voluntary. Mr. Haworth said there is no intent to make the program mandatory. He noted that the financial accreditation program is also voluntary, but the states recognize the value of being accredited.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.
The Privacy Protections (D) Working Group met in Austin, TX, Dec. 8, 2019. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (OK); Theodore J. Patton (MN); Kendall Cotton (MT); Bob Harkins (NE); and Don Beatty (VA). Also participating were Ryan James and Suzanne Tipton (AR); Peg Brown (CO); Angela Dingus (OH); Brian Fordham (OR); Travis Jordan (SD); and Tracy Klausmeier (UT).

1. **Heard Opening Remarks**

Ms. Amann said this is the first meeting of the Working Group, as it was appointed by the Market Regulation and Consumer Affairs (D) Committee during its Oct. 1 conference call. She said the Working Group is in the process of building its membership, as well as forming distribution lists for interested regulators and interested parties. Ms. Amann asked those interested in joining the Working Group or being added to a distribution list to contact Lois Alexander (NAIC).

2. **Heard a Presentation from NAIC Staff on Model #670, Model #672, GDPR, CCPA and State Data Privacy Legislation Chart**

Ms. Amann said Jennifer McAdam (NAIC) would be providing an overview of the Insurance Information and Privacy Protection Model Act (#670), the Privacy of Consumer Financial and Health Information Regulation (#672), the European Union’s (EU) General Data Protection Regulation (GDPR), the California Consumer Privacy Act (CCPA) and the research chart of State Data Privacy Legislation prepared by NAIC Legal Division staff.

Ms. McAdam said she would be discussing what is currently happening at the state level with data privacy laws, but she would like to first give a quick overview of the NAIC model laws already in existence that address consumer privacy. She clarified that data privacy is related to how data is collected and used by businesses; data security is related to how data is stored and protected.

Ms. McAdam said she brought this up because the two are often conflated and—to make things more confusing—there are some laws that address both, like the GDPR, for example. She said an example of a data privacy law would be the CCPA. Ms. McAdam said this law governs how businesses collect and use consumer data; the rights consumers have so they know how that data is being used; the consumer’s right to challenge the accuracy of the data; and, if it is being used, how it is being used. As such, these laws are focused on consumer protection and consumer rights.

She said an example of a data security law would be the Insurance Data Security Model Law (#668), which governs how businesses protect the data once it has been collected and what the businesses need to do in the event the company’s protections of that data fail during a data breach or cybersecurity event. Ms. McAdam said these laws are focused on business obligations, although such data security laws can have an impact on consumer protection, as well.

Ms. McAdam said the NAIC has three model laws governing data privacy: 1) The Health Information Privacy Model Act (#55); 2) Model #670; and 3) Model #672. She said because historical context is helpful, the first of these was Model #670, which was adopted in 1980. However, Ms. McAdam said the federal Fair Credit Reporting Act (FCRA) was enacted in 1970, and it addresses the fairness, accuracy and privacy of the personal information contained in the files of the consumer reporting agencies. Then, she said the Federal Privacy Act was enacted in 1974, and it governs the collection, maintenance, use and dissemination of personally identifiable information about individuals that is maintained in systems of records by federal agencies. So, Ms. McAdam said the NAIC began drafting Model #670 after the two federal laws were in already in place.

Ms. McAdam said Model #670 sets standards for the collection, use and disclosure of information gathered in connection with insurance transactions; it addresses how information is collected by insurance institutions, agents and insurance support organizations (ISOs). She also said the model balances the need for information by those conducting the business of insurance and the public’s need for fairness. Ms. McAdam said it establishes a regulatory mechanism to enable consumers to ascertain
what information is being, or has been, collected about them and to have access to such information so they can verify or dispute its accuracy. She said it limits the disclosure of information collected in connection with insurance transactions, and it enables insurance applicants and policyholders to find out the reasons for any adverse underwriting decision. Ms. McAdam said the model does this by requiring insurers to provide notice that alerts the individual of the insurer’s information practices and it gives consumers the right to request that an insurer: 1) give access to recorded personal information; 2) disclose the identity of the third parties to whom the insurance disclosed the information; 3) provide the source of the collected information; 4) correct and amend the collected information; 5) amend the personal information; and 6) delete the collected personal information.

Ms. McAdam said the definition of “personal information” is different from that of the protected information found in most of the data security or data breach notification laws. She said those laws tend to specifically enumerate the categories of data that must be protected. Ms. McAdam said in this model “personal information” means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual’s character, habits, avocations, finances, occupation, general reputation, credit, health or any other personal characteristics.

In 1998, following enactment of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), the NAIC adopted Model #55, which sets standards to protect health information from unauthorized collection, use and disclosure by requiring carriers to establish procedures for the treatment of all health information. Ms. McAdam said Model #55 requires carriers to: 1) create policies, standards and procedures governing health information; 2) notify consumers of those policies, standards and procedures; 3) establish consumers’ right to access their personal health information (PHI); 4) establish consumers’ right to amend their PHI; 5) provide a list of disclosures of PHI; and 6) obtain authorization for the collection, use or disclosure of PHI (with exceptions).

Following enactment of HIPAA at the federal level, Ms. McAdam said the federal Gramm-Leach-Bliley Act (GLBA) was enacted in 1999. She said GLBA imposes privacy and security standards on financial institutions and directs state insurance commissioners to adopt certain data privacy and data security regulations. She said that is when the NAIC adopted both Model #672 and the Standards for Safeguarding Customer Information Model Regulation (#673). Ms. McAdam said Model #672 is about consumer privacy, and Model #673 is about data security and was used as the basis for drafting Model #668.

Ms. McAdam said this Working Group will be addressing data privacy; it will not be addressing data security. She also said Model #672: 1) requires that insurers provide notice to consumers about its privacy policies and practices; 2) describes the conditions under which a licensee may disclose nonpublic PHI and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and 3) provides methods for individuals to prevent a licensee from disclosing that information (“opt out” for financial info and “opt in” for health information). Ms. McAdam said this model is intended to be enforced via the state’s Unfair Trade Practices Act. She said the provisions governing protection of health information were taken directly from Model #55, as well as the health information privacy regulations promulgated by the U.S. Department of Health and Human Services (HHS) pursuant to HIPAA. Ms. McAdam said the provisions governing the protection of financial information are based on privacy regulations promulgated by federal banking agencies.

Ms. McAdam said the key difference between the treatment of financial information and health information is that insurers must give consumers the right to “opt out” of the disclosure or sharing of their financial information, but insurers must get explicit authorization prior to sharing health information (which is considered “opt in”).

Ms. McAdam said the protected information under Model #672 is “health information” and “personally identifiable financial information.” She said 17 states have adopted Model #670 and every state has adopted a version of Model #672, although 19 states have only adopted the provision regarding financial information and not the provision regarding health information. Ms. McAdam said NAIC guidance on data privacy includes the privacy standard used in market conduct examinations. She said standards 10 through 16 address how companies are to handle data privacy pursuant to Model #670, Model #672, Model #55 and any other data privacy laws to which companies are subject.

Ms. McAdam said there are generally applicable data privacy laws that apply to all businesses; not just to the insurance sector. She said data privacy started getting more attention when the GDPR became effective in May 2018. Ms. McAdam said although it is an EU law, it affects many U.S. companies if they collect data from citizens of the EU over the internet. She said the GDPR
requires companies to obtain explicit consent from consumers to collect their data (“opt in”) with an explanation of how the data will be used and it contains standards for safeguarding the data.

Ms. McAdam said California became the first U.S. state to adopt an “omnibus” privacy law, which imposes broad obligations on businesses to provide consumers with transparency and control of their personal data. She said the CCPA was signed into law last summer, was amended last fall and becomes effective in 2020. Ms. McAdam said the CCPA gives consumers the right to request that a business:

- Disclose (a) the categories and specific pieces of personal information collected; (b) categories of sources the information was collected from; (c) the business purpose for collecting the information; and (d) the categories of third parties with whom the information is shared, and the specific pieces of personal information that was shared.
- Delete any personal information.
- Provide the right to opt-out of their information being disclosed to third parties, with separate opt-in requirements for minors.
- Provide the right to not be discriminated against for exercising rights.

Ms. McAdam said the CCPA is enforced by the state attorney general and there is a full exemption for protected health information governed by HIPAA and a partial exemption for information subject to the GLBA; if the information subject to GLBA is breached, the consumer can pursue a private civil action against the company.

Ms. McAdam said some states introduced similar data privacy laws to the CCPA that were generally applicable. She said amendments to the CCPA were introduced during the 2019 legislative session, but none of them specifically affect insurers; the full HIPAA exemption and partial GLBA exemption remain in place.

Ms. McAdam said, in 2019, 24 states had considered some type of data privacy legislation but only three states enacted laws: 1) Illinois, which bans insurers from using genetic testing information to set health or accident rates; 2) Maine, which bans internet providers from selling personal information without consent; and 3) Nevada, which requires businesses to allow consumers to opt out of any sale of their personal information and has exemptions for entities subject to the GLBA and HIPAA.

Ms. McAdam said five states passed bills establishing task forces to study the issue of data privacy by reviewing laws in other states and making recommendations for what would be appropriate privacy standards: Connecticut; Hawaii; Louisiana; North Dakota; and Texas. She said there are some states with legislation still pending and some that will carryover to 2020. For example, in New York, there was a bill pending that would go further than the CCPA and would establish a fiduciary duty for companies to act in the consumer’s best interest regarding their personal information; however, it did not make it out of committee but will be considered in 2020.

Ms. McAdam said a comparison of business obligations and consumer rights related to data privacy under both the CCPA and Model #670 shows the following similarities in those requirements.

<table>
<thead>
<tr>
<th>CCPA</th>
<th>Model #670</th>
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<tbody>
<tr>
<td>Consumer right to request that a business:</td>
<td>Individual right to request that an insurer:</td>
</tr>
<tr>
<td>Disclose the categories and specific pieces of personal information collected</td>
<td>Disclose types of personal information collected</td>
</tr>
<tr>
<td>Disclose categories of sources</td>
<td>Disclose sources of the collected information</td>
</tr>
<tr>
<td>Disclose business purpose for collecting the information</td>
<td>Disclose purpose for collecting the information</td>
</tr>
<tr>
<td>Disclose categories of third parties with whom the information is shared, and specific pieces of personal information shared</td>
<td>Disclose identity of the third parties to whom information is disclosed</td>
</tr>
<tr>
<td>Right to access, correct, delete</td>
<td>Right to access, correct, delete</td>
</tr>
</tbody>
</table>

Ms. McAdam said NAIC Legal Division staff created several legal research charts that were posted to the Privacy Protections (D) Working Group page on the NAIC website. She said one chart lists general state data privacy laws that are applicable to all businesses and are not specific to insurers. She also said the chart lists the entity responsible for enforcing the law; what exemptions there are, if any; whether it is “opt-in” or “opt-out”; and what consumer notice requirements are required.
Ms. McAdam said the Working Group will want to address insurance-specific data privacy issues while making sure that any new requirements work with already-existing laws. She said it will be important to consider the following questions going forward: 1) what types of data collection, sharing and usage are specific to insurers; 2) what privacy risks affect insurance consumers; 3) where the gaps are in federal and state law; 4) what obligations insurers should have to consumers; and 5) what rights consumers should have to control their personal information.

Ms. Amann said Ms. McAdam will continue to provide any legal assistance the Working Group needs throughout the process. She then asked if any Working Group members had any comments.

Mr. Cotton said he is concerned about the consumer data that insurers already are presenting to Montana in rate filings. He said rate filings have ballooned up to thousands of pages of different data points on consumers. Mr. Cotton said Montana has seen an increased reliance on third-party risk scores that aggregate consumer information in order to make determinations and conclusions about that information. He said insurers have a responsibility to make sure that the third parties used are following state laws and complying with the state’s standards for accuracy and fairness. Besides providing disclosure of those third parties when consumers request it, Mr. Cotton said insurers are required to report how the information was gathered; where it was drawn from (e.g., web traffic, geolocation data, social media, etc.); and why the company thinks it needs to use these particular data points as the possibilities available to insurers are endless.


Ms. Amann said the Working Group will need to stay on track in order to accomplish its charges by the deadline. She said the Working Group’s proposed charges will be considered for adoption by the Market Regulation and Consumer Affairs (D) Committee during its Dec. 9 meeting.

Ms. Amann said this Working Group will work closely with the other working groups in this arena—the Artificial Intelligence (EX) Working Group, the Accelerated Underwriting (A) Working Group, etc.—as each has its unique set of issues that nevertheless require coordination.

4. Heard Comments from Interested Parties

   a. NAMIC

Cate Paolino (National Association of Mutual Insurance Companies—NAMIC) urged regulators to consider the impact of California’s law and the likely passage in 2020 of other state laws that may differ dramatically from it. Ms. Paolino asked that regulators analyze and identify any gaps that might need insurance-specific language. She said regulators could then determine the most appropriate vehicle to deliver that solution; i.e., whether to amend existing models or to draft new models.

Ms. Paolino urged policymakers to consider several important concepts:

   - Workability – Allowing for various exemptions for operational and other reasons that acknowledge vital business purposes for insurers to collect, use, and disclose information. For example, she said Article IV of Model #672 was developed to implement the GLBA; it appears instructive on types of operational functions to preserve and facilitate. Ms. Paolino said it may also be useful to review the exceptions imbedded into Section 13 of the 1982 version of Model #672. She said clear and well-crafted provisions accounting for the GLBA and the FCRA would be important in any broader business legislation regulators may see.
   - Exclusivity – Avoiding dual regulation so insurers are not simultaneously subject to potentially inconsistent or conflicting interpretations by more than one regulator.
   - Clarity – Asking that care be taken to consider how best to dovetail with existing model laws/regulations; consulting other resources and educating legislators on how privacy bill language impacts the insurance industry, including the legal requirements to retain and use certain data, as well as data mandates.
   - Effective Date – Allowing advance time (like the two to five years that was afforded under the GDPR) for insurers to be ready for implementation, to avoid having revisions like the CCPA and the GDPR. She also suggested that a roll-out period with different dates for different provisions would be a more measured approach within that time frame to undertake such a significant endeavor.
b. APCIA

Angela Gleason (American Property Casualty Insurance Association—APCIA) agreed with NAMIC’s assessment with regard to the implementation time frame, the initial survey request and the complex array of laws that state legislatures may pass during the December to January time frame that could put insurers in the position of complying with omnibus privacy bills in one state and industry-specific bills in another state. She said it could bring about some difficult compliance issues, which could reduce, rather than enhance, existing consumer protections and generate significant operational challenges. She said state insurance departments could play an important role in these legislative conversations based on their experience with insurance-specific privacy laws that are consistent with regulators’ objectives to protect consumers and ensure insurer solvency.

Ms. Gleason said insurers are scrambling to be ready for the effective date of the CCPA that takes effect Jan. 1, 2020 and gives consumers more ability to control what information is shared about them.

c. ACLI

Kate Kiernan (American Council of Life Insurers—ACLI) said the regulatory environment is evolving. She said existing privacy laws have been on the books since the mid-1980s and late 1990s with little change, which reflects well on the stability of the insurance regulatory structure. However, she said that advances in technology and changes in the insurance industry have resulted in rendering some of the existing financial services privacy laws as being somewhat outdated.

Ms. Kiernan asked the Working Group to think about how ride- and home-sharing services, such as Uber and Airbnb, have disrupted the livery and hospitality industries. She asked the Working Group to look at the big picture to ensure that the insurance industry does not encounter a complete change of its industry like that which happened in the hospitality and livery industry.

Ms. Kiernan said even though policyholders might welcome stiffer regulation initially, stiffer regulation could unintentionally harm the companies that serve those consumers. She said caution is warranted when considering additional regulation to ensure a level playing field with how all other companies are collecting personal information, so insurance companies are not disadvantaged when compared to the technology sector.

Ms. Kiernan said consistency across states and business types is necessary so insurers will not be required to meet industry-specific privacy rules, while companies like Amazon, Google and the Insure Techs have different rules to meet.

Ms. Kiernan asked the Working Group to consider the following questions:

- How do you envision the current financial services privacy regulatory system meshing with new comprehensive laws such as the CCPA?
- How will financial services companies be able to compete with technology companies with differing rules on the use of personal information?
- How can we provide control and equal protections to all consumers regarding their personal information no matter where they live or with whom they are doing business? In other words, provide consumers with legal transparency and the same level enforceable rights?
- How can we develop a regime that is robust and supports growth and innovation?

Ms. Kiernan said to put these questions another way:

- How do we avoid consumer confusion over this already complex issue?
- How do we avoid the obstruction of the flow of data and impediments to interstate commerce?
- How do we prevent the distortion of competition (tech versus retail versus financial services)?

In conclusion, Ms. Kiernan said technology is transforming both social norms and business capabilities. The internet is universal, and information is global. Consumers and businesses need standards that are coherent, and that provide a common understanding of privacy protections. Ms. Kiernan said policymakers should avoid creation of a system that would provide differing consumer rights; differing levels of protections; fragmented implementation of consumer protections; and legal uncertainty.
Ms. Kiernan said this complex issue warrants a comprehensive review and she looks forward to working with the Working Group as it moves forward. Ms. Kiernan said she would like to align her comments with the recently submitted observations of NAMIC and the APCIA because she agrees with the thoughtful comments regarding specific issues and challenges that her sister national trade associations raised in their remarks.

d. **CEJ**

Birny Birnbaum (Center for Economic Justice—CEJ) said Model #670 addresses “personal information,” while Model #672 addresses “nonpublic personal financial information and nonpublic personal health information.” He said both models discuss “consumer reports” and “consumer reporting agencies,” as defined by the FCRA.

Mr. Birnbaum asked the Working Group to consider:

- Data vendors are scraping personal consumer information from public sources to produce consumer profiles, scores and other tools for insurers. The data vendor products, while assembled from public information, raise concerns over consumers’ digital rights and privacy.
- Many data vendors and many types of personal consumer information are not subject to FCRA consumer protections. In turn, many of the types of data and algorithms (essentially, a consumer report) used by insurers are not subject to either FCRA consumer protections or the NAIC model law/regulation protections.
- It is unclear if the NAIC models cover the new types of data being generated by consumers as part of, or related to, insurance transactions. For example, consumers are producing large volumes of data through telematics programs—from devices collecting personal consumer data in the vehicle or home or wearable devices.
- There are a lot of organizations working on consumer digital rights. He asked the Working Group to solicit input and presentations at Working Group meetings from, among others, the Center for Digital Democracy, the Electronic Privacy Information Center, the Electronic Frontier Foundation, the Public Knowledge-Privacy Rights Clearinghouse, the Public Citizen, the U.S. Public Interest Research Group and the World Privacy Forum. In addition, Mr. Birnbaum said there are several organizations active on digital rights in the EU that are familiar with the GDPR and whose perspectives would help the Working Group.
- He asked that if consumer disclosures are to be used, that the disclosure should be a compliance or enforcement tool that would be created using consumer focus testing and established best practices for the creation of such consumer disclosures.

Having no further business, the Privacy Protections (D) Working group adjourned.
The Antifraud (D) Task Force met in Austin, TX, Dec. 8, 2019. The following Task Force members participated: John G. Franchini, Chair, and Roberta Baca (NM); Trinidad Navarro, Vice Chair (DE); Lori K. Wing-Heier represented by Anna Latham (AK); Allen W. Kerr represented by Suzanne Tipton (AR); Keith Schraad represented by Scott Greenberg (AZ); Ricardo Lara represented by George Mueller (CA); Michael Conway represented by Damion Hughes (CO); Andrew N. Mais represented by Kurt Swan (CT); Stephen C. Taylor represented by Sharon Shipp (DC); John F. King represented by Margaret Witten (GA); Dean L. Cameron represented by Randy Pipal (ID); Vicki Schmidt represented by LeAnn Crow (KS); James J. Donelon represented by Matthew Stewart (LA); Anita G. Fox represented by Randall Gregg (MI); Steve Kelley represented by Michael Marben (MN); Chlora Lindley-Myers represented by Carrie Couch and Marjorie Thompson (MO); Mike Chaney represented by John Hornback (MS); Matthew Rosendale represented by Jeannie Keller (MT); Mike Causey and Tracy Biehn (NC); Jon Godfread represented by Johnny Palsgraaf (ND); Bruce R. Ramge represented by Peg Jasa (NE); Marlene Caride represented by Richard Besser (NJ); Barbara D Richardson represented by Stephanie McGee (NV); Jillian Froment represented by Angela Dingus and Jennifer Demory (OH); Glen Mulready represented by Rick Wagnon (OK); Andrew Stolfi represented by TK Keen (OR); Kent Sullivan represented by Leah Gillum and Chris Davis (TX); Todd E. Kiser represented by Armand Glick (UT); Scott A. White represented by Mike Beavers (VA); Mike Kreidler represented by John Haworth (WA); James A. Dodrill represented by Erin K. Hunter and Greg Elam (WV); and Jeff Rude represented by Bill Cole (WY). Also participating was: David Altmaier represented by Simon Blank (FL).

1. **Adopted its Oct. 31 and Summer National Meeting Minutes**

During its Oct. 31 meeting, the Task Force adopted its 2020 proposed charges. Mr. Marben made a motion, seconded by Mr. Beavers, to adopt the Task Force’s Oct. 31 (Attachment One) and Aug. 4 (see NAIC Proceedings – Summer 2019, Antifraud (D) Task Force) minutes. The motion passed unanimously.

2. **Discussed its 2020 Proposed Charges**

Superintendent Franchini said the Task Force adopted its 2020 proposed charges via an e-vote that concluded Nov. 4. He said the adopted charges had few changes, including the necessary changes to appropriately update the charges to reflect 2020 deadlines.

Superintendent Franchini said there were only two significant changes. The first was to remove the charge to coordinate with NAIC committees, task forces and working groups and provide a recommendation for the development of a database to be created and maintained by the Securities Valuation Office (SVO) specific to tracking the fraudulent financial reporting for chief executive officers (CEO), directors, and corporate officers. He said the charge was completed at the Spring National Meeting; therefore, the Task Force would not need to keep this on its list of charges. He said the second was to add a new charge to review and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.

Superintendent Franchini said the proposed charges would be presented and considered for adoption by the Market Regulation and Consumer Affairs (D) Committee during its Dec. 9 meeting. He said as the Task Force moves through 2020, he encourages Task Force members to bring other areas or potential goals that would assist with the fight against fraud.

3. **Received an Update from the Antifraud Education Enhancement (D) Working Group**

Greg Welker (NAIC) said the Antifraud Education Enhancement (D) Working Group has not met since the Summer National Meeting; however, it held an Investigator Safety Training Webinar on Oct. 30. He said the webinar had 315 participants, and it received a score of 4.6 out of 5 on its review. He said in 2020, the Working Group will be hosting a webinar on investigator safety training for state insurance department employees, and it will be reaching out to the fraud directors for assistance with presenting. He said the Working Group will also be working to arrange a course on open source investigation course for state investigators. He said the Working Group has encouraged the Task Force to send any potential topics for training at any time throughout the year.
4. Received an Update from the Antifraud Technology (D) Working Group

Mr. Glick said the Antifraud Technology (D) Working Group has not met since the Summer National Meeting; however, it has met with the Antifraud Education Enhancement (D) Working Group and NAIC staff concerning the state requirements for individual antifraud plans. He said, after further investigation, the Working Group was able to confirm requirements for all the states/jurisdiction concerning whether an antifraud plan is required. He said in addition to this investigation, it determined that a review of the NAIC Antifraud Plan Guideline was overdue. He said on Nov. 25, the Working Group distributed an email soliciting comments, and it suggested changes to the NAIC Antifraud Plan Guideline with a deadline of Dec. 31.

5. Discussed the Fraudulent Treatment of Consumers

Superintendent Franchini said the next item on the agenda is a topic that was brought to the Task Force’s attention concerning a BuzzFeed article dated Aug. 15, advising that insurance companies are paying law enforcement officers to investigate their customers. He said the article claims that an alliance between insurers and law enforcement has turned the justice system into the industry’s hired gun and left innocent customers facing prison. He said due to the activity that this article created, it was brought to the Task Force for further discussion. The Task Force discussed the article and posed the question of whether any state has encountered this type of fraud.

Mr. Blank said Florida has encountered some of these types of activities, and it has even prosecuted some law enforcement officials after concluding its investigation.

Superintendent Franchini said there have been some states that have reviewed and provided further information regarding this topic. He said he would work with the Commissioner Navarro and NAIC staff to reach out to those states and provide its findings at the 2020 Spring National Meeting.

6. Heard a Presentation from the HFPP

Superintendent Franchini said next on the agenda is to hear a presentation from the Healthcare Fraud Prevention Partnership (HFPP). He said presenting to the Task Force will be Matthew Smith, director of government affairs and general counsel with the Coalition Against Insurance Fraud (Coalition); Sparky Heevner, partner engagement lead and recruiter with HFPP; and Dan Kreitman, director of the HFPP.

Mr. Kreitman said the HFPP is a volunteer public-private partnership between federal government state agencies and private partners, law enforcement and antifraud associations. He said the HFPP helps the fight against fraud through a proactive approach using data and information sharing. He said the HFPP assists with this by an exchange of data between public and private sections, leveraging various analytic tools against statistics provided by its partners, and providing a forum for public leaders and members to speak out against insurance fraud. He said the overall goal of the HFPP is to promote training and information-sharing.

7. Heard an Update from the Coalition

Mr. Smith said, in 2019, the Coalition assisted with 198 bills that were introduced across the nation. He said from those bills introduced, there is now a total of 61 new antifraud bills in place to assist with the fight against insurance fraud. He said some of the highlights of those bills are two that were signed by New York concerning a bill called “Alice’s Law,” which is focused on staged auto accidents. In addition, New York signed an important storm chaser bill to protect consumers. Mr. Smith said Ohio has a similar bill pending. Florida has a number of bills pending, including an important auto glass bill.

Mr. Smith said the Coalition recently released an antifraud tool kit, which includes, videos, advertisements, graphics and press information available to all the states at no charge. He said the Coalition is gearing up to adopt its 2020 list of legislative priorities and encourage the states to reach out to the Coalition if there is a specific area that they can provide assistance. He said antifraud funding will remain a high priority on the legislative list for the Coalition as it moves into 2020. He said towing fraud also remains to be a big issue across the states, and the Coalition will continue to focus legislative issues on this type of fraud as well. He said in 2019, the Coalition reviewed and adopted a renewed version of their Insurance Fraud Act. He said the Coalition will be working this year to implement this within the states to assist with fighting insurance fraud.
Mr. Smith said in October of this year, he, along with Superintendent Franchini, attended the first ever International Insurance Fraud Summit, which took place in Spain. He said this summit was a gathering of 16 different nations to discuss in an open line of communication to discuss the issues being faced with insurance fraud. He said the summit will take place again in 2020, and the Coalition plans to be a leader.

Mr. Smith said the Coalition will also be participating with the French National Antifraud Group at a symposium taking place in Paris in February 2020 and the International Association of Special Investigator Units European conference taking place in Sweden sometime in June 2020. He said the Coalition will hold its annual year-end meeting Dec. 16–17 in Washington, DC.

Having no further business, the Antifraud (D) Task Force adjourned.
Antifraud (D) Task Force
Conference Call
October 31, 2019

The Antifraud (D) Task Force met via conference call Oct. 31, 2019. The following Task Force members participated:
John G. Franchini, Chair, represented by Roberta Baca (NM); Trinidad Navarro, Vice Chair (DE); Ricardo Lara represented by George Mueller (CA); Michael Conway represented by Damion Hughes (CO); Stephen C. Taylor represented by Phil Comstock (DC); David Altmaier represented by Matt Guy (FL); Nancy G. Atkins represented by Willie Skeens (KY); James J. Donelon represented by Trent Beach (LA); Steve Kelley represented by Michael Marben (MN); Chlora Lindley-Myers represented by Carrie Couch (MO); Matthew Rosendale represented by Jeannie Keller (MT); Mike Causey represented by Lisa Volpe (NC); Marlene Caride represented by Richard Besser (NJ); Barbara D. Richardson (NV); Andrew Stolfi represented by Stephanie Noren (OR); and Scott A. White represented by Mike Beavers (VA).

1. Discussed its 2020 Proposed Charges

 Commissioner Navarro said the purpose of this conference call is to review and consider adoption of the Task Force’s 2020 proposed charges. He said because there is no quorum, the Task Force would review the charges and discuss any comments. Then an e-vote request would be distributed to consider adoption of the proposed charges.

 Commissioner Navarro said that during the Summer National Meeting, the Task Force opened the 2019 charges to review and accept comments for its 2020 proposed charges. He said NAIC staff distributed the draft 2020 proposed charges, reflecting some minor changes regarding specific deadlines for next year. He said there were also two significant changes made to the 2019 charges.

 Commissioner Navarro said the first change was to remove the charge that states, “Coordinate with NAIC committees, task forces and working groups (e.g., Financial Condition (E) Committee, etc.) and provide recommendations for the development of a database to be created and maintained by the NAIC Securities Valuation Office (SVO) specific to tracking the fraudulent financial reporting for chief executive officers (CEO), directors, and corporate officers.” He said this charge was discussed and completed at the Spring National Meeting, so there would no longer be a need to have this listed as part of the Task Force’s charges moving forward.

 Commissioner Navarro said the second and only other change was to add a new charge under the Antifraud Technology (D) Working Group that states the Working Group will, “Review and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.”

 Mr. Mueller made a motion, seconded by Mr. Marben to adopt the Task Force’s 2020 proposed charges. Commissioner Navarro said with no quorum, NAIC staff will distribute an email with the proposed charges for an e-vote to finalize this process (Attachment One-A).

 Having no further business, the Antifraud (D) Task Force adjourned.
Antifraud (D) Task Force
E-Vote
November 4, 2019

The Antifraud (D) Task Force conducted an e-vote that concluded Nov. 4, 2019. The following Task Force members participated: John G. Franchini, Chair, represented by Roberta Baca (NM); Trinidad Navarro, Vice Chair, represented by Frank Pyle (DE); Allen W. Kerr (AR); Ricardo Lara represented by George Mueller (CA); Andrew N. Mais represented by Kurt Swan (CT); David Altmaier represented by Simon Blank (FL); Doug Ommen represented by Jared Kirby (IA); Dean L. Cameron represented by Weston Trexler (ID); Vicki Schmidt represented by Dennis Jones (KS); Nancy G. Atkins represented by Willie Skeens (KY); James J. Donelon represented by Matthew Stewart (LA); Al Redmer Jr. represented by James Wright (MD); Steve Kelley represented by Michael Marben (MN); Chlorinda Myers represented by Carrie Couch (MO); Mike Chaney represented by John Hornback (MS); Bruce R. Ramge (NE); Jon Godfread represented by Dale Pittman (ND); Barbara D. Richardson represented by Ted Bader (NV); Jillian Froment represented by Michelle Brugh Rafeld (OH); Glen Mulready represented by Rick Wagnon (OK); Kent Sullivan represented by Chris Davis (TX); Todd E. Kiser represented by Armand Glick (UT); Scott A. White represented by Mike Beavers (VA); and Jeff Rude represented by Todd Schildmeier (WY).

1. **Adopted its 2020 Proposed Charges**

The Task Force conducted an e-vote to consider adoption of its 2020 proposed charges. Mr. Mueller made a motion, seconded by Mr. Marben, to adopt the Task Force’s 2020 proposed charges (see NAIC Proceedings – Fall 2019, Executive (EX) Committee and Plenary, Attachment Two). The motion passed unanimously.

Having no further business, the Antifraud (D) Task Force adjourned.
The Market Information Systems (D) Task Force met in Austin, TX, Dec. 7, 2019. The following Task Force members participated: Lori K. Wing-Heier, Chair (AK); Chlora Lindley-Myers, Vice Chair, and Cynthia Amann (MO); Keith Schraad represented by Maria Ailor (AZ); Michael Conway represented by Damion Hughes (CO); Stephen C. Taylor represented by Sharon Shipp (DC); Robert H. Muriel represented by CJ Metcalf (IL); James J. Donelon represented by Jeff Zewe (LA); Steve Kelley represented by Paul Hanson (MN); Mike Causey represented by Chad Bridges (MS); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Johnny Palsgraaf (ND); Bruce R. Ramge represented by Matt Holman (NE); Jillian Froment represented by Angela Dingus (OH); Andrew Stolfi represented by Brian Fordham (OR); Kent Sullivan represented by Rachel Cloyd and Ignatius Wheeler (TX); Michael S. Pieciak represented by Christina Rouleau (VT); Mike Kreidler represented by John Haworth (WA).

1. Adopted its Oct. 29 Minutes

The Task Force met Oct. 29 and took the following action: 1) adopted its Summer National Meetings; 2) adopted the report of the Market Information Systems Research and Development (D) Working Group; and 3) adopted its 2020 proposed charges.

Director Lindley-Myers made a motion, seconded by Mr. Haworth, to adopt the Task Force’s Oct. 29 minutes (Attachment One). The motion passed unanimously.


Mr. Haworth said the Market Information Systems Research and Development (D) Working Group met Nov. 19, Nov. 15 and Sept. 19. He said the meetings were held via conference call in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings.

Mr. Haworth said the Working Group reviewed and prioritized the outstanding Uniform System Enhancement Request (USER) forms. He said the Working Group considered the anticipated benefits and the estimated level of effort of each request. He said three requests were selected as high priority, with a goal of having them completed by the end of this year. Those requests are: 1) USER form 10063 to add to the Regulatory Information Retrieval System (RIRS) the ability to search in iSite+ by the Financial Industry Regulatory Authority (FINRA) unique identifier; 2) USER form 10072 to allow companies to file new Market Conduct Annual Statement (MCAS) submissions for prior years; and 3) USER form 10080 to display data retention policies and terminology related to action dates in RIRS.

Mr. Haworth said the Working Group also considered the detailed analysis results for two USER forms. USER form 10072 is a request to add the ability for companies to submit new prior year MCAS filings, and USER form 10080 is a request to update the RIRS in iSite+ to include the data retention policies and terminology related to action dates. He said the Working Group adopted motions to move both requests to application development.

Finally, Mr. Haworth said the Working Group completed its review of the MIS data analysis results and made recommendations for the metrics, the presentation of the results and methods to improve data quality.
Ms. Dingus made a motion, seconded by Mr. Fordham, to adopt the Working Group’s report. The motion passed unanimously.

3. **Adopted the MIS Data Analysis Metrics and Recommendations**

Mr. Haworth said the metrics are designed to evaluate three aspects of data quality for each market information system. Those three aspects are completeness, accuracy and timeliness, which are all critical for state insurance regulators to conduct proper analysis.

   a. **CDS**

   Mr. Haworth said there is no automated way to ensure that states have successfully submitted all of their closed complaints to the NAIC; however, it is possible to determine whether the submitted data successfully loaded to the NAIC database. He said the first Complaint Database System (CDS) completeness metric identifies errors that prevented complaint data from loading. He said there were more than 117,000 new errors created last year, which reflects complaint data that did not initially load to the database. He noted that staff in the state insurance departments can, and often do, correct the errors and resubmit the data. He said that as of Nov. 25, about 6,000 of those errors were still outstanding. He said all states have access to the State Data Load Error Viewer in iSite+, where they can monitor the status of their submitted data.

   Mr. Haworth said that to make trending results from year to year more meaningful, the Working Group recommends adding a percentage of errors to total complaints.

   Mr. Haworth said the results for the CDS timeliness metric continued to improve in 2018, with three more jurisdictions submitting complaints at least monthly. He said many states submit complaints daily.

   Mr. Haworth said the Working Group recommends adding a measure of the percentage of months with no files received to the total number of months.

   Mr. Haworth said the Working Group also recommends adding a new timeliness metric for the CDS. He said the first timeliness metric only considers the files received by each jurisdiction and not the timeliness of the data within the files. He said the Working Group recommends adding a second timeliness metric that identifies jurisdictions that did not submit a current complaint at least monthly. He said a current complaint would be defined as one that was closed and submitted within 45 days.

   Mr. Haworth said the accuracy metrics for complaints are designed to determine if the complaints are appropriately designated as confirmed and whether the complaint is associated with the correct entity and line of business. He said, as directed by the Task Force, NAIC staff generate these results and distribute them to the state Consumer Services Directors quarterly.

   Mr. Haworth said the first accuracy metric identifies complaints submitted with a confirmed indicator with a disposition code that may indicate it is not confirmed. He said the results of this metric continue to improve.

   Mr. Haworth said the second accuracy metric identifies complaints submitted for a line of business on companies that did not report premiums written for that line of business in their financial annual statement. He said this metric includes both state-level premium and national-level premium results. He noted that for most lines of business, the state-level premium results more accurately identify miscoded complaints. For the life insurance lines of business, however, the national-level premium results are more accurate because people may move from state to state. He said this metric reflects a small decrease in accuracy from last year but still looks good.

   b. **MATS**

   Mr. Haworth said there is no automated method to ensure all market actions are reported in MATS. He said the closest method identified was to compare MATS actions to those reported in the NAIC **Insurance Department Resources Report (IDRR)**. He said the first completeness metric compares the number of closed exams, and the entities associated with those exams, reported in MATS to those reported in the IDRR. He said the second completeness metric compares the number of entities included in all closed market actions, which include exams, focused inquiries and non-exam regulatory interventions. Mr. Haworth noted the IDRR reporting instructions have been updated to clarify what should be reported. However, he said there are still significant discrepancies.

   Mr. Haworth said the Working Group recommends investigation to determine the reasons for the differences.
Mr. Haworth said the third completeness metric identifies RIRS records with an origin code of “Market Conduct Exam” that do not have a corresponding record in MATS. He said the results are not trending well. He said there is not a clear understanding of how MATS and RIRS actions should be associated. He also said the Working Group members shared that they were using the RIRS action and effective dates differently.

Mr. Haworth said the Working Group recommends best practices regarding the use of MATS and RIRS be defined and communicated, and that the RIRS action and effective dates be defined and communicated.

Mr. Haworth said the Working Group recommends completing the RIRS/MATS hard card next year.

Mr. Haworth said the Working Group recommends adding the percentage of RIRS actions taken with no MATS entry to the total RIRS actions with a “Market Conduct Exam” origin code.

Mr. Haworth said there are several MATS timeliness metrics. He said all the results are as of July 9, 2019. He said the first MATS timeliness metric identifies open actions that contain inactive values. He said there are no longer any actions that meet this criterion and that the Working Group recommends eliminating this metric.

Mr. Haworth said the remaining MATS timeliness metrics identify actions that contain a particular status for more than a specified period of time. He said the results indicate there is room for improvement. He noted, however, there are valid reasons for an action to remain in a particular status for an extended period of time.

Mr. Haworth said the Working Group recommends defining and providing education and training on MATS best practices, including how to ensure statuses are kept current.

Mr. Haworth said the Working Group recommends adding filters to the MATS “No Change” Personalized Information Capture System (PICS) event. He said the PICS event would provide subscribers a monthly listing of market actions that have been in a status longer than the specified time threshold. He said, however, there is currently no way to limit this listing to only those actions your state is participating in.

c. **MARS**

Mr. Haworth said there are two completeness metrics in the Market Analysis Review System (MARS). He said the first completeness metric identifies the number of jurisdictions that did not complete the minimum 10 reviews in 2018. Those results were consistent with the previous year. He said the metric should have reflected the threshold set by the Market Analysis Procedures (D) Working Group, which is set at 15 reviews but was not adjusted for 2018.

Mr. Haworth said to prevent such an oversight in the future, the Working Group recommends modifying this metric to identify jurisdictions that did not complete the minimum number of reviews in the past year per the Market Analysis Procedures (D) Working Group’s minimum guidelines.

Mr. Haworth said the Working Group also recommends adding premium volume and the number of companies writing business for each jurisdiction.

Mr. Haworth said the second MARS completeness metric identifies Level 1 reviews with a disposition that indicates a Level 2 analysis was planned but not completed within nine months. He said there are many scenarios where this could reasonably happen, so the Working Group recommends eliminating this metric for now because the current MARS does not allow the original disposition to be updated. He said a requested feature of the MARS redesign project is to allow this functionality.

Mr. Haworth said the first MARS timeliness metric identifies reviews that were started but not completed and subsequently deleted by the system after 60 days. He said the Working Group also recommends eliminating this metric. He said the Working Group did not find the results of this metric meaningful because MARS sends several notifications prior to deleting reviews. He said the reviews were likely created in error and should be deleted.

Mr. Haworth said the second timeliness metric identifies reviews that did not use the most current financial data. He said there was an improvement in the percentage of these reviews, with more than 96% of the reviews created last year using the most current financial data.
d. **MCAS**

Mr. Haworth said there are three MCAS completeness metrics. He said the first completeness metric reflects the number of non-participating states. He said there was no change. He said the second completeness metric reflects the number of missing filings and is consistent with last year. The second metric is of 2018 data results as of Nov. 5, 2019 and may continue to change as additional filings are received.

Mr. Haworth said the third completeness metric for the MCAS identifies companies that were required to file, requested a waiver, and the jurisdiction did not respond to the request. He said this is a new metric, and the results are trending positively.

Mr. Haworth said the Working Group recommends adding the percentage of waiver requests approved and denied.

Mr. Haworth said the first MCAS timeliness metric reflects the number of filings submitted 45 or more days after the filing deadline. He said those results improved this year. He said the second timeliness metric identifies companies that were required to file, requested an extension, and the jurisdiction did not respond to the request. The results of the second timeliness metric also show improvement.

Mr. Haworth said the Working Group recommends adding the percentage of extension requests approved and denied.

Mr. Hanson asked if it is possible to create a metric to identify companies that use the same reason in their waiver or extension multiple years in a row. Mr. Haworth said NAIC staff are working on a Tableau report to provide that information.

Mr. Haworth said validations are run on MCAS filing data when it is processed at the NAIC. He said the first accuracy metric reviews review the percentage of validation errors on the original filings and the current percentage of errors. He noted errors are generally fixed with subsequent filings. He said the results continue to be very good.

Mr. Haworth said the second MCAS accuracy metric identifies refilings. He said the number of refilings increased this year primarily because of the new lines of business—health and lender-placed insurance.

e. **RIRS**

Mr. Haworth said that last year, there were still two jurisdictions that had not submitted regulatory actions in the past five years. He said that after the Working Group chair reached out to them, both jurisdictions submitted actions in 2019.

Mr. Haworth said the second RIRS completeness metric identifies errors that prevented regulatory actions from successfully loading to the RIRS database. He said there were about 2,500 errors that prevented regulatory actions from loading last year. He said there are much fewer now.

Mr. Haworth said the Working Group recommends adding the percentage of errors to total regulatory actions.

Mr. Haworth said the goal of the RIRS timeliness metric is to have regulatory actions entered and made available to other state insurance regulators as soon as possible after the effective date. He said the RIRS timeliness metric results indicate there continues to be improvement in this area.

Mr. Haworth said the Working Group believes the metrics continue to perform as desired. He said there are caveats associated with most of the metrics, and in some cases, the results do not necessarily reflect data-quality issues. He said the metrics are helpful in identifying potential issues. He said the majority of the NAIC MIS data is of good quality. He noted there were several areas where the results improved from the previous year, but some areas in need of improvement have been identified.

Mr. Haworth said there appears a need for education and training regarding expectations and best practices to ensure data quality.

Mr. Haworth said the detailed results will be distributed to each state’s collaborative action designees, market analysis chiefs and market conduct chief examiners, with instructions to review the results and make appropriate updates where necessary.

Director Wing-Heier thanked the Working Group and NAIC staff for their good work on the MIS data analysis and recommendations. She said a motion to adopt the report will also include adoption of all the Working Group recommendations.

Mr. Hanson made a motion, seconded by Mr. Fordham, to adopt the Working Group’s MIS data analysis and recommendations. The motion passed unanimously.
4. Reviewed Outstanding USER Forms

Director Wing-Heier asked Ginny Ewing (NAIC) to give an update on outstanding USER forms.

a. USER Form 10051

Ms. Ewing said USER form 10051 is a request to implement the MATS web service in State Based Systems (SBS). She said when MATS was developed, services were created that could be used by state back-office systems to update MATS. She said this request would eliminate the need for states to enter data twice—in the back-office system and in MATS. She said the SBS team has begun initial investigation and plans to complete its review in the first quarter of 2020 and will then have a better idea of the effort to implement this request. She asked for state insurance regulators to volunteer to help with the design.

b. USER Form 10059

Ms. Ewing said USER form 10059 is complete. She said this request was made five years ago prior to the release of iSite+. She said the request improved navigation for the majority of report screens.

c. USER Form 10063

Ms. Ewing said USER form 10063 is a request to facilitate data sharing with FINRA. She said the request is complete, and state insurance regulators now have the ability to search on FINRA’s unique identifier on the Individual Entity Search in iSite+.

d. USER Form 10069A and Form 10069B

Ms. Ewing said USER form 10069A and form 10069B are requests to enhance CDS codes. She said USER10069A requests adding back previously eliminated reason and disposition codes, and USER form 10069B requests new codes for lender-placed insurance and pet insurance. She said the effort to implement these changes is relatively small, and the majority of the effort is related to testing the state implementations.

e. USER Form 10072

Ms. Ewing said USER form 10072 is a request to allow companies to submit new filings for prior years once the MCAS has been closed for the current filing period. She said the request was made prior to the release of the redesigned MCAS system. She noted the new redesigned MCAS will more easily accommodate this change, and it is being incorporated into the quarter one release in February and March.

f. USER Form 10080

Ms. Ewing said USER form 10080 is a request to update RIRS to provide data retention policies and terminology related to action dates. She said the request includes seven components, two of which are associated with data definitions and will be assisted by the RIRS SME group and will not be completed by the end of 2019, but the remaining components will be completed by the end of 2019.

g. USER Form 10081

Ms. Ewing said USER form 10081 is a request to make all MCAS data available through the Market Analysis Prioritization Tool (MAPT). She said in preliminary analysis, it appears this request could be addressed as part of the State Ahead strategic plan to provide market conduct regulators additional data access.

Ms. Ewing said the second section of the USER report includes the requests being addressed as part of a NAIC State Ahead strategic plan. She said when the strategic plan was drafted, many of the projects defined in the plan came from state insurance regulator requests like the ones the Market Information Systems Research and Development (D) Working Group had in its backlog. She said nine requests are being addressed by four State Ahead projects.

Ms. Ewing said the MARS redesign project will redesign MARS to combine the Level 1 and Level 2 reviews into a single level to provide a more focused review of a company. She said the project is scheduled to begin in April 2020.
Ms. Ewing said the market regulation self-service dashboard project will replace current iSite+ market regulation tools and provide visual representations of MIS data. She said the first phase of this project will deliver a dashboard for complaint and regulatory actions data.

Ms. Ewing said an initial kickoff meeting was held in July for the project to provide market conduct regulators additional data access. She said that based on feedback from the self-service dashboard project, NAIC staff will work with interested regulators to determine what data to provide and the appropriate methods to access it.

Ms. Ewing said the objective of the market conduct data improvements phase II project is to improve the MCAS MAPT by making the data accessible using Tableau dashboards. She said feedback is being gathered on a draft dashboard that has already been created.

Director Wing-Heier said that during the Summer National Meeting, some concern was expressed about the number of USER forms that have not progressed in the last few years. She said she asked the Market Information Systems Research and Development (D) Working Group to take a close look at the prioritization list to determine which projects should be reprioritized and which should be removed due to lack of activity. She said that during the Task Force’s conference call in November, it heard from Working Group about how it reprioritized the USER forms by moving three smaller projects to the top of the prioritization list. Additionally, the Working Group recommended not removing any projects from the list so as not to lose track of them as resources become available to address them.

Director Wing-Heier said that she and Director Lindley-Myers agreed that if a project is not being worked on, it should be removed from the prioritization list. She said some of the projects may lose relevance as the NAIC State Ahead strategic plan nears completion. Director Wing-Heier said the Task Force will schedule a conference call in the first week of January to assess each USER form project.

5. Discussed Recommendations for AI in the MIS

Director Wing-Heier said the Task Force adopted a new charge to discuss recommendations for the use of artificial intelligence (AI) in MIS. She said that given the prioritization of the State Ahead projects and resource demand of the other projects, she does not anticipate any action on these recommendations immediately, but said the Task Force’s work will lay the groundwork for moving market analysis into the future.

Director Wing-Heier invited comments on this topic for consideration at the 2020 Spring National Meeting. She also said she would like to have speakers at the next national meeting who can provide additional information regarding what AI is and what is needed to incorporate AI into the MIS. She said the Task Force will also explore the potential uses and benefits and possible risks of AI.

Director Wing-Heier invited all comments and requests to give presentations to the Task Force should be sent to Randy Helder (NAIC) by February.

Having no further business, the Market Information Systems (D) Task Force adjourned.
The Market Information Systems (D) Task Force met via conference call Oct. 29, 2019. The following Task Force members participated: Lori K. Wing-Heier, Chair (AK); Chlora Lindley-Myers, Vice Chair, and Brent Kabler (MO); Keith Schraad represented by Maria Ailor (AZ); Ricardo Lara represented by Pam O’Connell (CA); Robert H. Muriel represented by Erica Weyhenmeyer (IL); Nancy G. Atkins represented by Russell Hamblen (KY); James J. Donelon represented by Jeff Zewe (LA); Mike Causey represented by Tracy Biehn (NC); John Godfread represented by Johnny Palsgraaf (ND); Bruce R. Ramge represented by Reva Vandevoorde (NE); Jillian Froment represented by Angela Dingus (OH); Glen Mulready represented by Joel Sander (OK); Kent Sullivan represented by Ignatius Wheeler (TX); Michael S. Pieciak represented by Isabelle Turpin Keiser (VT); and Mike Kreidler represented by John Haworth (WA).

1. **Adopted its Summer National Meeting Minutes**

Director Lindley-Myers made a motion, seconded by Mr. Zewe, to adopt the Task Force’s Aug. 3 minutes (*see NAIC Proceedings – Summer 2019, Market Information Systems (D) Task Force*). The motion passed unanimously.


Director Wing-Heier said the Market Information Systems Research and Development (D) Working Group maintains a prioritization list of Uniform System Enhancement Request (USER) forms received from state insurance regulators. After the Working Group’s report at the Summer National Meeting, a Task Force member asked about the status of USER forms that have been on the prioritization list for several years without any additional action.

Director Wing-Heier said she asked the Working Group chair, Mr. Kabler, to lead the Working Group in a review of the prioritization list to determine whether some of the USER forms could be wrapped into *State Ahead* projects, and which of the older USER forms could be removed from the list due to inactivity. She also asked the Working Group to take a fresh look at the prioritization to see if any re-prioritization was needed.

Mr. Kabler said the Working Group met Sept. 19, in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings, to review the USER form prioritization. He said the USER requests werequantified according the hours needed to complete. He said most of the requests were considered extra-large, meaning the estimated time of completion was more than 400 hours. He said there were three requests that were classified as small (less than 40 hours), and they were moved to the top of the prioritization list. He noted that there were severe staffing constraints affecting the others.

Ginny Ewing (NAIC) said the development teams are at capacity, but they have room to complete the three projects moved to the top of the priority list. She said the high priority projects being worked on by the development teams are the *State Ahead* projects that include transitioning to the cloud, the Online Fraud Reporting System (OFRS) redesign, and the Enterprise Data project. She said upcoming *State Ahead* projects include the Market Analysis Review System (MARS) redesign and the Regulatory Data Collection (RDC) tool enhancements. Additionally, the developments have ongoing support and maintenance responsibilities.

Mr. Kabler said the Working Group considered whether any requests should be removed from the USER list and decided against doing so. He said all the requests have merit, and even though there may not currently be the time to address them, the Working Group does not want to lose sight of them for the future. He said the Working Group was looking for guidance on how to address these.

Director Wing-Heier asked Ms. Ewing if there was any possibility for the resource demand to lessen in the near future. Ms. Ewing said *State Ahead* projects will be completed and consulting dollars are available to assist.
Director Lindley-Myers said she understands Mr. Kabler’s concerns, but, at some point, the old items that are not being worked on need to be removed. She said there may still be opportunities to put those projects back on the list later. She suggested that a determination could be made at the Fall National Meeting when Ms. Ewing may have clearer projections of resource availability.

Director Wing-Heier agreed and said some of the projects may not be relevant after the State Ahead work is completed. She said the Task Force may need to consider the list project by project. Mr. Kabler suggested creating a new category called “tabled” rather than removing them from the list entirely.

Mr. Kabler said the Working Group also received the recommendations from the Regulatory Information Retrieval System (RIRS) subject-matter experts (SMEs). He noted that there was a delay in completing the recommendations due to the difficulty arising at a consensus among so many different states. He said this is a high priority project that is extra-large. He said it is possible that it could be stalled in implementation, and he suggested that it be pushed along by the Task Force.

Director Wing-Heier suggested adding this to the agenda for the Task Force at the Fall National Meeting. Mr. Kabler said the Working Group plans to meet Nov. 15 and can present the entire proposal to the Task Force at the Fall National Meeting. Director Wing-Heier said a summary would be enough, and anyone who wants the entire proposal can reach out to the Working Group.

Ms. Dingus made a motion, seconded by Mr. Hamblen, to adopt the report of the Market Information System Research and Development (D) Working Group. The motion passed unanimously.

3. **Adopted its 2020 Proposed Charges**

Director Wing-Heier said there is essentially one change to the charges. She said charge to develop a plan to make public data collected in the NAIC Market Information Systems more meaningful and widely available was removed and replaced with a charge to, “[d]evelop recommendations for the incorporation of artificial intelligence (AI) abilities in NAIC Market Information Systems for use in market analysis.”

Director Wing-Heier said the old charge has been a Task Force charge for several years, and in the last year, the Task Force had a few comments but very little other interest in the charge. She said that during the Spring National Meeting, the Task Force heard a presentation on the redesign of the Consumer Insurance Search (CIS), which met many of the goals of this charge.

Director Wing-Heier said the new charge aligns the Task Force with the direction of many other NAIC Committees and Task Forces considering the value, benefits and risks of the use of AI. She said, given the prioritization of the State Ahead projects and resource demand of the other projects, she did not anticipate any action on these recommendations immediately, but they will lay the groundwork for moving the NAIC market systems into the future.

Mr. Hamblen made a motion, seconded by Director Lindley-Myers, to adopt the Task Force’s 2020 proposed charges (Attachment One-A). The motion passed unanimously.

Having no further business, the Market Information Systems (D) Task Force adjourned.
MARKET INFORMATION SYSTEMS (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Market Information Systems (D) Task Force** will:
   A. Ensure the NAIC Market Information Systems support the strategic direction set forth by the Market Regulation and Consumer Affairs (D) Committee.
   B. Develop a plan for making public data collected in the NAIC Market Information Systems more meaningful and widely available by the 2019 Fall National Meeting.
   C. Develop recommendations for the incorporation of Artificial Intelligence (AI) abilities in market information systems for use in market analysis by the 2020 Fall National Meeting.
   D. Analyze the data in the NAIC Market Information Systems. If needed, recommend methods to ensure better data quality by the 2019 Summer-Fall National Meeting.
   E. Provide guidance on appropriate use of the NAIC Market Information Systems and data entered in them.
      1. Complaint Database System (CDS).
      2. Electronic Forums.
      4. Market Analysis Profile.
      5. Market Analysis Prioritization Tool (MAPT).
      9. 1033 State Decision Repository (in conjunction with the Antifraud (D) Task Force).

2. The **Market Information Systems Research and Development (D) Working Group** will:
   A. Serve as the business partner to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure an efficient use of available NAIC staffing and resources.
   B. Assist the Task Force with tasks as assigned, such as:
      1. Analyze NAIC Market Information Systems data.
      2. Provide state users with query access to NAIC Market Information Systems data.
      3. Provide guidance on appropriate use of the NAIC Market Information Systems.

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

Producer Licensing (D) Task Force Dec. 7, 2019, Minutes................................................................. 9-174
Producer Licensing (D) Task Force Oct. 25, 2019, Minutes (Attachment One) ............................................. 9-176
Producer Licensing (D) Task Force 2020 Proposed Charges (Attachment One-A) ........................................... 9-178
Producer Licensing Uniformity (D) Working Group Oct. 30, 2019, Minutes (Attachment Two) ..................... 9-180
Producer Licensing Uniformity (D) Working Group Oct. 10, 2019, Minutes (Attachment Three) ....................... 9-182
Producer Licensing Uniformity (D) Working Group Sept. 26, 2019, Minutes (Attachment Four) ....................... 9-184
Producer Licensing Uniformity (D) Working Group Sept. 12, 2019, Minutes (Attachment Five)..................... 9-186
Producer Licensing Uniformity (D) Working Group Aug. 29, 2019, Minutes (Attachment Six) ......................... 9-188
Producer Licensing Uniformity (D) Working Group Aug. 21, 2019, Minutes (Attachment Seven) ................. 9-190
Uniform Education (D) Working Group Oct. 31, 2019, Minutes (Attachment Eight) ........................................ 9-193
Uniform Education (D) Working Group Aug. 22, 2019, Minutes (Attachment Nine) ....................................... 9-194
The Producer Licensing (D) Task Force met in Austin, TX, Dec. 7, 2019. The following Task Force members participated: Larry Deiter, Chair (SD); Mike Kreidler, Vice Chair, represented by Jeff Baughman (WA); Lori K. Wing-Heier represented by Jacob Lauten (AK); Allen W. Kerr represented by Letty Hardee (AR); David Altmaier represented by Matt Tamplin (FL); Doug Ommen represented by Andria Seip (IA); Vicki Schmidt (KS); James J. Donelon represented by Barry Ward (LA); Anita G. Fox represented by Michele Riddering (MI); Chlora Lindley-Myers represented by Carrie Couch and Marjorie Thompson (MO); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by John Arnold (ND); Bruce R. Ramge represented by Peg Jasa (NE); Marlene Caride represented by Phil Gennace (NJ); John G. Franchini represented by Victoria Baca (NM); Jillian Froment represented by Jana Jarrett (OH); Glen Mulready represented by Teresa Green (OK); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Raymond G. Farmer represented by Lee Hill (SC); Kent Sullivan represented by Chris Herrick (TX); Todd E. Kiser represented by Randal Overstreet (UT); Scott A. White represented by Mike Beavers (VA); James A. Dodrill represented by Ellen Potter (WV); and Jeff Rude (WY).

1. **Adopted its Oct. 25 Minutes**

The Task Force met Oct. 25 and took the following action: 1) adopted its Summer National Meeting minutes; 2) adopted its 2020 proposed charges; 3) discussed amendments to the NAIC Uniform Licensing Standards (ULS) for surplus lines; 4) discussed the role of chatbots in the distribution of insurance; and 5) discussed NAIC/Financial Industry Regulatory Authority (FINRA) data sharing.

Mr. Hill made a motion, seconded by Mr. Baughman, to adopt its Oct. 25 minutes (Attachment One). The motion passed unanimously.

2. **Adopted Revisions to the Handbook**

Mr. Beavers said the Producer Licensing Uniformity (D) Working Group reviewed the *State Licensing Handbook* (Handbook) during conference calls, with all comments and drafts being shared with interested parties on the NAIC website. The first conference call occurred Aug. 21, and the Working Group met six more times via conference call. The Working Group adopted the revised Handbook during its Oct. 30 conference call.

Mr. Beavers said some of the more significant changes include: 1) exact language of the *Producer Licensing Model Act* (#218), when referenced, was added to the Handbook; 2) the appendix was removed from future hard copy publications and will be made available in an electronic format on the NAIC website; 3) a link was added to the NAIC web page for current information about the National Association of Registered Agents and Brokers (NARAB); 4) language was removed regarding the National Insurance Producer Registry’s (NIPR) implementation of the Contact Change Request application; and 5) the licensing reciprocity examples were clarified.

Mr. Overstreet made a motion, seconded by Mr. Lauten, to adopt the revised *State Licensing Handbook* (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Four). The motion passed unanimously.

3. **Adopted the 2019 CER Agreement**

Mr. Beavers said the form was created by combining information from the 2004 Continuing Education Declaration regarding continuing education (CE) reciprocity course approval and the 2004 Continuing Education Reciprocity (CER) Agreement. Mr. Beavers said the Uniform Education (D) Working Group adopted the CER Agreement during its Oct. 31 conference call. This agreement is used to support the use of the Uniform Continuing Education Reciprocity Course Filing Form, which CE providers may use to streamline the course-approval process in multiple states. Through the reciprocal approval process, the CE provider’s home state conducts a substantive review of the CE course; therefore, non-resident states do not need to perform a similar review.

Ms. Potter made a motion, seconded by Mr. Hill, to adopt the 2019 CER Agreement Handbook (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Five). The motion passed unanimously.
4. Discussed Amendments to the NAIC ULS for Surplus Lines

Director Deiter said the Surplus Lines (C) Task Force sent a request to the Producer Licensing (D) Task Force Aug. 4, 2018, to consider whether the requirement of a resident producer to hold underlying property/casualty (P/C) licenses before a surplus lines license is issued should be expanded to permit an accident and health (A&H) license to fulfill this underlying license requirement.

Director Deiter said the Task Force had multiple discussions on this topic at NAIC national meetings and during an interim conference call in October. Upon the last review of comments submitted Nov. 15, Director Deiter said there continues to be divergent views on what, if any, changes should be made to the ULS. Because of this, Director Deiter suggested it may be premature to modify the ULS for surplus lines and the chapter of the State Licensing Handbook that addresses surplus lines licensing. Director Deiter said he believed it would be better for consumers and the industry if each state implements changes to state laws, as needed, as the market for A&H surplus lines products develops.

Director Deiter asked if there were any objections or comments regarding his suggested direction.

John Fielding (Council of Insurance Agents & Brokers—CIAB) said the CIAB does not object to this direction and requested the Task Force be willing to address this issue in the future if there is a need for states to move in uniform direction.

Director Deiter said the Task Force could revisit this issue in the future, if needed, to ensure the necessary consumer protections are in place and the regulatory framework is appropriate to facilitate the delivery of needed insurance products through the surplus lines market.

Hearing no other comments, Director Deiter said there is not a need for a motion since the Task Force is not taking any affirmative action to change the ULS. Director Deiter said this concludes the Task Force’s discussion of the request.

5. Adopted the Reports of the Producer Licensing Uniformity (D) Working Group and the Uniform Education (D) Working Group

Director Deiter said Chris Murray, Producer Licensing Uniformity (D) Working Group chair, and Rachel Chester, Uniform Education (D) Working Group chair, were not able to attend this meeting and that written reports have been made available. Director Deiter asked if there were any questions or comments on the reports.

Commissioner Schmidt made a motion, seconded by Mr. Hill, to adopt the reports of the Producer Licensing Uniformity (D) Working Group, including its Oct. 30 (Attachment Two), Oct. 10 (Attachment Three), Sept. 26 (Attachment Four), Sept. 12 (Attachment Five), Aug. 29 (Attachment Six) and Aug. 21 (Attachment Seven) minutes, and the Uniform Education (D) Working Group, including its Oct. 31 (Attachment Eight) and Aug. 22 (Attachment Nine) minutes. The motion passed unanimously.

6. Heard a Report from the NIPR Board of Directors

Director Deiter said the NIPR Board of Directors met Dec. 6. During this meeting, the Board heard a report from the NIPR Audit Committee, which reported NIPR’s total revenues are $3,555,225 (10.2%) above budget through October and 13.9% above the prior year. The Board approved NIPR’s 2020 budget, with projected revenues of $46.1 million and projected expenses of $43.3 million. The Board heard an update on the progress of implementing NIPR’s strategic plan, which will be completed in 2020. In addition to the general progress on the plan, two major strategic initiatives have been accomplished this year. NIPR implemented Florida for resident licensing for its individual insurance producers, and it is anticipated Florida’s resident business entities will be available before year-end.

Having no further business, the Producer Licensing (D) Task Force adjourned.
The Producer Licensing (D) Task Force met via conference call Oct. 25, 2019. The following Task Force members participated: Larry Deiter, Chair, and Dan Nelson (SD); Mike Kreidler, Vice Chair, represented by Jeff Baughman (WA); Lori K. Wing-Heier represented by Chris Murray (AK); Ricardo Lara represented by Charlene Ferguson (CA); Michael Conway represented by Steven Giampaolo (CO); Trinidad Navarro represented by Ashley Webb (DE); David Altmaier represented by Matt Guy (FL); Vicki Schmidt represented by Lee Modesitt (KS); Nancy G. Atkins represented by Lee Webb (KY); James J. Donelon represented by Barry Ward (LA); Chlora Lindley-Myers represented by Carrie Couch (MO); Bruce R. Ramge represented by Kevin Schlautman (NE); John G. Franchini represented by Venessa DeJesus and Victoria Baca (NM); Jillian Froment represented by Karen Vourvopoulos (OH); Glen Mulready represented by Courtney Khodabakhsh (OK); Andrew Stolfi represented by Kirsten Anderson (OR); Todd E. Kiser represented by Randy Overstreet (UT); James A. Dodrill represented by Robert Grishaber (WV); and Jeff Rude (WY).

1. **Adopted its Summer National Meeting Minutes**

   Mr. Murray made a motion, seconded by Ms. Webb, to adopt the Task Force’s Aug. 3 minutes *(see NAIC Proceedings – Summer 2019, Producer Licensing (D) Task Force)*. The motion passed unanimously.

2. **Adopted its 2020 Proposed Charges**

   Director Deiter said the next agenda item is to consider adoption of the Task Force’s 2020 proposed charges. He said charge 1.H was changed to reflect that the white paper on the role of chatbots will be finalized by the 2020 Spring National Meeting. In addition, the reference to the year 2019 was changed to 2020 in charge 2.C and charge 3.A. He said charge 1.I was added to develop procedures for amending the NAIC’s uniform producer licensing applications and uniform appointment form to ensure consistency with the NAIC membership’s goal of maintaining uniform and stable applications that encourage the efficient use of electronic technology. He said this charge is consistent with other areas across the NAIC, which have developed more structured procedures for NAIC work products that are used by NAIC members for regulatory purposes. For example, he said the Market Conduct Annual Statement Blanks (D) Working Group has guidelines regarding the process for amending or adding a new Market Conduct Annual Statement (MCAS) blank, and the Market Conduct Examination Standards (D) Working Group has guidelines for the discussion and adoption of revisions to the *Market Regulation Handbook*.

   Mr. Baughman made a motion, seconded by Ms. Khodabakhsh, to adopt the Task Force’s 2020 proposed charges (Attachment One-A). The motion passed unanimously.

3. **Discussed Amendments to the NAIC Uniform Licensing Standards for Surplus Lines**

   Director Deiter said the Task Force circulated a proposal at the Summer National Meeting that would permit a state the flexibility to require: 1) both an underlying property/casualty (P/C) license and accident and health (A&H) license; 2) only an underlying P/C license; or 3) only an underlying A&H license prior to the issuance of a resident surplus lines license.

   Based on the discussions of the Task Force at the Summer National Meeting, Director Deiter said there are three other options the Task Force should consider. The first option is for states to require an underlying P/C license prior to the issuance of a resident surplus lines license regardless of the type of insurance the surplus lines producer will be selling, soliciting or negotiating. This is the general standard in the market today.

   Director Deiter said the second option is for states to require an underlying P/C license prior to the issuance of a resident surplus lines license if the surplus lines producer is selling, soliciting or negotiating P/C insurance and require an underlying A&H license prior to the issuance of resident surplus lines license if the surplus lines producer will be selling, soliciting or negotiating A&H insurance. He said there seems to be some agreement around this option at the Summer National Meeting.

   Director Deiter said the third option is for the states to require either an underlying P/C license or an underlying A&H license prior to the issuance of resident surplus lines license. He said he does not believe this option was widely supported because almost all surplus business involves P/C risks.
Director Deiter said he believes the second option is the most appropriate approach and requested state insurance regulators and interested parties to submit comments on the second option so the Task Force can make a final decision at the Fall National Meeting.

John Fielding (Council of Insurance Agents & Brokers—CIAB) said the CIAB wants to avoid a situation where a surplus lines producer has to obtain both an underlying P&C license and A&H license unless the surplus lines producer is selling both P&C and A&H insurance.

Keri Kish (Wholesale & Specialty Insurance Association—WSIA) said she agrees with the position of the CIAB and believes the WSIA can support the second option.

David Kodama (American Property Casualty Insurance Association—APCIA) asked if the second option would permit a surplus lines producer who is only selling A&H products to only obtain an underlying A&H license.

Director Deiter said this is the intent of the second option. He asked for any additional comments to be submitted by the middle of November.

4. Discussed the Role of Chatbots in the Distribution of Insurance

Tim Mullen (NAIC) said a draft outline of a white paper discussing the role of chatbots and artificial intelligence (AI) has been circulated. He said the outline has four sections: 1) an introduction; 2) examples of chatbots and AI; 3) regulatory considerations for licensing requirements; and 4) regulatory considerations for marketplace practices. He said the white paper is not intended to establish public policy but rather explain current marketplace activities.

Director Deiter said he would appreciate state insurance regulators and interested parties submitting comments, noting that a small drafting group might be formed to create an initial draft of the paper.

Ms. Ferguson suggested the white paper include a section on cybersecurity and fraud.

Mr. Kodama asked if this work will overlap with the work of the Artificial Intelligence (EX) Working Group. Mr. Mullen said he is coordinating with the NAIC staff support for this Working Group and would ensure there is proper coordination between the two groups.

5. Discussed NAIC/FINRA Data Sharing

Mr. Mullen said the NAIC and the Financial Industry Regulatory Authority (FINRA) are finalizing a memorandum of understanding (MOU) for the sharing of information to enhance state insurance regulators’ awareness of actions FINRA has taken against security brokers who are also operating in the insurance industry. Similarly, the data-sharing will enhance FINRA’s awareness of actions state insurance regulators have taken against insurance producers who are also operating in the securities industry.

Mr. Mullen said FINRA sends a file to the NAIC containing the following data fields for matching against the State Producer Licensing Database (SPLD): 1) first name; 2) last name; 3) year of birth; and 4) last four digits of the Social Security number (SSN). The file also contained FINRA’s Central Registration Depository (CRD) number active/inactive status. The NAIC retains matches and deletes all other information from FINRA. The NAIC then sends FINRA the National Producer Number and active/inactive status of matched individuals in the SPLD.

Mr. Mullen said the NAIC and FINRA are exchanging this information for regulatory purposes and will not disclose each organization’s data to the public. He said the MOU should be finalized within the next 30 days, noting that state insurance regulators will be see new data fields for CRD and FINRA Active/Inactive status in the SPLD.

Having no further business, the Producer Licensing (D) Task Force adjourned.
Draft: 10/7/19

Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Market Regulation and Consumer Affairs (D) Committee, TBD
Adopted by the Producer Licensing (D) Task Force, Oct. 25, 2019

2020 PROPOSED CHARGES

PRODUCER LICENSING (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Producer Licensing (D) Task Force will:

   A. Work closely with the National Insurance Producer Registry (NIPR) to encourage full utilization of NIPR products and services by all of the states and producers, and encourage accurate and timely reporting of state administrative actions to the NAIC’s Regulatory Information Retrieval System (RIRS) to ensure this data is properly reflected in the State Producer Licensing Database (SPLD) and the Producer Database (PDB).

   B. Facilitate roundtable discussions, as needed, with the state producer licensing directors for the exchange of views, opinions and ideas on producer-licensing activities in the states and at the NAIC.

   C. Discuss, as necessary, state perspectives regarding the regulation and benefit of the activities of the federal Affordable Care Act (ACA) established enrollment assisters (including navigators and non-navigator assisters and certified application counselors) and the activities of producers in assisting individuals and businesses purchasing in the health insurance marketplaces. Coordinate with the Health Insurance and Managed Care (B) Committee and the Antifraud (D) Task Force, as necessary.

   D. Monitor the activities of the National Association of Registered Agents and Brokers (NARAB) in the development and enforcement of the NARAB membership rules, including the criteria for successfully passing a background check.

   E. Coordinate through NAIC staff to provide guidance to NIPR on producer licensing-related electronic initiatives. Hear a report from NIPR at each national meeting.

   F. Coordinate with the Market Information Systems (D) Task Force and the Antifraud (D) Task Force to evaluate and make recommendations regarding the entry, retention and use of data in the NAIC’s Market Information Systems (MIS).

   G. Monitor state implementation of adjuster licensing reciprocity and uniformity; update, as necessary, NAIC adjuster licensing standards.

   H. Finalize the white paper on the role of chatbots and artificial intelligence (AI) in the distribution of insurance and the regulatory supervision of these technologies by the 2020 Spring National Meeting.

   I. Draft procedures for amending the NAIC’s uniform producer licensing applications and uniform appointment form to ensure consistency with the NAIC membership’s goal of maintaining uniform and stable applications that encourage the efficient use of electronic technology.

2. The Producer Licensing Uniformity (D) Working Group will:

   A. Work closely with state producer licensing directors and exam vendors to ensure: 1) the states achieve full compliance with the standards in order to achieve greater uniformity; and 2) the exams test the qualifications for an entry-level position as a producer.

   B. Provide oversight and ongoing updates, as needed, to the State Licensing Handbook. Complete by the 2020 Fall National Meeting.

   C. Monitor and assess the state implementation of the Uniform Licensing Standards (ULS) and update the standards, as needed. Complete by the 2020 Fall National Meeting.

   D. Review and update, as needed, the NAIC’s uniform producer licensing applications and uniform appointment form. Provide any recommended updates to the Producer Licensing (D) Task Force by June 1.
3. The **Uniform Education (D) Working Group** will:
   
   A. Update, as needed, the reciprocity guidelines, the uniform application forms for continuing education (CE) providers, and the process for state review and approval of courses. Provide any recommended updates to the Producer Licensing (D) Task Force by the 2020 Fall National Meeting.
   
   B. Coordinate with NAIC parent committees, task forces and/or working groups to review and provide recommendations, as necessary, on prelicensing education and CE requirements that are included in NAIC model acts, regulations and/or standards.

NAIC Support Staff: Timothy D. Mullen/Greg Welker

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The Producer Licensing Uniformity (D) Working Group of the Producer Licensing (D) Task Force met via conference call Oct. 30, 2019. The following Working Group members participated: Chris Murray, Chair (AK); Melissa Grisham (AR); Charlene Ferguson (CA); Lisa Tordjman (ID); Leslie Page, Paige McCully and Tracy Lord-Bishop (MI); Kevin Schlautman (NE); Karen Vourvopoulos (OH); Dan Nelson (SD); Randy Overstreet (UT); Mike Beavers and Richard Tozer (VA); and Melody Esquivel (WI).

1. Reviewed the NAIC State Licensing Handbook

Mr. Murray said the intent of this Working Group was to hold a minimum of two conference calls a month since August to review comments submitted over the chapters in the NAIC State Licensing Handbook (Handbook). He said during the Oct. 10 call, the Working Group finalized reviewing the comments received on the last of the remaining chapters. He said the individual chapters, deadlines, conference call dates, comments received, and the redlined chapters have been posted on the Working Group webpage. He said the purpose of this call is to finalize any remaining areas of the Handbook and potentially adopt the revisions.

Mr. Murray said the Producer Licensing (D) Task Force held a conference call on Oct. 25 to review and adopt its 2020 proposed charges in addition to other agenda items, including surplus lines. The Working Group has been holding off the review of Chapter 10 Surplus Lines Producer Licenses pending the Task Force’s discussion and adoption of surplus lines standard language. He advised that during the Task Force conference call, it was determined that further comments and discussion would be accepted before the Task Force finalizes its review. Mr. Murray said the Working Group would not be opening up chapter 10 for review until the Task Force discussion has been completed. He said the Working Group will proceed with adopting all other reviewed chapters, excluding chapter 10.

Mr. Murray said during the first few conference calls, the Working Group discussed the creation of a Handbook webpage under the Working Group. He said the webpage will house the appendix for the Handbook and serve as a centralized location for all information concerning notices regarding the Handbook and potential chapter updates that may be required. He said the webpage is being created and will be available prior to the completion of the Handbook.

Mr. Murray said during its last conference call, the Working Group finished up the review of Chapters 26–30. He said the only comments received were from Nebraska concerning Chapter 29 Title Insurance Agents. He said the Working Group discussed all the comments submitted on this chapter, which were also sent to NAIC staff support for the Title Insurance (C) Task Force to review. He said NAIC staff support confirmed that the suggestions made would not go against NAIC language; however, it would be up to the Working Group to determine whether this language needs to be changed in the Handbook or if it should be kept as is at a broader level. He advised that during the last call, the decision was made to accept the following changes pending further direction from the NAIC staff support:

- Third paragraph, first sentence specifically regarding the word “lender’s policy”; the Working Group’s decision was to remove “lender’s,” and replace it with “Loan.”

- The third paragraph addresses two types of title insurance policies that are commonly used; however, only one type is discussed. The Working Group’s decision was that Nebraska would provide new language to be applied that would address both.

- Third paragraph at the end of the last sentence. The Working Group’s decision was that the current language may cause confusion. The buyer/borrower typically pays for the loan policy, but the buyer/borrower is not covered under the loan policy; only the lender is covered. Therefore, additional language would be supplied by Nebraska to clarify.

- Fourth paragraph, second sentence. The Working Group’s decision was to remove “the title page” and add the language, “Schedule A of the Policy.”
Fourth paragraph, third sentence questioning the language “policy is generally the original amount of the loan.” The Working Group’s decision was to remove “original” from the sentence.

Ninth and last paragraph. The Working Group’s decision was that the language, “[i]n addition to state laws, rebates and referrals related to most residential real estate transactions are prohibited under the federal Real Estate Settlement Procedures Act (RESPA)” should also mention the TILA-RESPA Integrated Disclosure (TRID) Rule.

Mr. Murray said since NAIC staff support has agreed with the changes, the Working Group will accept the changes. He said Nebraska has also submitted language as requested for paragraph three. The Working Group discussed and agreed to the suggested language. The paragraph would now read:

Two types of title insurance policies are commonly issued: the owner's policy and the loan policy. The owner's policy ensures that the title to the real property is vested as described in the policy, that the title is marketable, that there is a right of access to the property, and against defects in or lien or encumbrances on the title. The loan policy is usually based on the dollar amount of the loan and only protects the lender’s interests in the property, should a problem with the title arise. Title insurance does not require a written application. Policies often are ordered by real estate agents or lenders. The title insurance agent issues a commitment or binder basically revealing the current state of title to the property and agreeing to insure the property, provided that the requirements in the commitment are met to the satisfaction of the title insurer. Typically, even though the buyer/borrower pays for the loan policy, only the lender is covered by the loan policy.

Mr. Murray said the next area to be brought before the Working Group is concerning Chapter 2 The Producer Licensing Model Act. He said during the first round of accepting comments, California submitted a comment concerning the “Section-by-Section of the PLMA,” suggesting adding language to the second bullet point under Section 14: Appointments stating, “if states require the appointment to be renewed.” The Working Group discussed and determined that this is language specific to the Producer Licensing Model Act (#218) and could not be changed. Mr. Murray said it was decided that this language could be better addressed in Chapter 11 Appointments. He said after further discussion, the decision was to add language to the “key elements” under chapter 11. The language would now read:

In states that are required to renew appointments, the key elements include:
1. States shall provide or publish a pre-renewal notice to insurers informing them that appointment renewals are imminent.
2. At the time for renewal, a state will deliver an invoice. The invoice may not be altered, amended or used for appointing or terminating producers.
3. Insurers shall return the invoice and the payment to the department or its designee.
4. States shall establish a dispute resolution process to accommodate errors after the fact.

The Working Group discussed the suggestion for chapter 11 and agreed that this would be the best place without affecting language from the Model #218 or changing the meaning of the current language.

Mr. Murray said that concludes the complete review of the Handbook and all the comments submitted.

Mr. Beavers made a motion, seconded by Mr. Nelson, to adopt the revisions to the NAIC State Licensing Handbook, including the changes made to chapters 11 and 29, and excluding revisions to chapter 8 (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Four). The motion passed unanimously.

Mr. Murray said the adopted revisions would be presented to the Producer Licensing (D) Task Force for adoption at the Fall National Meeting.

Having no further business, the Producer Licensing Uniformity (D) Working Group adjourned.
The Producer Licensing Uniformity (D) Working Group of the Producer Licensing (D) Task Force met via conference call Oct. 10, 2019. The following Working Group members participated: Chris Murray, Chair (AK); Peggy Dunlap (AR); Charlene Ferguson (CA); Lisa Tordjman (ID); Lorelei Brillante (MD); Leslie Page (MI); Greg Nelson (ND); Kevin Schlautman (NE); Otis Phillips (NM); Karen Vourvopoulos (OH); Rachel Chester (RI); Randy Overstreet (UT); Richard Tozer (VA); and Melody Esquivel (WI).

1. Reviewed the NAIC State Licensing Handbook

Mr. Murray said the Working Group last met via conference call Sept. 26 and was able to finalize the review up through chapter 25. He said that would complete the review of all chapters 1–25, excluding Chapter 10 Surplus Lines Producer Licenses. He said the purpose of today’s conference call is to review chapters 26–30, in addition to circling back to chapter 4 concerning the examples of reciprocity.

Mr. Murray said Alaska, California, Rhode Island and Virginia reviewed the reciprocity examples found in chapter 4, on page 18. He said the group submitted revisions for examples A–F, which were exposed and posted on the Working Group webpage. The Working Group discussed the revisions and agreed to all changes made to the reciprocity examples.

Mr. Murray said the Working Group only received comments from one state regarding chapters 26–30 from Nebraska concerning Chapter 29 Title Insurance Agents. He said Nebraska submitted several comments throughout this chapter for the Working Group to review. He said these comments were also shared with the NAIC staff for the Title Insurance (C) Task Force to confirm that the suggestions would fall within the uniformity that are trying to be maintained with the Handbook content. He said the goal will be for the Working Group to review and determine whether these comments should be changed with the final say coming from NAIC staff.

Mr. Murray said the first comment can be found in the first sentence of the third paragraph, specifically regarding the word “lender’s policy.” He said Nebraska submitted the question, “Why did this article not discuss the loan policy coverages like it did for the owner’s policy?” He said Nebraska suggests removing “lender’s” and replacing it with “loan.” The Working Group discussed and agreed that the correct verbiage should be “loan policy.”

Mr. Murray said the next comment in the third paragraph is concerning the language, “that the buyer or borrower typically pays for the loan policy, but the buyer/borrower is not covered under the loan policy—only the lender is covered.” Mr. Schlautman said this relates back to the two types of title insurance policies. The Working Group agreed that this should be added and suggests that Nebraska provide suggested language to be added to this section.

Mr. Murray said the next comment is in the second sentence of the fourth paragraph, suggesting removing, “the title page” and adding the language, “Schedule A of the Policy.” Mr. Schlautman said this suggestion is to correct an inaccuracy with the current language. The Working Group discussed and agreed that adding additional language could be getting too specific and change the chapter to have a granular level, which is not the intent of the Handbook. Mr. Murray said he recommends that Nebraska provide draft language if this is an area, they deem necessary to change. The Working Group agreed.

Mr. Murray said the next comment is in the second sentence of the fourth paragraph, suggesting removing, “the title page” and adding the language, “Schedule A of the Policy.” Mr. Schlautman said this suggestion is to correct an inaccuracy with the current language. The Working Group discussed and agreed that they would verify with NAIC staff whether this would be an accurate statement. The Working Group agreed that if NAIC staff confirms that the suggested language is accurate, it would be added.

Mr. Murray said the next comment was in the third sentence of the fourth paragraph, questioning the language, “policy is generally the original amount of the loan.” Mr. Schlautman said Nebraska suggests that this is not a true statement. The day the policy is issued, the face amount of the policy will be that of the original amount of the loan. The Working Group discussed and agreed to remove “original” from the sentence.

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Mr. Murray said the next comment is within the fifth paragraph concerning the premiums advising that some states also set the rates. The Working Group discussed and agreed to avoid getting too specific with the language, and it would remain with no change.

Mr. Murray said the next comment is within the seventh paragraph, suggesting that some states also separately license escrow agents. The Working Group discussed and determined that no change would be necessary at this time.

Mr. Murray said the final comment from Nebraska is found in the last sentence of the last paragraph stating, “[i]n addition to state laws, rebates and referrals related to most residential real estate transactions are prohibited under the federal Real Estate Settlement Procedures Act (RESPA).” Mr. Schlautman said the suggestion is to also mention the TILA-RESPA Integrated Disclosure (TRID) Rule. The Working Group discussed and agreed that they would defer to NAIC staff on whether this should be added.

Mr. Murray said with the exception of Chapter 10 Surplus Lines Producer Licenses, this concludes the review of the Handbook, aside from and the verification from NAIC staff concerning chapter 29 and some minor outstanding issues that were originally discussed in the first five chapters that the Working Group determined should be applied somewhere else other than the Handbook.

Mr. Murray said the redline for the chapters have been posted on the webpage and that chapters 26–30 would be updated and posted as well. He said the next conference call scheduled for Oct. 24 and the Working Group will utilize that call to finalize any outstanding issues so it can potentially adopt them.

Having no further business, the Producer Licensing Uniformity (D) Working Group adjourned.
The Producer Licensing Uniformity (D) Working Group of the Producer Licensing (D) Task Force met via conference call Sept. 26, 2019. The following Working Group members participated: Chris Murray, Chair (AK); Peggy Dunlap (AR); Charlene Ferguson (CA); Matt Guy (FL); Lorelei Brillante (MD); Leslie Page (MI); Kevin Schlautman (NE); Karen Vourvopoulos (OH); Randy Overstreet (UT); and Richard Tozer (VA).

1. Reviewed the NAIC State Licensing Handbook

Mr. Murray said the Working Group last met Sept. 12 and finalized the review of Chapter 8 Testing Programs. He said that completes the review of chapters 1–15, excluding Chapter 10 Surplus Lines Producer Licenses since that discussion is on hold pending further discussion from the Producer Licensing (D) Task Force. He reminded everyone that emails have been sent out explaining the game plan to move forward with the review of the entire NAIC State Licensing Handbook (Handbook). He said to meet the Working Group’s Oct. 31 deadline, he has set up an aggressive comment and conference call schedule moving forward.

Mr. Murray said for the purposes of today’s conference call, the Working Group will start with reviewing chapters 16–20. He said the only comments were from California and the Securities and Insurance Licensing Association (SILA). He said the majority of the comments are on Chapter 18 Adjusters and one comment on Chapter 17 Post Licensing Producer Conduct Reviews.

Mr. Murray said the first comment is from California regarding chapter 17, page 65 found within the License Reinstatement or Reissuance After Disciplinary Action section in the first paragraph. He said the suggestion is to add the language, “reconsideration of the action taken on the license whether it be.” The Working Group discussed and agreed to the change. The new language now reads:

Reinstatement or reissuance of a license after disciplinary action usually is not automatic. A producer whose license has been revoked or suspended by order, or who forfeited a license in connection with a disciplinary matter, should be required to make a written request to the insurance commissioner for reconsideration of the action taken on the license whether it be reinstatement or reissuance in accordance with the terms of the order of revocation or suspension or the order accepting the forfeiture.

Mr. Murray said the next comment is from California regarding chapter 18, page 69 found within the second paragraph. He said California suggests changing three kinds of adjusters to “four” so as to include crop. The Working Group discussed and agreed that no change would be made, and the language would remain the same.

Mr. Murray said the next comment is from SILA regarding the same chapter on page 70 found within the Reciprocity section. He said the request is to reference the Public Adjuster Licensing Model Act’s (#228) definition for home state. Linda Brunette (SILA) said under the Reciprocity section within this chapter, there is a reference to Model #228’s definition, but this section does not include the definition of home state noted within the Independent Adjuster Licensing Guideline (#1224). She said SILA recommends adding this language:

“Home State” means the District of Columbia and any state or territory of the U.S. in which an Independent Adjuster maintains his or her principal place of residence or principal place of business and is licensed to act as an independent adjuster. If such a state does not issue an independent adjuster license for the line of business sought, the independent adjuster may designate as their “Home State” any state in which the independent adjuster qualifies pursuant to Section 6 of this Act.

Ms. Brunette said SILA would also recommend modifying the Best Practice for Regulators section to state: “Use the definition of ‘home state’ as defined in Model #228 and Guideline #1224 as the basis of reciprocity.” The Working Group discussed and agreed to the addition.
Mr. Murray said that the next comment from SILA is also on page 70 and concerning Model #228. He said in the Handbook it lists the title as the “New” NAIC Public Adjuster Model Act. SILA recommends that “new” be removed since this is no longer accurate. The Working Group discussed and agreed that “new” would be removed where appropriate.

Mr. Murray said the next comment from SILA on chapter 18 suggests that an inclusion and reference to the Independent Adjuster Reciprocity Best Practices and Guidelines under the Best Practices section be added to state, “use the Independent Adjuster Reciprocity Best Practices and Guidelines as the structure for license qualifications, continuing education (CE), and designated home state (DHS) requirements for nonresident licensing.” The Working Group discussed and agreed that this is already present in the Handbook. Ms. Brunette said SILA would withdraw the comment.

Mr. Murray said this completes the review of chapters 1–20 except for Chapter 10 Surplus Lines Producer Licenses, which is pending further discussion from Producer Licensing (D) Task Force. He said the remaining chapters are very short, and at this point, nothing has been received covering chapters 21–25. He said the deadline for these chapters has passed, unless there are any comments to bring forward to the Working Group. No comments were made, and Mr. Murray said chapters 21–25 would be considered completed as well.

Mr. Murray said there were a few areas that the Working Group agreed it would circle back on for additional discussion as the Working Group moves forward with its conference calls. He said one of those areas can be found in chapter 2, page 8 in the last paragraph under the Change of Home State section concerning the National Insurance Producer Registry (NIPR) launch of Contact Change Request (CCR). He said the Working Group deferred to NIPR to make suggested changes. He said Laurie Wolf (NIPR) submitted a suggestion that this language be eliminated. He said the fact that NIPR has not enhanced its CCR product to allow business entities the ability to change their addresses has no bearing on the Change of Home State language in this section and the need for the states to eliminate paper letters of clearance. Rather than provide language to incorporate the future state of NIPR’s CCR product, NIPR’s recommendation is to remove the last paragraph regarding the Change of Home State. Mr. Murray saidiker Group agreed to the deletion of this chapter.

Mr. Murray said Alaska, California, Rhode Island and Virginia reviewed the reciprocity examples found in chapter 4 on page 18. He said the group submitted revisions for examples A–F, and they have been posted on the Working Group webpage. He said the Working Group will be discussing this during its next conference call.

Mr. Murray said the deadline for chapters 26–30 will be Sept. 27, and at this point, there has been no comment submitted. He said the next call is scheduled for Oct. 10, and the Working Group will review chapters 26–30 in addition to any outstanding issues.

Having no further business, the Producer Licensing Uniformity (D) Working Group adjourned.
The Producer Licensing Uniformity (D) Working Group of the Producer Licensing (D) Task Force met via conference call Sept. 12, 2019. The following Working Group members participated: Chris Murray, Chair (AK); Peggy Dunlap (AR); Charlene Ferguson (CA); Matt Guy (FL); Lisa Tordjman (ID); Lorelei Brillante (MD); Leslie Page (MI); Karen Vourvopoulos (OH); Rachel Chester (RI); Larry Deiter (SD); Randy Overstreet (UT); Richard Tozer (VA); and Jeff Baughman (WA). Also participating was: Jeannie Keller (MT).

1. Reviewed the NAIC State Licensing Handbook

Mr. Murray said the Working Group’s last conference call was on Aug. 29, during which it finished up the review on chapters 11–15. He said that finalizes the review on chapters 1–15, excluding Chapter 8 Testing Exams and Chapter 10 Surplus Lines.

Mr. Murray said during the last conference call, it was decided that the Working Group would not be adopting the chapters as they are reviewed, but to wait until the review of all chapters has been completed. He said the deadline for this review has not changed and remains to be the end of October.

Mr. Murray said the Working Group has completed the review of all chapters in which comments have been received. During the last conference call, the Working Group did not discuss Chapter 8 Testing Exams since a representative from the American Council of Life Insurers (ACLI) could not be present. Mr. Murray said the ACLI submitted several comments on this chapter, and it will use today’s call to review and finalize any changes.

Mr. Murray said the first comment on chapter 8 can be found at the bottom of page 31. David Leifer (ACLI) stated that he would be speaking to the comments submitted by the ACLI. He said at the bottom of page 31, concerning the fourth item, he suggests adding the following language:

4. Depending on test volume, test performance, and the need for content changes, either an annual (or at least biannual) substantive review of the examination and the psychometric properties of the test items and the test, including:
   o These efforts should include The involvement of content or test development professionals, department personnel, and industry representatives, including recent, entry-level producers. Industry representatives should include a balanced mix of both recently licensed and more experienced producers.

Mr. Leifer said industry is asking the Working Group to adopt some broad criteria for reviews in order to bring uniformity to the process and ensure that these important events are executed in a meaningful manner that is consistent with the goals of maintaining fair, entry-level exams. He said industry is particularly interested in seeing the NAIC State Licensing Handbook (Handbook) include more language stressing the need to involve recently licensed producers in reviews and ensure that a system is in place to make sure all questions get reviewed over a reasonable course of time. This point is raised in an effort to address a situation we see in some states where reviews always begin with the Life & Health Bank and routinely run out of time before getting to the Life-only questions.

Ms. Vourvopoulos said she has concerns with a “balanced mix.” This would be difficult due to the availability of individuals. Mr. Tozer said Virginia would agree with this concern of having a “balance mix.” The Working Group discussed and agreed that the language would be accepted, excluding the word “balance.” The new language would now read:

4. Depending on test volume, test performance, and the need for content changes, either an annual (or at least biannual) substantive review of the examination and the psychometric properties of the test items and the test, including:
   o The involvement of content or test development professionals, department personnel, and industry representatives. Industry representatives should include a mix of both recently licensed and more experienced producers.
Mr. Murray said the next suggestion was to further add a bullet point to the same section reading:

- A determination by the assembled Subject Matter Experts (SMEs) of the difficulty level to be used for the test using proper psychometric procedures.

Ms. Chester said she would have concerns that this language would be beyond the scope of the state insurance regulators. She said the Working Group members are not psychometricians and should not add language to this section that would clearly be from a higher level of expertise than what the licensing directors on the call would possess. Ms. Keller said this suggestion would be adding new unnecessary language that gives a more detailed view, which goes beyond the scope of the Handbook.

Barb Gavitt (A.D. Banker) said these suggested comments are not pertaining to the difficulty of the individual questions, but rather the difficulty of the overall exam. She said there would be a difference from the individual questions and the exam as a whole. Mr. Murray said he would agree that there is more to the psychometricians formula that the state insurance regulators depend on for proper testing to take place.

Paula Sisneros (Pearson VUE) said she would agree that this does bring additional and unnecessary detail, which should actually be discussed and addressed outside of the review of the Handbook. She said she would encourage discussions outside of the Handbook discussion if the Working Group deemed them necessary.

Mr. Murray said he agrees that this should be set aside until further discussion is warranted. The Working Group discussed and agreed that no change would be made for this bulletin point.

Ms. Sisneros said she would echo her comments for the remaining suggestions from the ACLI. Ms. Chester and Ms. Vourvopoulos said they would agree.

The Working Group discussed and agreed that all remaining suggested changes on this section would not be accepted; however, further discussions outside of the Handbook review may be warranted to determine further issues that might be present.

Mr. Murray said the final comment from the ACLI can be found at the bottom of the chapter within the Producer Exam Content and Testing Administration Recommended Best Practices for Insurance Regulators. Mr. Murray said the suggestion is to the sixth bullet point to add “rate” to the second sentence of this bullet point. The Working Group discussed and agreed with adding language. The new language would read:

- At least annually, reports regarding exam pass rates, candidate demographics when collected, and number of exams administered should be made available to the public. Reports should include first-time pass rate, success rate and average scoring by subject area. Whenever possible, the reports should be available by education provider and provided to them.

Mr. Murray said this would conclude the discussion concerning Chapter 8 Testing Exams. He said the review of Chapter 10 Surplus Lines will remain on hold pending the discussion by the Producer Licensing (D) Task Force. He said the deadline for chapters 16–20 ended Aug. 30 and chapters 21–25 will end tomorrow, Sept. 13. He said the next conference call is scheduled for Sept. 26 and the goal will be to start reviewing chapters 16–25. He said at this point, the Working Group has only received two comments on chapter 18; however, since these comments were recently received, they have not been exposed long enough to discuss at this time. He said the deadlines for chapters 26–30 will be Sept. 27. He said the Working Group will have three remaining calls to finalize the review, Oct. 10, Oct. 24 and Oct. 30.

Having no further business, the Producer Licensing Uniformity (D) Working Group adjourned.
The Producer Licensing Uniformity (D) Working Group of the Producer Licensing (D) Task Force met via conference call Aug. 29, 2019. The following Working Group members participated: Chris Murray, Chair (AK); Peggy Dunlap (AR); Charlene Ferguson (CA); Matt Guy (FL); Lisa Tordjman (ID); Lorelei Brillante (MD); Leslie Page (MI); Karen Vourvopoulos (OH); Rachel Chester (RI); Larry Deiter (SD); Randy Overstreet (UT); Richard Tozer (VA); and Jeff Baughman (WA).

1. Reviewed the NAIC State Licensing Handbook

Mr. Murray said the purpose of this conference call is to continue on with discussions that ended during its Aug. 21 conference call. He reminded everyone that emails have been sent out explaining the plan to move forward with the review of the entire NAIC State Licensing Handbook (Handbook). He said the review would consist of five chapters at a time. He said to meet the Working Group’s Oct. 31 deadline, he has set up an aggressive comment and conference call schedule moving forward.

Mr. Murray said during the last conference call, the Working Group finalized the review of chapters 1–5 and began reviewing chapters 6–10. He said several comments were received from the American Council of Life Insurers (ACLI) concerning chapter 8; however, he has confirmed that a representative from the ACLI would not be able to attend today’s conference call, so he will push off this discussion until the next conference call. He said chapter 10 concerning surplus lines would also be skipped during today’s discussion and potentially even further since the Working Group is awaiting further discussion by the Producer Licensing (D) Task Force on adopting amendments to the Uniform Licensing Standards (ULS) for surplus lines. He said since the review of these two chapters is going to be put on hold, the decision was to be that the Working Group would continue to review the remaining chapters and then circle back to chapters 8 and 10 when appropriate, then a final adoption of the entire Handbook would be made once all the chapters have been reviewed, instead of adopting as each chapter is reviewed.

Mr. Murray said moving forward with the next step is to review chapters 11–15. He said the Working Group only received comments from California, Virginia, and the Securities and Insurance Licensing Association (SILA) concerning these chapters.

Mr. Murray said the first comment was from Virginia on chapter 11, page 51 found in the first paragraph. He said Virginia stated that there is a debate among the states on whether National Association of Registered Agents and Brokers (NARAB) membership would eliminate appointments for nonresidents. NARAB’s goal is to be revenue neutral for the states. The Working Group discussed and agreed that no change would be made.

Mr. Murray said California submitted a comment on chapter 12, page 53. Before the last two paragraphs on the page it states:

The PLMA does require that all producers, including BEs, notify the insurance commissioner prior to using an assumed name. Section 10 of the PLMA states:

An insurance producer doing business under any name other than the producer’s legal name is required to notify the insurance commissioner prior to using the assumed name.

Ms. Ferguson said California submitted the comment to verify whether the intent was to not only notify the commissioner, but also for the commissioner to have the authority to accept or reject it. The Working Group discussed and agreed that there is no reason to add further clarification.

Mr. Murray said the next comment was from SILA concerning chapter 12, page 53 towards the bottom of page found in the second to last paragraph. He said SILA’s comment states that it does not recall that a recent assessment of all state insurance departments licensing units has occurred to determine compliance with state uniformity requirements, so it would suggest removal of the word “recent.” However, SILA strongly agrees with the last sentence. The Working Group discussed and agreed that “recent” be changed to “prior.”

Mr. Murray said the next comment was from California on chapter 14, page 59 found in the second paragraph suggesting that “annuity” be added to the sentence “A specific CE standard, which is derived from federal mandates, may be imposed on nonresidents such as for long-term care insurance (LTCI), annuity, flood or crop insurance and would not violate the ULS.”
The Working Group discussed and agreed that following “long-term care insurance (LTCI),” the word “annuity” would be added.

Mr. Murray said California submitted a comment on chapter 14, page 59 within the third paragraph adding language to clarify that for a contact course, each state is to use its own method to award credit for self-study courses. The Working Group discussed and agreed to change this paragraph to now read:

Under the ULS, producers are to complete 24 credits of CE for each biennial compliance period. Three of the 24 credits must be in ethics.

Calculation of one credit hour of continuing education (CE) should be based on the NAIC Guidelines for CE. If applicable, the CE compliance period should coincide with the license renewal. The ULS indicate that the license term should be tied to the birth date or birth month.

Mr. Murray said the next comment from California on chapter 14, page 60 was within the second paragraph. Ms. Ferguson said California would like to verify what level of quality check is required. The Working Group discussed and agreed that no change would be made.

Mr. Murray said that completes the review of chapters 11–15. He said the deadline for comments on chapters 16–20 will be Aug. 30. He said the next conference call will be on Sept. 12.

Having no further business, the Producer Licensing Uniformity (D) Working Group adjourned.
Attachment Seven
Producer Licensing (D) Task Force
12/7/19

Draft: 11/5/19

Producer Licensing Uniformity (D) Working Group
Conference Call
August 21, 2019

The Producer Licensing Uniformity (D) Working Group of the Producer Licensing (D) Task Force met via conference call Aug. 21, 2019. The following Working Group members participated: Chris Murray, Chair (AK); Melissa Grisham (AR); Charlene Ferguson (CA); Matt Tamplin (FL); Leslie Page (MI); Karen Vourvopoulos (OH); Larry Deiter (SD); Randy Overstreet (UT); Richard Tozer (VA); Jeff Baughman (WA); and Melody Esquivel (WI). Also participating was: Greg Nelson (ND).

1. Reviewed the Handbook

Mr. Murray said the purpose of this conference call is to continue the review of the State Licensing Handbook (Handbook).

Mr. Murray said the review would consist of five chapters at a time. Mr. Murray said to meet the Working Group’s Oct. 31 deadline, he has set up an aggressive comment and conference call schedule moving forward.

Mr. Murray said to continue on with the review from the last conference call, the Working Group will begin with Chapter 2. He said Oregon submitted a question to clarify language pertaining to Chapter 2 that addresses Section 9 of the Producer Licensing Model Act (#218). Mr. Murray said Oregon also submitted a comment concerning the Producer Licensing Database (PDB) and State Producer Licensing Database (SPLD). Mr. Murray said a representative from Oregon is not on the conference call but would accept any discussion on their suggestions. The Working Group had no discussion on these comments.

Mr. Murray said the next comment is from South Carolina. Mr. Murray said the comment was a question concerning the following statement in the Handbook: “Some states still require the producer to provide a letter of clearance from the former state before the new state will grant the producer an active resident status.” South Carolina inquired whether this is still true. The Working Group discussed and agreed that some states require a letter of clearance, and no change was made.

Mr. Murray said Virginia submitted a comment pertaining to the same topic suggesting language be added stating: “despite the fact that all states have access to the PDB.” Mr. Tozer stated Virginia removed that comment.

Mr. Murray said the next comment from Virginia is in regard to the Reciprocity section addressing the National Insurance Producer Registry’s (NIPR) launch of the Contact Change Request (CCR). Mr. Tozer said Virginia suggested adding “individual” after “service allows.” Mr. Tozer said Virginia also recommends changing the current language reading “once all states” have fully implemented the CCR service. Mr. Tozer said all states have fully implemented the CCR service. Laurie Wolf (NIPR) said that NIPR can review the language and provide edits to reflect the appropriate changes. The Working Group discussed and agreed.

Mr. Murray said the next comment from Virginia concerns Chapter 2, page 10 under Section 16: Reciprocity. Mr. Murray said the suggestion is to add language to the second bullet point so that it mirrors the language found in Model #218. The new language would read: “A nonresident producer’s satisfaction of his or her home state’s continuing education requirements for licensed insurance producers shall constitute satisfaction of this state’s continuing education requirements if the non-resident producer’s home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this state on the same basis”.” The Working Group discussed and agreed to add the language.

Mr. Murray said the next few comments from Virginia concern Chapter 2 under the PLMA Implementation FAQ. The first is on Question 1. Mr. Tozer stated that Virginia would like to remove that suggestion. Mr. Tozer said the second comment concerns Question 2. The Working Group discussed and agreed no change would be made.

Mr. Murray said the next comment is on Chapter 4 from California. He said the suggestion is at the beginning of Chapter 4 under the four key components to licensing reciprocity. The suggestion is to add language to the fourth key component so that it would now read: “Reciprocity with Other States.” The Working Group discussed and agreed to make the change and to apply this throughout the chapter in other places were appropriate.

Mr. Murray said California submitted comments concerning the reciprocity examples found in Chapter 4. The Working Group discussed the examples and agreed to further review and provide new language to give further clarification.

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Mr. Murray said the next comment is on Chapter 4, page 18 requesting that the section on Limitations on Nonresident spell out U.S. as United States. The Working Group discussed and agreed with the change.

Mr. Murray said the next comment is from Virginia on Chapter 5, page 23 under the Commissions section. He said Virginia suggests adding language to stay consistent with Model #218 and adding a caveat that reads: “unless the payment would violate a state’s anti-rebating statues.” The Working Group discussed and agreed.

Mr. Murray said Virginia also suggests adding a language from the Model #218 language within the Exceptions to Licensing section specifically to the summary of types of persons and entities that are exempted from licensing. The new language would read:

1. An officer, director or employee of an insurer or insurance producer, provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in the state.
2. A person who secures and furnishes information for, or enrolls individuals in, group life insurance, group P/C insurance, group annuities or group, or blanket accident and health insurance; where no commission is paid to the person for the service.
3. An employer or association; its officers, directors, employees; or the trustees of an employee trust plan; not in any manner compensated, directly or indirectly, by the company issuing the contracts.
4. Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks.
5. A person whose activities in a state are limited to advertising without the intent to solicit insurance in that state.
6. A person who is not a resident of a state who sells, solicits or negotiates a contract of insurance for commercial P/C risks to an insured with risks located in more than one state insured under that contract.
7. A salaried, full-time employee who counsels or advises the employer relative to the insurance interests of the employer who does not receive commission.

Mr. Murray said that concludes the review on Chapters 1–5. He said since the decision was made to further discuss a few areas, the Working Group will hold off adopting Chapters 1–5 until the additional discussion has been completed.

Mr. Murray said moving forward with the Handbook review, the Working Group will start looking at Chapters 6–10. He said the first comment is from California on Chapter 6, page 25, third paragraph. Mr. Murray said since this section covers continuing education (CE), he would like to discuss with Rachel Chester, Uniform Education (D) Working Group chair, before making a final decision.

Mr. Murray said the next comment from Michigan concerns Chapter 8, page 32 under the PLMA Guidelines on Examination section, in the first paragraph. He said Michigan suggests adding language regarding the use of the PDB. The Working Group discussed and agreed no change would be made.

Mr. Murray said the next comment is also from Michigan on Chapter 8 at the bottom of page 34 concerning the professional test vendor, specifically the first step—“Conducting a committee-based job analysis”—and whether this is preferred over survey-based. The Working Group discussed, and no change was made.

Mr. Murray said California submitted a comment on Chapter 7 under the Fingerprinting section suggesting 1033 waiver guidelines be added to this section. The Working Group discussed and agreed that a link would be provided to Authorization for Criminal History Record Check Model Act (#222).

Mr. Murray said the next comment is from Michigan concerning Chapter 9, page 43 under the CE last sentence stating, “Under federal law, insurance producers selling MPCI are required to attend CE classes each year.” He said the questions is whether this is tracked or monitored by the federal government. There was no discussion by the Working Group.

Mr. Murray said that completes the review on Chapters 1–9. He said, however, the review of chapter 10 will be on hold pending further discussion by the Producer Licensing (D) Task Force on adopting amendments to the Uniform Licensing Standards (ULS) for surplus lines.

Mr. Murray said the redline for Chapters 1–9 would be posted on the Working Group’s web page for review. He said the
deadline for comments on Chapters 11–15 is Aug. 23 and to date, the Working Group has not received any comments. Mr. Murray said depending on what is received, the Working Group will begin discussing Chapter 11 during the Working Group’s next conference call, which is scheduled for Aug. 29.

Having no further business, the Producer Licensing Uniformity (D) Working Group adjourned.

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The Uniform Education (D) Working Group of the Producer Licensing (D) Task Force met via conference call Oct. 31, 2019. The following Working Group members participated: Rachel Chester, Chair (RI); Mike Beavers, Vice Chair (VA); Katie Damian (AK); Peggy Dunlap (AR); Charlene Ferguson (CA); Gene June and Matt Guy (FL); Lorelei Brillante (MD).

1. **Adopted the 2019 CER Agreement**

Ms. Chester said the Working Group has reviewed all comments submitted concerning the draft 2019 Continuing Education Reciprocity (CER) Agreement and made revisions as agreed upon by the Working Group. Ms. Chester said the updated version has been exposed for over several months and is considered complete except for one minor change. Ms. Chester said under “The Commissioners agree as follows:” section number 5(d) the Working Group agreed to add “ethics” to the list of items that are acceptable subject matter. Ms. Chester said the language would not read:

   d. Credits will only be awarded for courses whose subject matter will increase technical knowledge of insurance principles, coverages, ethics, laws or regulations and will not be awarded for topics such as personal improvement, motivation, time management, supportive office skills or other matters not related to technical insurance knowledge. If any credits are awarded for sales and/or marketing those credits will be separately noted on the course approval document. Credits for sales and/or marketing will only be awarded in States that are permitted by law or regulation to accept credit for those topics. Additional guidance can be found in the NAIC’s Recommended Approved/Not Approved Course Topics (APPENDIX C).

Mr. Beavers made a motion, seconded by Mr. Murray, to adopt the 2019 CER Agreement (*see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Five*). The motion passed unanimously.

Having no further business, the Uniform Education (D) Working Group adjourned.
Uniform Education (D) Working Group
Conference Call
August 22, 2019

The Uniform Education (D) Working Group of the Producer Licensing (D) Task Force met via conference call Aug. 22, 2019. The following Working Group members participated: Rachel Chester, Chair (RI); Mike Beavers, Vice Chair (VA); Katie Damian (AK); Peggy Dunlap (AR); Charlene Ferguson (CA); Gene June and Matt Guy (FL); and Lorelei Brillante (MD).

1. Discussed the CER Agreement

Ms. Chester said that during the Working Group’s last conference call on May 15, the recent draft version of the 2019 Continuing Education Reciprocity (CER) Agreement was distributed to the Working Group for review and comment. She said the Working Group previously reviewed comments from Washington and the Securities & Insurance Licensing Association (SILA). She said the Working Group also received comments from Florida, which it will be reviewing today.

Ms. Chester said Florida’s first comment was on page 1 of the draft 2019 CER Agreement pertaining to, “provider has procedures for reviewing course material in order to keep it up to date and timely.” She said Florida feels that it seems to be something more appropriate for a provider approval application vs. a course approval application. Wondering how other states will confirm/address this part of the substantive review. Mr. Gene said Florida does not want the providers to have to send some kind of procedure they have with each course submittal. Mr. June said Florida is questioning if it could either be removed or put in the instructions as some type of “understanding.” In Florida, keeping a course updated is a requirement in the Administrative Rule, but they are not asked to show how they plan to do it. Mr. June said Florida would like an example that would be substantive changes to a course requiring a new course submittal. The Working Group discussed and determined that each state has the duty to review the outlines they have in place for course approval and work with their provider to ensure that these state business rules and requirements are in place.

Ms. Chester said Florida’s second comment was on page 1 pertaining to, “[a] reciprocal State agrees to approve a course submission within 30 days of receipt, provided that the course is filed using the NAIC Uniform CER Course Filing Form (Exhibit A) or an equivalent electronic submission method and contains a home state course approval.” She said Florida advised that this seems to limit the documentation that a reciprocal state can ask for when a course application is submitted using the CER form. She said that Florida has a robust auditing program for education courses. When it comes time to audit one of these courses, which could be two months after approval or two years after approval, the auditor needs most all documentation related to the course. Ms. Chester said Florida would like to confirm that their two options are: 1) ask for the course documentation prior to an audit; or 2) ask for the course documentation during the course submission process, but not use it as part of the approval (the preferred option). The Working Group discussed and confirmed that the CER Form instructions require that details be submitted including an outline for course details to the home state. Ms. Chester said since this is listed in the CER Form and not listed in the CER Agreement, duplication should be avoided. Mr. June said Florida’s concern would be that the submission of course documentation is sent to the home state; however, if Florida wants to audit a non-resident state course, they would not have the course documentation. The Working Group discussed and confirmed with Florida that if they are conducting an audit, they can request documentation from the course provider at that time. Mr. June said that would satisfy Florida’s concerns.

Ms. Chester said Florida’s third comment was on page 2 pertaining to, “[e]ach State agrees that it will notify other States when a CE provider or instructor has been the subject of a formal administrative action or other disciplinary action by that State.” She said Florida’s concerns are that it does not sound like there is currently an electronic/efficient mechanism for doing this, but until one is developed, the states would work together to notify one another via a more manual process. The Working Group discussed using the NAIC Producer Licensing Bulletin Board or other distribution method to assist with distributing an action taken on a continuing education (CE) provider or instructor. Ms. Chester said she would discuss with NAIC staff viewing other potential options, including the bulletin board for distributing these actions amongst the states.

Having no further business, the Uniform Education (D) Working Group adjourned.
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The Financial Condition (E) Committee met in Austin, TX, Dec. 9, 2019. The following Committee members participated: David Altmaier, Chair (FL); Kent Sullivan, Vice Chair, and Jamie Walker (TX); Michael Conway represented by Rolf Kaumann (CO); Robert H. Muriel and Kevin Fry (IL); Eric A. Cioppa and Vanessa Sullivan (ME); Steve Kelley and Kathleen Or th (MN); Chlora Lindley-Myers and John Rehagen (MO); Matthew Rosendale represented by Steve Matthews (MT); Marlene Caride (NJ); Glen Mulready represented by Eli Snowbarger (OK); Raymond G. Farmer represented by Lee Hill (SC); James A. Dodrill represented by Justin Parr (WV); and Jeff Rude (WY).

1. **Adopted its Oct. 31, Aug. 29 and Summer National Meeting Minutes**

The Committee met Oct. 31, Aug. 29 and Aug. 5. During its Oct. 31 meeting, the Committee took the following action: 1) adopted its 2020 proposed charges; 2) adopted a Request for NAIC Model Law Development related to the group capital calculation (GCC); and 3) adopted revisions to the Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (#1556). During its Aug. 29 meeting, the Committee adopted proposed changes to the Annual Statement Instructions – Property/Casualty specifically related to the actuarial opinion, including, among other things, the definition of “qualified actuary.”

Commissioner Sullivan made a motion, seconded by Ms. Orth, to adopt the Committee’s Oct. 31 (Attachment One) Aug. 29 (Attachment Two) and Aug. 5 (see NAIC Proceedings – Summer 2019, Financial Condition (E) Committee) minutes. The motion passed unanimously.

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

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

Commissioner Lindley-Myers made a motion, seconded by Commissioner Caride, to adopt the following task force and working group reports: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; Valuation of Securities (E) Task Force; Group Capital Calculation (E) Working Group (Attachment Three); Mortgage Guaranty Insurance (E) Working Group (Attachment Four); National Treatment and Coordination (E) Working Group (Attachment Five); Restructuring Mechanisms (E) Working Group (Attachment Six); and Group Solvency Issues (E) Working Group (Attachment Seven). The motion passed unanimously.

The Financial Analysis (E) Working Group met Oct. 28 and Oct. 7 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses related to second-quarter 2019 financial results. Additionally, the Valuation Analysis (E) Working Group met Nov. 25 and Nov. 15 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss valuation items related to specific companies.

3. **Adopted the 2019 Examiners’ Suggested Salary Rate**

Commissioner Altmaier reminded the Committee members that each year, NAIC staff provide an average recommended increase for examiners’ salaries based on the consumer price index (CPI) for the prior year ending July 31. Commissioner Altmaier emphasized that in order to avoid negative impact to any states, the base compensation on the current salary and per diem guidelines, NAIC staff have continued to maintain the existing Financial Condition Examiners Handbook guidance on compensation, which is being updated via this memorandum. NAIC staff also recommend that the Risk-Focused
Surveillance (E) Working Group assume the responsibility to oversee development of updates to all compensation-related
guidance.

Commissioner Caride made a motion, seconded by Commissioner Lindley-Myers, to adopt the 2020 examiners’ suggested
salary rate (Attachment Eight). The motion passed unanimously

4. Adopted Revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions

Mr. Rehagen reminded members of the Committee that the NAIC originally adopted this process now being considered for
modification in 2013 as a method of evaluating the reinsurance supervisory systems of non-U.S. jurisdictions. He stated the
purpose was for developing and maintaining a list of jurisdictions for recognition by the states as qualified jurisdictions for
reinsurance collateral reduction purposes. He described how the process worked well over the years, and noted the NAIC
currently has seven qualified jurisdictions: Bermuda; France; Germany; Ireland; Japan; Switzerland; and the United Kingdom
(UK). He stated the expectation is that the NAIC Executive (EX) Committee and Plenary will approve the re-evaluations of
these seven qualified jurisdictions upon the completion of their initial five-year periods, effective for Jan. 1, 2020, during its
Dec. 10 meeting.

Mr. Rehagen noted that given the NAIC membership’s adopted revisions to the Credit for Reinsurance Model Law (#785) and
the Credit for Reinsurance Model Regulation (#786) in June, the proposed revisions for the process conform the models to the
reinsurance collateral elimination provisions of the “Bilateral Agreement Between the United States of America and the
European Union on Prudential Measures Regarding Insurance and Reinsurance” and the “Bilateral Agreement Between the
United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (Covered
Agreements). In addition, not only are jurisdictions that are subject to Covered Agreements treated as reciprocal jurisdictions
for reinsurance collateral purposes, but other qualified jurisdictions can also qualify for collateral elimination as reciprocal
jurisdictions. States that meet the requirements of the NAIC Financial Regulation Standards and Accreditation Program are
also considered to be reciprocal jurisdictions.

Mr. Rehagen reported that the Reinsurance (E) Task Force amended the process to reflect the revisions to Model #785 and
Model #786 and to add a new section on the review of qualified jurisdictions as reciprocal jurisdictions. In addition, the
Task Force added several improvements with respect to the evaluation of qualified jurisdictions, most important being the
elimination of the five-year re-evaluation requirement. He stated that, as revised, qualified jurisdictions and reciprocal
jurisdictions will remain on the lists until such time that there is a reason identified to remove them from the lists. He stated the
evaluations of Bermuda, Japan and Switzerland as reciprocal jurisdictions under this revised process will be considered by the
Executive (EX) Committee and Plenary during their Dec. 10 meeting, but this Committee needs to first approve the documented
modified process.

Mr. Rehagen made a motion, seconded by Superintendent Cioppa, to adopt the revised process for evaluating qualified and
reciprocal jurisdictions (Attachment Nine).

Having no further business, the Financial Condition (E) Committee adjourned.
The Financial Condition (E) Committee met via conference call Oct. 31, 2019. The following Committee members participated:

David Altmaier, Chair (FL); Kent Sullivan, Vice Chair, represented by Doug Slape, Jamie Walker and James Kennedy (TX); Ricardo Lara represented by Susan Bernard and Kim Hudson (CA); Michael Conway represented by Rolf Kaumann (CO); Robert H. Muriel represented by Susan Berry (IL); Chlora Lindley-Myers represented by John Rehagen (MO); Eric A. Cioppa represented by Vanessa Sullivan (ME); Mike Chaney represented by Chad Bridges (MS); Marlene Caride and Diana Sherman (NJ); Glen Mulready represented by Joel Sander (OK); Raymond G. Farmer represented by Lee Hill (SC); James A. Dodrill represented by Jamie Taylor (WV); and Jeff Rude represented by Linda Johnson (WY).

1. Adopted its 2020 Proposed Charges

Commissioner Altmaier stated that proposed charges had previously been shared and now incorporate final charges from task forces reporting to the Committee.

Mr. Kaumann made a motion, seconded by Commissioner Caride, to adopt its 2020 proposed charges (Attachment One-A). The motion passed unanimously.

2. Adopted a Request for NAIC Model Law Development

Commissioner Altmaier discussed that the Group Capital Calculation (E) Working Group recently adopted a Request for NAIC Model Law Development that requests the authority to make changes to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to add important confidentiality requirements to a group capital calculation (GCC) filing. He emphasized that the request seeks authority only to require such filing and hold it confidential but does not include any level of regulatory intervention as a result of the filing. He noted that technical changes would be contemplated as the confidentiality language is developed, but first it must seek the approval of the Committee and the Executive (EX) Committee. He noted that the Working Group will work with the Group Solvency Issues (E) Working Group to complete the task if approved.

Mr. Slape made a motion, seconded by Ms. Berry, to adopt the Request for NAIC Model Law Development (Attachment One-B). The motion passed unanimously.

3. Adopted a Guideline for Stay on Termination of Netting Agreements and QFCs

Mr. Kennedy said that the Receivership and Insolvency (E) Task Force drafted amendments to the NAIC’s Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (#1556). He stated that Guideline #1556 was originally adopted in 2013 to provide a temporary stay on qualified financial contracts (QFCs). He stated that currently Section 711 of the Insurer Receivership Model Act (#555) does not allow any type of a stay when a company is placed into receivership. He stated that in 2017, the Board of Governors of the Federal Reserve System (Federal Reserve), the Federal Deposit Insurance Corporation (FDIC) and the Office of the Comptroller of the Currency (OCC) each adopted final rules regarding financial contracts, including a definition of a master netting agreement. This definition recognizes the stay under federal rules but does not recognize stays under state receivership laws. This created a conflict with the current guideline. On Dec. 2, 2017, the Receivership and Insolvency (E) Task Force received a referral from the Financial Stability (EX) Task Force to evaluate whether there are any current misalignments between federal and state laws that could be an obstacle to achieving effective and orderly recovery and resolutions for U.S. insurance groups. To address the conflict with the federal rule, the drafting group proposed amendments to the drafting note of Guideline #1556 explaining the issue.

Mr. Kennedy made a motion, seconded by Mr. Rehagen, to adopt the revised Guideline #1556 (Attachment One-C). The motion passed unanimously.

Having no further business, the Financial Condition (E) Committee adjourned.
The mission of the Financial Condition (E) Committee is to be the central forum and coordinator of solvency-related considerations of the NAIC relating to accounting practices and procedures; blanks; valuation of securities; financial analysis and solvency; multistate examinations and examiner and analysis training; and issues concerning insurer insolvencies and insolvency guarantees. In addition, the Committee interacts with the technical task forces.

Ongoing Support of NAIC Programs, Products or Services

1. The Financial Condition (E) Committee will:
   B. Appoint and oversee the activities of the following: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Long-Term Care Insurance (B/E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; and Valuation of Securities (E) Task Force.
   C. Recommend salary rate adjustments for examiners.
   D. Oversee a process to address financial issues that may compromise the consistency and uniformity of the U.S. solvency framework, referring valuation and other issues to the appropriate committees as needed.
   E. Use the Risk-Focused Surveillance (E) Working Group to address specific industry concerns regarding regulatory redundancy and review any issues industry subsequently escalates to the Committee.

2. The Financial Analysis (E) Working Group will:
   A. Analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled; determine if appropriate action is being taken.
   B. Interact with domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and action(s).
   C. Support, encourage, promote and coordinate multistate efforts in addressing solvency problems, including identifying adverse industry trends.
   D. Increase information-sharing and coordination between state regulators and federal authorities, including through representation of state regulators in national bodies with responsibilities for system-wide oversight.

3. The Group Capital Calculation (E) Working Group will:
   A. Construct a U.S. group capital calculation (GCC) using a RBC aggregation methodology. Complete by the 2020 Summer National Meeting. Liaise as necessary with the ComFrame Development and Analysis (G) Working Group on international capital developments and consider group capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation.
   B. Provide direction to the Group Solvency Issues (E) Working Group on appropriate changes to existing authority or existing regulatory guidance related to the GCC. Complete by the 2020 Fall National Meeting.
   C. Liaise, as necessary, with the International Insurance Relations (G) Committee on international group capital developments and consider input from participation of U.S. state insurance regulators in the International Association of Insurance Supervisors (IAIS) monitoring process.
   D. Continually review and monitor the effectiveness of the GCC and consider revisions, as necessary, to maintain the effectiveness of its objective under U.S. solvency system.

4. The Group Solvency Issues (E) Working Group will:
   A. Continue to develop potential enhancements to the current regulatory solvency system as it relates to group- solvency-related issues.
B. Critically review and provide input and drafting to the International Association of Insurance Supervisors (IAIS), Insurance Groups Working Group or on other IAIS material dealing with group supervision issues.

C. Continually review and monitor the effectiveness of the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) and consider revisions as necessary to maintain effective oversight of insurance groups.

C-D. Assess the IAIS Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) and make recommendations on its implementation in a manner appropriate for the U.S.

5. The ORSA Implementation (E) Subgroup of the Group Solvency Issues (E) Working Group will:
   A. Continue to provide and enhance an enterprise risk management (ERM) education program for regulators in support of the Own Risk and Solvency Assessment (ORSA) implementation.
   B. Continually review and monitor the effectiveness of the Risk Management and Own Risk and Solvency Assessment Model Act (#505) and its corresponding NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual; consider revisions as necessary.

6. The Mortgage Guaranty Insurance (E) Working Group will:
   A. Develop changes to the Mortgage Guaranty Insurance Model Act (#630) and other areas of the solvency regulation of mortgage guaranty insurers, including, but not limited to, revisions to Statement of Statutory Accounting Principles (SSAP) No. 58—Mortgage Guaranty Insurance and develop an extensive mortgage guaranty supplemental filing. Oversee the work of the consultant on the testing and finalization of proposed risk-based mortgage guaranty capital model and finalize Model #630 by the 2019 SpringSummer National Meeting.

7. The NAIC/AICPA (E) Working Group will:
   A. Continually review the Annual Financial Reporting Model Regulation (#205) and its corresponding implementation guide; revise as appropriate.
   B. Address financial solvency issues by working with the American Institute of Certified Public Accountants (AICPA) and responding to AICPA exposure drafts.
   C. Monitor the federal Sarbanes-Oxley Act, as well as rules and regulations promulgated by the U.S. Securities and Exchange Commission (SEC), the Public Company Accounting Oversight Board (PCAOB) and other financial services regulatory entities.
   D. Review annually the premium threshold amount included in Section 16 of Model #205, with the general intent that those insurers subject to the Section 16 requirements would capture at least approximately 90% of industry premium and/or in response to any future regulatory or market developments.

8. The National Treatment and Coordination (E) Working Group will:
   A. Increase utilization and implementation of the Company Licensing Best Practices Handbook.
   B. Encourage synergies between corporate changes/amendments and rate and form filing review and approval to improve efficiency.
   C. Continue to monitor the usage and make necessary enhancements to the Form A Database.
   D. Maintain educational courses in the existing NAIC Insurance Regulator Professional Designation Program for company licensing regulators.

9. The Biographical Third-Party Review (E) Subgroup of the National Treatment and Coordination (E) Working Group will:
   A. Increase the uniformity of the third-party vendors that prepare background investigative reports to those state insurance departments that require them. Reduce the inefficiency of applications by developing procedures and approval processes.
   B. Monitor the ongoing adherence of background investigation reports and third-party vendors.
   C. Encourage uniformity of requirements in relation to individuals’ fitness and propriety and the company’s responsibility in notifying state insurance departments of concerns or changes to key individuals.

10. The Restructuring Mechanisms (E) Working Group will:
    A. Evaluate and prepare a White Paper that:
        1. Addresses the perceived need for restructuring statutes and the issues those statutes are designed to remedy.
        Also, consider alternatives that insurers are currently employing to achieve similar results.
2. Summarizes the existing state restructuring statutes.
3. Addresses the legal issues posed by an Order of a Court (or approval by an Insurance Department) in one state affecting the policyholders of other states.

**FINANCIAL CONDITION (E) COMMITTEE (continued)**

4. Considers the impact that a restructuring might have on Guaranty Associations and policyholders that had Guaranty Fund protection prior to the restructuring. Complete by the 2020 Summer National Meeting.
   B. Identifies and addresses the legal issues associated with restructuring using a protected cell. Complete by the 2020 Summer National Meeting.
   B.C. Consider requesting approval from the Executive (EX) Committee on developing changes to specific NAIC models as a result of findings from the development of the White Paper. Complete by the 2020 Fall National Meeting.
   Review and propose changes to the Guaranty Association Model Act to ensure that policyholders that had guaranty fund protection prior to a restructuring continue to have it after the restructuring.
   Review and propose changes to the Protected Cell Companies Model Act to allow for restructuring mechanisms.
   Develop financial solvency and reporting requirements for companies in runoff (create subgroup of qualified financial regulators to address this charge).

11. The Restructuring Mechanisms (E) Subgroup will:
   A. Develop best practices to be used in considering the approval of proposed restructuring transactions, including among other things, the expected level of reserves and capital expected after the transfer along with the adequacy of long-term liquidity needs, and also develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for their consideration. Complete by the 2020 Summer National Meeting.
   Consider the development of financial surveillance tools that are specifically designed for companies in runoff (companies that are no longer actively writing insurance business or collecting premiums).
   B. Consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff. Complete by the 2020 Fall National Meeting.
   C. Review the various restructuring mechanisms and develop, if deemed needed, protected cell accounting and reporting requirements for referring to the Statutory Accounting Principles (E) Working Group. Complete by the 2020 Fall National Meeting.
      A. Minimum standards of review
      B. Minimum capital requirements
      C. Specific actuarial guidance in determining initial reserving levels
      D. Protected cell reporting requirements
      E. Proposed accreditation standards

12. The Risk-Focused Surveillance (E) Working Group will:
   A. Continually review the effectiveness of risk-focused surveillance and develop enhancements to processes as necessary.
   B. Continually review regulatory redundancy issues identified by interested parties and provide recommendations to other NAIC committee groups to address as needed.
   C. Oversee and monitor the Peer Review Program to encourage consistent and effective risk-focused surveillance processes.
   D. Consider recommendations to the Financial Regulation Standards and Accreditation (F) Committee for the purpose of evaluating the suitability of insurance department staffing in relation to the necessary skill sets. Complete by the 2019 Fall National Meeting.
   E. Continually maintain and update standardized job descriptions/requirements and salary range recommendations for common solvency monitoring positions to assist insurance departments in attracting and maintaining suitable staff.
   F. D. Review the Financial Condition Examiners Handbook salary and per diem guidelines to determine the applicability, value and use to the states; consider alternative approaches based on current financial solvency responsibilities. Complete by the 2019 Fall National Meeting.

13. The Valuation Analysis (E) Working Group will:
   A. Respond to states in a confidential forum regarding questions and issues arising during the course of annual principle-based reserving (PBR) reviews or PBR examination and which also may include consideration of asset adequacy analysis questions and issues.
B. Work with NAIC resources to assist in prioritizing and responding to issues and questions regarding PBR and asset adequacy analysis including actuarial guidelines or other requirements making use of or relating to PBR such as Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38), Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued Under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48), and the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).

C. Develop and implement a plan with NAIC resources to identify outliers/concerns regarding PBR/asset adequacy analysis.

D. Refer questions/issues as appropriate to the Life Actuarial (A) Task Force that may require consideration of changes/interpretations to be provided in the Valuation Manual.

E. Assist NAIC resources in development of a standard asset/liability model portfolio used to calibrate company PBR models.

F. Make referrals as appropriate to the Financial Analysis (E) Working Group.

G. Perform other work to carry out the Valuation Analysis (E) Working Group procedures.

14. The Variable Annuities Issues (E) Working Group will:
   A. Oversee the NAIC’s efforts to study and address, as appropriate, regulatory issues resulting in variable annuity captive reinsurance transactions.

NAIC Support Staff: Dan Daveline/Julie Gann/Bruce Jenson
2020 Proposed Charges

ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Accounting Practices and Procedures (E) Task Force will:

2. The Blanks (E) Working Group will:
   A. Consider improvements and revisions to the various annual/quarterly statement blanks to:
      1. Conform these blanks to changes made in other areas of the NAIC to promote uniformity in reporting of financial information by insurers.
      2. Develop reporting formats for other entities subject to the jurisdiction of state insurance departments.
      3. Conform the various NAIC blanks and instructions to adopted NAIC policy.
      4. Oversee the development of additional reporting formats within the existing annual financial statements as needs are identified.
   B. Continue to monitor state filing checklists to maintain current filing requirements.
   C. Continue to monitor and improve the quality of financial data filed by insurance companies by recommending improved or additional language for the Annual Statement Instructions.
   D. Continue to monitor and review all proposals necessary for the implementation of statutory accounting guidance to ensure proper implementation of any action taken by the Accounting Practices and Procedures (E) Task Force affecting annual financial statements and/or instructions.
   E. Continue to coordinate with other task forces of the NAIC to ensure proper implementation of reporting and instructions changes as proposed by these task forces.
   F. Coordinate with the Life Actuarial (A) Task Force to use any special reports developed and avoid duplication of reporting.
   G. Review requests for investment schedule blanks and instructions changes in connection with the work being performed by the Investment Risk-Based Capital (E) Working Group.
   H. Review changes requested by the Valuation of Securities (E) Task Force relating to its work on other invested assets reporting for technical consistency within the investment reporting schedules and instructions.

3. The Statutory Accounting Principles (E) Working Group will:
   A. Maintain codified statutory accounting principles by providing periodic updates to the guidance that address new statutory issues and new generally accepted accounting principles (GAAP) pronouncements. Provide authoritative responses to questions of application and clarifications for existing statutory accounting principles. Report all actions and provide updates to the Accounting Practices and Procedures (E) Task Force.
   B. At the discretion of the Working Group chair, develop comments on exposed GAAP and International Financial Reporting Standards (IFRS) pronouncements affecting financial accounting and reporting. Any comments are subject to review and approval by the chairs of the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee.
   C. Coordinate with the Life Actuarial (A) Task Force on changes to the Accounting Practices and Procedures Manual (AP&P Manual) related to the Valuation Manual VM-A, Requirements, and VM-C, Actuarial Guidelines, as well as other Valuation Manual requirements. This process will include the receipt of periodic reports on changes to the Valuation Manual on items that require coordination.
ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE (continued)

D. Obtain, analyze and review information on permitted practices, prescribed practices or other accounting treatments suggesting that issues or trends occurring within the industry may compromise the consistency and uniformity of statutory accounting, including, but not limited to, activities conducted by insurers for which there is currently no statutory accounting guidance or where the states have prescribed statutory accounting that differs from the guidance issued by the NAIC. Use this information to consider possible changes to statutory accounting.

E. Develop specific statutory accounting guidance for certain limited derivative contracts hedging variable annuity guarantees, subject to fluctuations as a result of interest rate sensitivity, reserved for in accordance with Actuarial Guideline XLIII—CARVM for Variable Annuities (AG 43). This guidance shall place an emphasis on reducing non-economic surplus volatility for these specific hedges in situations where strong risk management is in place, with safeguards to ensure appropriate financial statement presentation and disclosures, sufficient transparency, and regulatory oversight. This charge shall be a high priority, with the earliest effective date feasible that allows for adequate development of guidance and related reporting schedules. Complete by the 2019 Summer National Meeting.

F. Consider whether current or future changes to reserves resulting from implementation of the Variable Annuities Framework will be reported in the annual financial statement as a “change in basis.” Complete by the 2019 Summer National Meeting.

G. Review and possibly modify Schedule F and any corresponding annual financial statement pages to determine how best to reflect the expected changes to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786). Give due consideration to alternatives, including whether an allowance for doubtful accounts is appropriate. Complete by the 2020 Fall National Meeting.

H. Develop a model guideline that represents narrowly defined statutory language the states may use in removing the limitations that may exist within their investment statutes that may otherwise limit the extent of hedges an insurer may use in its risk management. Complete by the 2019 Fall National Meeting.

NAIC Support Staff: Robin Marcotte
Attachment One-A
Financial Condition (E) Committee
12/9/19

Draft: 10/17/19
Adopted by the Executive (EX) Committee and Plenary, Dec. 10, 2019
Adopted by the Financial Condition (E) Committee, Oct. 31, 2019
Adopted by the Capital Adequacy (E) Task Force, Sept. 18, 2019

2020 Proposed Charges

CAPITAL ADEQUACY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Capital Adequacy (E) Task Force will:
   A. Evaluate emerging “risk” issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
   B. Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
   C. Review and possibly modify the life and health RBC formulas specific to reinsurance credit risk charges to be based on the financial strength of the reinsurer consistent with the property/casualty (P/C) RBC formula, giving due consideration to public default experience and current factors used by credit rating agencies. Consider also whether adjustments are needed to the P/C RBC formula to consider such information relative to non-rated reinsurers. Complete by the 2020 Fall National Meeting.

2. The Health Risk-Based Capital (E) Working Group, Life Risk-Based Capital (E) Working Group and Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Evaluate refinements to the existing NAIC risk-based capital (RBC) formulas implemented in the prior year. Forward the final version of the structure of the current year life and fraternal, property/casualty (P/C), and health and fraternal RBC formulas to the Financial Condition (E) Committee by June.
   B. Consider improvements and revisions to the various RBC blanks to: 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity; and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified. Any proposal that affects the RBC structure must be adopted no later than April 30 in the year of the change, and adopted changes will be forwarded to the Financial Condition (E) Committee by the next scheduled meeting or conference call. Any adoptions made to the annual financial statement blanks or statutory accounting principles that affect an RBC change adopted by April 30 and results in an amended change may be considered by July 30 for those exceptions where the Capital Adequacy (E) Task Force votes to pursue by super-majority (two-thirds) consent of members present, no later than June 30 for the current reporting year.
   C. Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the revised Accounting Practices and Procedures Manual (AP&P Manual) to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives.
   D. Review the effectiveness of the NAIC’s RBC policies and procedures as they affect the accuracy, audit ability, timeliness of reporting access to RBC results and comparability between the RBC formulas. Report on data quality problems in the prior year RBC filings at the summer and fall national meetings.

3. The Investment Risk-Based Capital (E) Working Group will:
   A. Evaluate relevant historical data and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the risk-based capital (RBC) formulas and delivering those recommendations to the Capital Adequacy (E) Task Force.

4. The Variable Annuities Capital and Reserve (E/A) Subgroup, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor the impact of the changes to the variable annuities reserve framework and risk-based capital (RBC) calculation, and determine if additional revisions need to be made. Develop and recommend changes to C-3 Phase II, Actuarial Guideline XLIII—CARVM for Variable Annuities (AG 43) and VM-21, Requirements for Principle-Based Reserves for Variable Annuities, that implement the Variable Annuities Framework. Complete by the 2019...
Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.

CAPITAL ADEQUACY (E) TASK FORCE (continued)

5. The Longevity Risk (A/E) Subgroup, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Provide recommendations for recognizing longevity risk in statutory reserves and/or risk-based capital (RBC), as appropriate. Complete by the 2020 Spring National Meeting.

6. The Operational Risk (E) Subgroup will:
   A. Evaluate growth-related operational risk for life risk-based capital (RBC) and health RBC. Any recommendations for remaining work on growth risk will be referred to the Life Risk-Based Capital (E) Working Group and/or the Health Risk-Based Capital (E) Working Group, after which the Subgroup will be disbanded. Complete by the 2019 Spring National Meeting.

7. The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Recalculate the premium risk factors on an ex-catastrophe basis, if needed.
   B. Continue to update the U.S. and non-U.S. catastrophe event list.
   C. Continue to evaluate the need for exemption criteria for insurers with minimal risk.
   D. Evaluate the risk-based capital (RBC) results inclusive of a catastrophe risk charge.
   E. Refine instructions for the catastrophe risk charge.
   F. Continue to evaluate any necessary refinements to the catastrophe risk formula.
   G. Evaluate other catastrophe risks for possible inclusion in the charge.

NAIC Support Staff: Jane Barr
2020 Proposed Charges

EXAMINATION OVERSIGHT (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Examination Oversight (E) Task Force will:
   A. Accomplish its mission using the following groups:
      5. IT Examination (E) Working Group.

2. The Electronic Workpaper (E) Working Group will:
   A. Monitor and support the state insurance departments in using electronic workpaper software tools to conduct and document solvency monitoring activities.
   B. Provide ongoing oversight to the NAIC’s Electronic Workpaper Hosting Project.
   C. Develop a framework to meet the long-term hosting and software needs of state insurance regulators in using electronic workpapers to conduct and document solvency monitoring activities. Ensure that solutions developed consider various state insurance regulator uses, as appropriate.

3. The Financial Analysis Solvency Tools (E) Working Group will:
   A. Provide ongoing maintenance and enhancements to the Financial Analysis Handbook and related applications for changes to the NAIC annual/quarterly financial statement blanks, as well as enhancements developed to assist in the risk-focused analysis and monitoring of the financial condition of insurance companies and groups. Monitor the coordination of analysis activities of holding company groups, and coordinate and analyze input received from other state regulators.
   B. Provide ongoing development maintenance and enhancements to the automated financial solvency tools developed to assist in conducting risk-focused analysis and monitoring the financial condition of insurance companies and groups. Prioritize and perform analysis to ensure that the tools remain reliable and accurate.
   C. Coordinate with the Financial Examiners Handbook (E) Technical Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.
   D. In compliance with the framework developed by the former PBR Review (EX) Working Group.
   E. Continue to provide advice to regulators, identifying and judging risk, establishing appropriate procedures, identifying frequency of model reviews, and documenting best practices. Address all risks, financial and non-financial; e.g., enterprise risk management (ERM), board, corporate governance and the Own Risk and Solvency Assessment (ORSA).
   F. Continue to adjust the Financial Analysis Handbook and current financial analysis solvency tools for life insurance companies based on any recommendations as requested from the Life Actuarial (A) Task Force to incorporate...
principle-based reserving (PBR) changes.

EXAMINATION OVERSIGHT (E) TASK FORCE (continued)

4. The Financial Examiners Coordination (E) Working Group will:
   A. Develop enhancements that encourage the coordination of examination activities with regard to holding company groups.
   B. Promote coordination by assisting and advising domiciliary regulators and exam coordinating states as to what might be the most appropriate regulatory strategies, methods and actions regarding financial examinations of holding company groups.
   C. Facilitate communication among regulators regarding common practices and issues arising from coordinating examination efforts.
   D. Provide ongoing maintenance and enhancements to the Financial Examination Electronic Tracking System (FEETS).

5. The Financial Examiners Handbook (E) Technical Group will:
   A. Continually review the Financial Condition Examiners Handbook and revise, as appropriate.
   B. Coordinate with the Risk-Focused Surveillance (E) Working Group to monitor the implementation of the risk-assessment process by developing additional guidance and exhibits within the Financial Condition Examiners Handbook, including consideration of potential redundancies affected by the examination process, corporate governance and other guidance as needed to assist examiners in completing financial condition examinations.
   C. Coordinate with the Financial Analysis Handbook (E) Working Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.
   D. Coordinate with the IT Examination (E) Working Group and the Financial Examiners Coordination (E) Working Group to maintain specialized areas of guidance within the Financial Condition Examiners Handbook related to the charges of these specific working groups.
   E. In compliance with the framework developed by the former PBR Review (EX) Working Group:
      1. Continue to provide advice to regulators, identifying and judging risk, building repositories, evaluating controls, determining the extent of data quality testing (by actuaries and examiners), identifying frequency of model reviews and documenting best practices. Address all risks, financial and non-financial; e.g., enterprise risk management (ERM), board, corporate governance and the Own Risk and Solvency Assessment (ORSA).
      2. Continue to adjust the Financial Condition Examiners Handbook based upon any recommendations as requested from the Life Actuarial (A) Task Force to incorporate principle-based reserving (PBR) changes.

6. The IT Examination (E) Working Group will:
   A. Continually review and revise, as needed, the “General Information Technology Review” and “Exhibit C—Evaluation of Controls in Information Systems” sections of the Financial Condition Examiners Handbook.
   B. Coordinate with the Market Conduct Examination Standards (D) Working Group to assist in the development of regulatory oversight policy with respect to cybersecurity examination issues, as requested by the Innovation and Technology (EX) Task Force.

NAIC Support Staff: Miguel Romero
LONG-Term CARE INSURANCE (B/E/B) TASK FORCE

Ongoing Support of NAIC Programs, Products or Services

1. The Long-Term Care Insurance (B/E/B) Task Force of the Health Insurance and Managed Care (B) Committee and Financial Condition (E) Committee will:
   A. Coordinate all aspects of the NAIC’s work regarding the long-term care insurance (LTCI) market. In addition to coordinating all current Health Insurance and Managed Care (B) Committee and Financial Condition (E) Committee projects, the Task Force should pursue the following general objectives:
      2. Evaluate the sufficiency of current financial reporting. Complete by the 2019 Fall National Meeting.
      3. Assess state activities regarding the regulatory considerations on rate increase requests on blocks and to identify common elements for achieving greater transparency and predictability.
      5. Provide periodic reports to the Health Insurance and Managed Care (B) Committee and the Financial Condition (E) Committee, as well as the Executive (EX) Committee, regarding key issues and progress toward the general objectives set forth above. Conduct meetings in regulator-to-regulator session, as appropriate.

NAIC Support Staff: Dan Daveline/Jolie Matthews
2020 Proposed Charges

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Receivership and Insolvency (E) Task Force will:
   A. Monitor and promote efficient operations of insurance receiverships and guaranty associations funds.
   B. Monitor and promote state adoption of insurance receivership and guaranty association related-model acts and regulations and monitor other legislation related to insurance receiverships and guaranty associations.
   C. Provide input and comments to the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB) or other related groups on issues regarding international resolution authority.
   D. Monitor, review and provide input on federal rulemaking and studies related to insurance receiverships.
   E. Provide ongoing review of maintenance and enhancements to the Receiver's Handbook for Insurance Company Insolvencies (Receiver's Handbook), other related NAIC publications, and the Global Receivership Information Database (GRID), and make any necessary updates.
   F. Monitor the work of other NAIC committees, task forces and working groups to identify and address any issues that affect receivership law and/or regulatory guidance.
   G. Perform additional work as directed by the Financial Condition (E) Committee and/or received through referral by other groups.

2. The Receivership Financial Analysis (E) Working Group will:
   A. Monitor receiverships involving nationally significant insurers/groups within receivership to support, encourage, promote and coordinate multistate efforts in addressing problems.
   B. Interacting with the Financial Analysis (E) Working Group, domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and/or action(s) with regard to potential or pending the receiverships.

3. The Receivership Large Deductible Workers' Compensation (E) Working Group will:
   A. Perform Complete work based on recommendations for possible enhancements to the U.S. receivership regime, as approved and directed by the Receivership and Insolvency (E) Task Force, resulting from a study of the states' receivership laws and practices related to the receivership of insurers with significant books of large deductible workers' compensation business. Complete by the 202019 FallSummer National Meeting.

4. The Receivership Model Law (E) Working Group will:
   A. Review and provide recommendations on any issues identified that may affect the states’ receivership and guaranty association model laws; for example, any issues that arise as a result of market conditions, insurer insolvencies, federal rulemaking and studies, international resolution initiatives or as a result of the work performed by other NAIC committees, task forces and/or working groups.
   B. Discuss significant cases that may affect the administration of receiverships.
C. Complete work, as assigned from the Task Force, to address recommendations from the Financial Stability (EX) Task Force’s Macroprudential Initiative (MPI) referral as follows:

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE (continued)

2. Explore if bridge institutions could be implemented under regulatory oversight pre-receivership to address an early termination of qualified financial contracts (QFCs), and if appropriate, develop applicable guidance. Review the Receiver's Handbook guidance on QFCs and, if necessary, draft enhancements. Identify related pre-receivership considerations related to QFCs and, if necessary, make referrals to other relevant groups to enhance pre-receivership planning, examination and analysis guidance. and,
   — Review and provide recommendations for remedies to ensure continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Consult with the Group Solvency Issues (E) Working Group as the topic relates to affiliated intercompany agreements.

3. Complete by the 2020 Fall National Meeting.

A. Monitor, and provide recommendations for possible enhancements to the U.S. receivership regime and the states' receivership laws and practices based on, international supervisory and advisory developments regarding recovery, resolution, receivership and liquidation, including, but not limited to, the Financial Stability Board's (FSB) Key Attributes of Effective Resolution Regimes for Financial Institutions (KA) and Assessment Methodology (AM) and the International Association of Insurance Supervisors' (IAIS) Insurance Core Principles (ICPs) and its Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) (particularly ICP 10, Preventive and Corrective Measures and ICP 12, Winding up and Exit from the Market, as well as related ComFrame materials). Complete by the 2019 Fall National Meeting.

NAIC Support Staff: Jane Koenigsman
2020 Proposed Charges

REINSURANCE (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Reinsurance (E) Task Force will:
   A. Provide a forum for the consideration of reinsurance-related issues of public policy.
   C. Oversee the activities of the Qualified Jurisdiction (E) Working Group.
   D. Monitor the implementation of the 2011, 2016 and 2019 revisions to the Credit for Reinsurance Model Law (#785), and the 2011 and 2019 revisions to the Credit for Reinsurance Model Regulation (#786), and the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).
   E. Communicate and coordinate with the Federal Insurance Office (FIO) and other federal authorities on matters pertaining to reinsurance.
   F. Consider any other issues related to the revised Model #785, Model #786 and Model #787.
   G. Monitor the development of international principles, standards and guidance with respect to reinsurance. This includes, but is not limited to, monitoring the activities of various groups within the International Association of Insurance Supervisors (IAIS), including the Reinsurance and Other Forms of Risk Transfer Subcommittee, the Reinsurance Mutual Recognition Subgroup and the Reinsurance Transparency Group.
   H. Consider the impact of reinsurance-related federal legislation, including, but not limited to, the federal Nonadmitted and Reinsurance Reform Act (NRRA) and the Federal Insurance Office Act, and coordinate any appropriate NAIC action.
   I. Consider Continue to monitor the impact of reinsurance-related international agreements, including the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Bilateral Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement) between the U.S. and the United Kingdom.
   J. The Reinsurance (E) Task Force is directed to develop revisions to Model #785 and Model #786 to conform to the terms of the Bilateral Agreement.
   K. The Reinsurance (E) Task Force is directed to develop revisions to Model #785 and Model #786 to allow reinsurers domiciled in NAIC-qualified jurisdictions other than within the European Union (EU) to realize reinsurance collateral requirements similar to those provided under the Bilateral Agreement under specified circumstances. In order for an insurer domiciled in a qualified jurisdiction outside of the EU to receive the same collateral requirement treatment as provided to EU-domiciled reinsurers, that non-EU qualified jurisdiction must agree to adhere to all other standards imposed upon the EU in the Bilateral Agreement, including the requirement that the qualified jurisdiction must agree to recognize the states’ approach to group supervision, including group capital. As part of its deliberations, the Task Force should consult with international regulators, in addition to all other interested parties.
   L. The Reinsurance (E) Task Force is directed to develop revisions to Model #785 and Model #786 to address the effect of a breach of the Bilateral Agreement (as determined pursuant to its terms) on a reinsurance’s collateral obligations and the effect of a failure of a non-EU qualified jurisdiction to meet the standards imposed by its agreement or acknowledgment to adhere to the terms of the Bilateral Agreement and/or the model law and regulation.
   M. In conjunction with any revisions to Model #785 and Model #786, the Qualified Jurisdiction (E) Working Group is directed to consider changes to the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions to require that qualified jurisdictions recognize key NAIC solvency initiatives, including group supervision and group capital standards, as well as require strengthening of the information-sharing requirements between the states and qualified jurisdictions, in order for reinsurers domiciled in qualified jurisdictions to receive similar treatment to EU reinsurers under the Bilateral Agreement, and processes of removal of qualified jurisdiction status in the event of a breach.
2. The **Reinsurance Financial Analysis (E) Working Group** will:
   A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings and operate in open session when discussing certified reinsurance topics and policy issues, such as amendments to the Uniform Application for Certified Reinsurers.
   B. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.
   C. Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities or individuals.
   D. Support, encourage, promote and coordinate multistate efforts in addressing issues related to certified reinsurers, including, but not limited to, multistate recognition of certified reinsurers.
   E. Provide analytical expertise and support to the states with respect to certified reinsurers and applicants for certification.
   F. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.
   G. Ensure the public passporting website remains current.
   H. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.

3. The **Qualified Jurisdiction (E) Working Group** will:
   A. Maintain the [NAIC List of Qualified Jurisdictions](#) and the [NAIC List of Reciprocal Jurisdictions](#) in accordance with the [Process for Evaluating Qualified and Reciprocal Jurisdictions](#).
REINSURANCE (E) TASK FORCE (continued)

F. Interact with domiciliary regulators of ceding insurers and certifying states to assist and advise on the most appropriate regulatory strategies, methods and actions with respect to certified reinsurers.

G. Provide guidance and expertise on regulatory policy and practices with respect to certified reinsurers.

H. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.

I. Monitor and ensure the public passporting website remains current and provide recommendations to the Task Force if amendments are required.

J. Consider changes in its current methods of monitoring certified reinsurers domiciled in qualified jurisdictions to incorporate changes to state reinsurance collateral requirements caused by the “Bilateral Agreement Between the United States of America and the European Union (EU) on Prudential Measures Regarding Insurance and Reinsurance” (Bilateral Agreement) and any changes to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) to provide similar treatment to reinsurers domiciled in qualified jurisdictions. Complete by the 2019 Fall National Meeting. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.

2. The Qualified Jurisdiction (E) Working Group will:

   A. Develop and maintain the NAIC List of Qualified Jurisdictions in accordance with the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions.

   B. In conjunction with any revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786), the Working Group is directed to consider changes to the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions to require that qualified jurisdictions recognize key NAIC solvency initiatives, including group supervision and group capital standards, as well as require strengthening of the information-sharing requirements between the states and qualified jurisdictions, in order for reinsurers domiciled in qualified jurisdictions to receive similar treatment to reinsurers domiciled in Europe under the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Bilateral Agreement), and processes of removal of qualified jurisdiction status in the event of a breach.

   Maintain the NAIC List of Qualified Jurisdictions and the NAIC List of Reciprocal Jurisdictions in accordance with the Process for Evaluating Qualified and Reciprocal Jurisdictions.

   B. Perform a yearly due diligence review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions.

   C. Consider evaluations of any additional jurisdictions for inclusion on the NAIC List of Qualified Jurisdictions.

NAIC Support Staff: Jake Stultz/Dan Schelp
Draft: 10/17/19
Adopted by the Executive (EX) Committee and Plenary, Dec. 10, 2019
Adopted by the Financial Condition (E) Committee, Oct. 31, 2019
Adopted by the Risk Retention Group (E) Task Force, Oct 7, 2019

2020 Proposed Charges

RISK RETENTION GROUP (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Becky Meyer
**2020 Proposed Charges**

**VALUATION OF SECURITIES (E) TASK FORCE**

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

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

1. The **Valuation of Securities (E) Task Force** will:
   
   A. Review and monitor the operations of the NAIC Securities Valuation Office (SVO) and the NAIC Structured Securities Group (SSG) to ensure they continue to reflect regulatory objectives.
   
   B. Maintain and revise the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to provide solutions to investment-related regulatory issues for existing or anticipated investments.
   
   C. Monitor changes in accounting and reporting requirements resulting from the continuing maintenance of the *Accounting Practices and Procedures Manual*, as well as financial statement blanks and instructions, to ensure that the P&P Manual continues to reflect regulatory needs and objectives.
   
   D. Consider whether improvements should be suggested to the measurement, reporting and evaluation of invested assets by the NAIC as the result of: 1) newly identified types of invested assets; 2) newly identified investment risks within existing invested asset types; or 3) elevated concerns regarding previously identified investment risks.
   
   E. Identify potential improvements to the credit filing process, including formats and electronic system enhancements.
   
   F. Provide effective direction to the NAIC’s mortgage-backed securities modeling firms and consultants.
   
   G. Coordinate with other NAIC working groups and task forces—including, but not limited to, the Capital Adequacy (E) Task Force, the Investment Risk-Based Capital (E) Working Group, the Statutory Accounting Principles (E) Working Group and the Blanks (E) Working Group—to formulate recommendations and to make referrals to such other NAIC regulator groups to ensure expertise relative to investments, or the purpose and objective of guidance in the P&P Manual, is reflective in the guidance of such other groups and that the expertise of such other NAIC regulatory groups and the objectives of their guidance is reflected in the P&P Manual.
   
   H. Identify potential improvements to the filing exempt process (the use of credit rating provider ratings to determine an NAIC designation) to ensure greater consistency, uniformity and appropriateness to achieve the NAIC’s financial solvency objectives. Implement to the different areas of the NAIC, and to the state-based insurance regulatory structure, the modification of the existing NAIC credit assessment framework by adding NAIC designation categories. Complete by the 2019 Fall National Meeting.

NAIC Support Staff: Charles Therriault
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

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

   Group Capital Calculation (E) Working Group

2. NAIC staff support contact information:

   Dan Daveline
ddaveline@naic.org
(816) 783-8134

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

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

   In 2015, the NAIC adopted the following charge to the Financial Condition (E) Committee who subsequently formed the Group Capital Calculation (E) Working Group to carry out such a change.

   “Construct a U.S. group capital calculation using an RBC aggregation methodology; liaise as necessary with the Comframe Development and Analysis (G) Working Group on international capital developments and consider group capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation.”

   The Group Capital Calculation (E) Working Group has been developing the group capital calculation (GCC) since receiving its charge and in May, with the assistance of 33 insurance groups and 15 lead states, began testing the current construction. The lead states are currently reviewing the completed templates and take aways from the testing are expected to be summarized and discussed at the Fall National Meeting in Austin. Upon completion of the field-testing, state regulators will use the results to further improve the construction of the calculation and at this junction, the Working Group is striving to adopt the calculation sometime in 2020. In order to allow states to be able to adopt the GCC, the Working Group is seeking approval to modify the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). While the Working Group has not concluded the exact construct of such changes, the Working Group expects Section 4 of #440 will need to be revised to require a new filing and #450 will need to be revised to add the new filing and a related new section (Form G).

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

   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).
a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? 

☐ Yes or ☐ No (Check one)

If yes, please explain why:

State insurance regulators currently perform group analysis on all U.S. insurance groups, including assessing the risks and financial position of the insurance holding company system based on currently available information. However, state regulators currently do not have the benefit of a consolidated statutory accounting system and financial statements to assist them in these efforts. The GCC is expected to fill this void since it requires an aggregation and display of the individual company’s available capital and operating figures. More specifically, the GCC and related reporting will provide more transparency to insurance regulators regarding the insurance group and make risks more identifiable and more easily quantified. In this regard, the tool will assist regulators in holistically understanding the financial condition of non-insurance entities, how capital is distributed across an entire group, and whether and to what degree insurance companies may be subsidizing the operations of non-insurance entities, potentially undermining the insurance company’s financial condition and/or placing upward pressure on premiums to the detriment of insurance policyholders. It is envisioned that this calculation will provide an additional early warning signal to regulators so they can begin working with a company to resolve any concerns in a manner that will ensure that policyholders will be protected. Importantly, the GCC will complement existing group supervisory tools already available to state insurance regulators, such as the Form F Enterprise Risk Report\(^1\), the Own Risk and Solvency Assessment Summary Report\(^2\) and the Form B Holding Company Filings\(^3\). As such, we would expect it to be a national standard.

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

☐ Yes or ☐ No (Check one)

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

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:

As previously noted, the Working Group is striving to adopt the calculation sometime in 2020 and it is expected that revisions to the model be adopted by the NAIC within that same time period so that states can begin to implement through changes to state law.

\(^1\) Insurance Holding Company System Regulatory Act (#440) and supporting Insurance Holding Company System Model Regulation (#450) require the annual filing of an Enterprise Risk Report (Form F) which requires the disclosure on material risks within the insurance holding company system that could pose enterprise risk to the insurer.

\(^2\) Risk Management and Own Risk and Solvency Assessment (ORSA) Model Act (#505) require the annual filing of an ORSA Summary report that includes 1) Description of the Insurer’s Risk Management Framework; 2) Insurer’s Assessment of Risk Exposure; and 3) Group Assessment of Risk Capital and Prospective Solvency Assessment.

\(^3\) Insurance Holding Company System Regulatory Act (#440) and supporting Insurance Holding Company System Model Regulation (#450) require the annual filing of a Registration Statement (Form B) which includes, among other items, the annual financial statements of the ultimate controlling person in the insurance holding company system and all of its affiliates and subsidiaries.
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1 High Likelihood ☐ 2 ☐ 3 ☐ 4 ☐ 5 Low Likelihood (Check one)

Explanation, if necessary: See previous discussion.

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

☐ 1 High Likelihood ☐ 2 ☐ 3 ☐ 4 ☐ 5 Low Likelihood (Check one)

Explanation, if necessary:

At this juncture, the changes to the NAIC models are expected to 1) require the filing of the GCC with the state; 2) provide important confidentiality protections; 3) provide exemptions for who is not expected to file the GCC. As such, variations by states related to these elements are not expected.

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

The Group Capital Calculation (E) Working Group has not discussed whether the GCC should be an accreditation standard. However, because the GCC is expected to be required of the largest and most complex U.S. insurance group who operate in all states, a national standard is appropriate.

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

Yes. Under Title V of the Dodd-Frank Act, the U.S. Department of the Treasury and the Office of the U.S. Trade Representative are authorized to jointly negotiate covered agreements, defined under the Dodd-Frank Act as written bilateral or multilateral agreements between the United States and one or more foreign governments, authorities or regulators regarding prudential measures with respect to insurance or reinsurance, on the condition that the prudential measures subject to a covered agreement achieve a level of protection for insurance or reinsurance consumers that is “substantially equivalent” to the level of protection achieved under U.S. state insurance laws. On Sept. 22, 2017, the U.S. Department of the Treasury and the Office of the U.S. Trade Representative signed the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement). On December 18, 2018, a separate Covered Agreement was signed between the U.S. and the United Kingdom, which is mirrors the language from the agreement with the EU, and has the same timing requirements for implementation.

The Covered Agreement includes requirements on reinsurance collateral, group supervision and group capital. Specifically, Article 4(h) provides that the host supervisor (i.e., a supervisory authority from the territory in which an insurance group has operations but which is not the territory where the worldwide parent is domiciled or headquartered) may not impose a group capital assessment or requirement at the level of the worldwide parent, but only if the insurance group is subject to a group capital assessment imposed by the home supervisor. The group capital assessment of the home supervisor must include a worldwide group capital calculation capturing risk at the level of the entire group, and the home supervisor must have the authority to impose preventive, corrective or otherwise responsive measures on the basis of the assessment, including the authority to impose capital measures where appropriate.

Under Article 10(e) of the Covered Agreement, supervisory authorities in the European Union shall not impose a group capital requirement at the level of the worldwide parent undertaking of the insurance or reinsurance group, with regard to a U.S. insurance or reinsurance group with operations in the European Union, for 60 months after the date of provisional application of the Covered Agreement; i.e., Nov. 7, 2022. The NAIC is developing a group capital calculation intended to serve as an analytical tool for evaluating an insurer’s capital position at the group level, but which is not intended to be applied as a group-level capital requirement or standard. The Statement of the United States on the Covered Agreement with the European Union provides further clarification with respect to this group capital assessment:
The Agreement limits the worldwide application of EU prudential group insurance measures on U.S. insurers operating in the EU. The Agreement provides that U.S. insurers and reinsurers can operate in the EU without the U.S. parent being subject to the group level governance, solvency and capital, and reporting requirements of Solvency II, and reinforces that the EU system of prudential insurance supervision is not the system in the United States. The Agreement does not require development of a group capital standard or group capital requirement in the United States. Article 4(h) contemplates that the states will develop a group-wide capital assessment. Through the National Association of Insurance Commissioners (NAIC), the states are in the process of developing a group capital calculation which is intended to serve as an analytical tool for evaluating a firm’s capital position at the group level. The United States expects that the NAIC’s group capital calculation will satisfy the “group capital assessment” condition of Article 4(h), provided that the work is completed and implemented within five years of the date on which the Agreement is signed. [Emphasis added].

Any state with U.S. groups operating in either the European Union or the United Kingdom will need to adopt these legislative changes by Nov. 7, 2022 in order to effectuate compliance with the Covered Agreement.
GUIDELINE FOR STAY ON TERMINATION OF NETTING AGREEMENTS AND QUALIFIED FINANCIAL CONTRACTS

Drafting Note: State receivership and insolvency laws may permit a contractual right to cause the termination, liquidation, acceleration or close-out obligations with respect to any netting agreement or qualified financial contract (QFC) with an insurer because of the insolvency, financial condition or default of the insurer, or the commencement of a formal delinquency proceeding. These laws are based upon similar provisions contained in the federal bankruptcy code and the Federal Deposit Insurance Act (FDIA). The FDIA also provides for a twenty-four-hour stay to allow for the transfer of QFCs by the receiver to another entity rather than permitting the immediate termination and netting of the QFC. 12 U.S.C. § 1821(e)(9)-(12). States that permit the termination and netting of QFCs may want to consider adopting a similar stay provision following the appointment of a receiver.

States that consider the enactment of a stay should take into account the relevant federal rules. In 2017 the Board of Governors of the Federal Reserve System (the Federal Reserve), the Federal Deposit Insurance Corporation (the FDIC) and the Office of the Comptroller of the Currency (the OCC) each adopted final rules and accompanying interpretive guidance (Final Rules) setting forth limitations to be placed on parties to certain financial contracts exercising insolvency-related default rights against their counterparties that have been designated as a global systemically important banking organization (GSIB). The Final Rules include the definition of master netting agreement that allows netting even though termination of the transaction in the event of an insolvency may be subject to a “stay” under several defined resolution regimes including Title II of Dodd Frank, the FDIA, as well as comparable foreign resolution regimes. Notwithstanding NAIC’s request for inclusion, stays under the state insurance receivership regime (State Receivership Stays) were not included as an exemption within the definition. Therefore, unless the Final Rules are amended to recognize State Receivership Stays, if a state implements a stay as contemplated by the Guideline, insurers would find themselves disadvantaged, potentially resulting in additional costs and/or collateral requirements given the regulatory treatment for contracts that do not meet requirements for QFCs. Therefore, if a state is considering implementation of this Guideline, consideration should be given to whether the rules of the Federal Reserve, FDIC and OCC have been amended to recognize State Receivership Stays. For example, a state could adopt a stay that would be effective if and when the Final Rules recognize State Receivership Stays.

The following statutory language is not an amendment to the NAIC receivership models, but is intended as a Guideline for use by those states seeking to require a stay with respect to the termination of a netting agreement or QFC of an insurer in insolvency:

Stay on Termination of Netting Agreements and Qualified Financial Contracts

A person who is a party to a netting agreement or qualified financial contract under [cite to applicable state law addressing qualified financial agreements] with an insurer that is the subject of an insolvency proceeding may not exercise any right that the person has to terminate, liquidate, accelerate or close-out the obligations with respect to the contract by reason of the insolvency, financial condition or default of the insurer, or by the commencement of a formal delinquency proceeding,

(1) Until 5:00 p.m. (eastern time) on the business day following the date of appointment of a receiver; or

(2) After the person has received notice that the contract has been transferred pursuant to [cite applicable state law addressing transfer of qualified financial contracts].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)


The Financial Condition (E) Committee met via conference call Aug. 29, 2019. The following Committee members participated: David Altmaier, Chair (FL); Kent Sullivan, Vice Chair, represented by Jamie Walker (TX); Ricardo Lara represented by Susan Bernard and Kim Hudson (CA); Robert H. Muriel and Kevin Fry (IL); Chlora Lindley-Myers represented by Debbie Doggett (MO); Matthew Rosendale represented by Steve Matthews (MT); Marlene Caride represented by Daniel Morris (SC); James A. Dodrill represented by Jamie Taylor (WV); and Jeff Rude represented by Linda Johnson (WY). Also participating was: Rich Piazza (LA).

1. **Adopted the Report of the Accounting Practices and Procedures (E) Task Force**

Commissioner Altmaier asked that upon receiving the report of the Accounting Practices and Procedures (E) Task Force, that any motion to adopt exclude both 2019-20BWG and the 2020 proposed charges. He stated that excluding the charges was appropriate, as they will be considered with other task force and working group charges in a conference call that takes place in October.

Ms. Walker provided the report of the Accounting Practices and Procedures (E) Task Force, which met Aug. 22. During this meeting, the Task Force adopted its 2020 proposed charges, including deletion of two completed charges and deletion of one charge proposed to be disposed as unnecessary. All the deleted charges of the Statutory Accounting Principles (E) Working Group related to variable annuities. She stated the report also included adoption of the Aug. 20 report of the Blanks (E) Working Group, with one minor modification to agenda item 2019-20BWG. The Task Force also adopted the July 2 and June 24 minutes of the Blanks (E) Working Group. The two blanks proposals adopted are: 1) 2019-18BWG, which adds an NAIC designation modifier to accommodate the NAIC designation category granularity framework adopted by the Valuation of Securities (E) Task Force, with an annual 2020 effective date; and 2) 2019-20BWG, which will be considered separately, but in summary it adds a “Qualification Documentation” to the property/casualty (P/C) Statement of Actuarial Opinion instructions, as requested by the Casualty Actuarial and Statistical (C) Task Force and the Executive (EX) Committee, requiring the appointed actuary to maintain workpapers explaining how the actuary meets the definition of “qualified actuary.” The minor Accounting Practices and Procedures (E) Task Force modification to the proposal changed the name of the term in the proposal from “NAIC Accepted Actuarial Designation” to “Accepted Actuarial Designation.” The proposal was adopted by the Task Force, with two dissenting votes. Finally, Ms. Walker noted that blanks proposal 2019-19BWG on unaffiliated certificates of deposit was withdrawn to allow for further work, and the Blanks (E) Working Group also: 1) deferred revisions to its procedures to allow for further discussion; 2) exposed three proposals for a public comment period ending Oct. 8; and 3) adopted the editorial listing.

Mr. Sirovetz made a motion, seconded by Ms. Walker, to adopt the Task Force’s report, except for its 2020 proposed charges and blanks proposal 2019-20BWG. The motion passed, with Missouri dissenting.

2. **Adopted Blanks Proposal 2019-20BWG**

Commissioner Altmaier asked Mr. Piazza to summarize the proposal. Mr. Piazza noted that he was the chief actuary in Louisiana. He said over the past 10 years, he served as chair of the Casualty Actuarial and Statistical (C) Task Force for seven years and as vice chair for three years. He stated that the proposal concerns the qualification definition of the appointed actuary contained in the Annual Statement Instructions – Property/Casualty. He described the role of the appointed actuary and how it may be the most important role actuaries serve in the state insurance regulator’s eyes.

Mr. Piazza indicated that state insurance regulators that review reserve adequacy for company solvency in order to protect the interests of their state’s consumers rely heavily upon the accuracy of the appointed actuary’s reserve assessment and information contained in the appointed actuary’s Statement of Actuarial Opinion. To be able to provide the Statement of Actuarial Opinion, an appointed actuary must meet the qualification requirements defined in the Annual Statement Instructions – Property/Casualty.
Mr. Piazza stated that the proposal has a long history at the NAIC. It began about seven years ago, when the Task Force was asked to determine if the Society of Actuaries’ (SOA) new educational track met the NAIC’s basic education requirement for the qualified actuary. After many open discussions, the Task Force realized this was a time-consuming project that needed help from an independent, unbiased education expert. So, the Task Force asked for outside help. This request went to the Property and Casualty Insurance (C) Committee and then to the Executive (EX) Committee.

The Executive (EX) Committee set out to develop an objective, principled-based definition for the qualified actuary and to determine if the SOA and Casualty Actuarial Society’s (CAS) designations meet the basic education requirement of that definition. The Executive (EX) Committee hired a consultant, and with many months of hard work from more 30 subject-matter experts (SMEs), it completed a job analysis for the appointed actuary. The Executive (EX) Committee then, again with assistance from SMEs, established basic education standards for the qualified actuary and evaluated the examination syllabi of the actuarial organizations to see if they met those standards. These projects resulted in the proposal.

Mr. Piazza provided a summary of the highlights in the proposal. The proposal sets forth a workable, objective and principle-based definition of a property/casualty (P/C) qualified actuary and recognizes the SOA’s general insurance track designation, along with the CAS designations, as meeting the minimum basic education requirement for a qualified actuary. He described how the proposal adds qualification documentation to the instructions, which effectively pulls together an actuary’s resume and continuing education documentation as a workpaper so state insurance regulators can view that information if they wish and companies can use it in their governance review of the appointed actuary. The proposal has an effective date coinciding with the 2019 annual financial statement. He stated that the 2019 effective date was agreed to by all three actuarial organizations.

Mr. Piazza noted that the proposal has little impact to any actuary currently appointed. All former appointed actuaries remain “qualified” under the new definition, with the only impact being they must document their qualifications. During the Accounting Practices and Procedures (E) Task Force’s Aug. 22 conference call, Texas offered a friendly amendment to original blanks proposal 2019-20BWG that removed “NAIC” from the label that is now called the “acceptable actuarial designations.”

Mr. Piazza noted that this proposal was not performed in a vacuum as the proposed instruction changes were vetted many times since the beginning of this project. He described how in the past year-and-a-half, there were four exposures and one hearing with input considered from interested parties, the Task Force and commissioners directly. He stated that like other large, multi-faceted NAIC projects, there was a bit of compromise in the development of the proposal, and not all participants in the development process were 100% satisfied with the result.

Mr. Piazza closed by stating that the proposal clearly met the Executive (EX) Committee’s objective at the start of its project by setting forth a workable, objective and principle-based “qualified actuary” definition that includes actuarial designations from both the SOA and the CAS that meet the minimum basic education standard in that definition. He asked the Committee to adopt the proposal without further revision.


Having no further business, the Financial Condition (E) Committee adjourned.
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met in Austin, TX, Dec. 7, 2019. The following Working Group members participated: David Altmaier, Chair, and Ray Spudeck (FL); Kathy Belfi, Vice Chair, (CT); Philip Barlow (DC); Jim Armstrong and Mike Yanachea (IA); Kevin Fry, Bruce Sartain and Vincent Tsang (IL); Roy Eft (IN); Christopher Joyce (MA); Judy Weaver (MI); Kathleen Orth (MN); John Rehagen (MO); Jackie Obusek (NC); Justin Schrader (NE); Marlene Caride and Diana Sherman (NJ); James Regalbuto (NY); Dale Bruggeman and Tim Biler (OH); Joe DiMemmo (PA); Trey Hancock and Patrick Merkel (TN); Doug Slape and Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. Adopted its Oct. 30, Aug. 29 and Summer National Meeting Minutes

Commissioner Altmaier said the Working Group met Oct. 30 and Aug. 29. During its Oct. 30 meeting, the Working Group adopted a revised memorandum on debt and a Request for NAIC Model Law Development related to the group capital calculation (GCC). During its Aug. 29 meeting, the Working Group discussed needed confidentiality protections.

Ms. Belfi made a motion, seconded by Mr. Schrader, to adopt the Working Group’s Oct. 30 (Attachments Three-A), Aug. 29 (Attachment Three-B) and Aug. 3 (see NAIC Proceedings – Summer 2019, Financial Condition (E) Committee, Attachment Two) minutes. The motion passed unanimously.

2. Received a Summary of Data Review and Initial Observations from the Field Test

Commissioner Altmaier stated that NAIC staff would be presenting preliminary observations from the group capital calculation (GCC) field test (Attachment Three-C) and asked Lou Felice (NAIC) to begin that summary.

Mr. Felice highlighted some of the more significant aspects of that summary, including how suggestions were made on how the template and instructions could be improved. He said those types of suggestions were included in the observations and that the NAIC supported many of those. He said that testing was near complete, pending only final meetings with some of the volunteers, which is driven more by the difficulty of coordinating schedules than anything else. He emphasized that for capital instruments, there would need to be clarifications for the reporting of foreign debt, what is meant by tracked debt and the reporting of surplus notes.

Dan Daveline (NAIC) stated the with respect to XXX/AXXX assets and liabilities, several commenters suggested this information be disclosure only and not included in the actual calculation. Mr. Felice noted that in the area of materiality, some companies did use different approaches, but the test did not provide any type of clear indication of one approach to use.

Ned Tyrrell (NAIC) noted that one issue that still needs to be dealt with is scalars in regimes not considered thus far. He said another issue arises when the underlying capital calculation is fixed.

Mr. Felice said NAIC staff used the inventory as the base GCC ratio and that the rest of the observations were based on factors that cause that base to go up or down.

Mr. Tyrrell discussed the results of the GCC base calculation based on the trend test level. He reinforced Mr. Felice’s point that the subsequent charts in the observations show the impact from the base calculation, meaning the item is either an increase or a decrease from that base. With respect to the observations on included business, most groups had no difference when the groups included all their companies, but there were a small number of property/casualty (P/C) companies that had a larger difference.
Mr. Tyrrell described how there were similar observations when it comes to the non-insurance tests where the revenue tests generally did not show a significant impact, but there were a handful of outlier groups. However, he said that the book/adjusted carrying value (BACV) test tended to have a large impact on a number of groups. He also noted that the banking tests had little impact on the groups with such entities.

Mr. Felice described the impact of using 30% for debt, noting that when the test did so, it picked up most companies.

Mr. Tyrrell highlighted how the differences in the scalar testing was largely driven by the three different types of groups participating in the field-testing, including specifically that some non-U.S. groups chose to participate and were most impacted, while most groups had no or little non-U.S. business, including most of the internationally active insurance groups (IAIGs).

Bill Schwegler (Transamerica) reiterated Transamerica’s concerns with on-top adjustment that have the impact of modifying state legal entity rules. He stated Transamerica appreciated the work to assemble the results, but stated he hopes that further information would be disclosed in the future regarding: 1) non-XXX/AXXX captives; 2) treatment of subsidiaries where the GCC amends; 3) nonadmitted entities that are zeroed out; and 4) use of the trend test level versus the company act level.

Mariana Gomez-Vock (American Council of Life Insurers—ACLI) asked if clarity could be provided between the GCC and the aggregation method, noting that it was the GCC that the U.S. intends to submit.

Commissioner Altmaier stated the short answer is “yes,” but this specific matter is more of an issue for the International Insurance Relations (G) Committee. He stated that an aggregate-based framework that is jurisdictional-agnostic is preferred to allow, for example, Hong Kong to use its own version of the aggregation method.

Ms. Gomez-Vock said she recognizes that this was also probably a more appropriate question for the International Insurance Relations (G) Committee, but she asked whether the GCC would have a trigger of intervention.

Commissioner Altmaier responded that nothing has changed and the GCC does not intend to have any type of trigger for intervention. (Editor’s Note: For more discussion on this issue, see NAIC Proceedings – Fall 2019, International Insurance Relations (G) Committee, agenda item #4.)

Commissioner Altmaier said conversations regarding the information would begin in the future weeks.

Having no further business, the Group Capital Calculation (E) Working Group adjourned.
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met via conference call Oct. 30, 2019. The following Working Group members participated: David Altmaier, Chair, and Ray Spudeck (FL); Kathy Belfi, Vice Chair (CT); Kim Hudson (CA); Carrie Mears (IA); Susan Berry (IL); Roy Eft (IN); Judy Weaver (MI); Barbara Carey (MN); John Rehagen (MO); Justin Schrader (NE); Edward Kiffel (NY); Dale Bruggeman (OH); Kimberly Rankin (PA); Trey Hancock (TN); Mike Boerner (TX); Doug Stolte (VA); and Amy Malm (WI).

1. **Adopted a Revised Debt Memorandum**

Commissioner Altmaier stated that the issue of debt was one that had received considerable discussion by the Working Group in the past and that it was currently testing different approaches during field testing. He noted that the way the original memorandum on this topic was drafted created some confusion, and over the past several months, there had been some work to try to resolve the confusion. He stated the purpose of revisions was not to change any of the approaches being tested, but to clarify language to alleviate some of the concerns that had been presented. He stated the revisions specifically remove some of the language related to rating agencies that seem to be causing most of the confusion.

Mr. Hudson stated his understanding was that the Working Group was moving forward with field testing and that after receiving additional data, the Working Group would be in a better position to make a final decision. Commissioner Altmaier agreed, noting the revisions do not change that fact.

Ms. Belfi highlighted the fourth page of the memorandum where field testing is discussed and noted that none of that language had been revised outside of minor cosmetic editorial changes along with the information related to rating agencies.

Ms. Belfi made a motion, seconded by Mr. Hudson, to adopt the revised changes and to have the revised memorandum posted to the website (Attachment Three-A1). The motion passed unanimously.

2. **Adopted a Request for NAIC Model Law Development**

Commissioner Altmaier stated the Working Group previously discussed the need for the group capital calculation (GCC) to be confidentially filed with the state insurance department and the need for legal authority for this to occur, which requires an NAIC model law. He stated that included in the materials is a document that requires adoption by the Working Group, the Financial Condition (E) Committee and the Executive (EX) Committee before a project to make such changes to an NAIC model law can begin.

Commissioner Altmaier stated the document specifically requests changes to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). Commissioner Altmaier emphasized that the request envisions changes to the model that will not create a regulatory intervention point for the GCC. He stated this is only for the purpose of requiring the filing and its confidentiality.

Mr. Bruggeman said this does not preclude the incorporation of something that already exists within confidentiality provisions and noted, for example, the *Risk Management and Own Risk and Solvency Assessment Model Act* (#505).

Mr. Hudson asked Commissioner Altmaier if he expects the work to be completed by the Group Solvency Issues (E) Working Group. Commissioner Altmaier stated that the Group Solvency Issues (E) Working Group owns that model. He stated he envisions a liaison with that Working Group and a process where both groups are heavily involved. He stated that with all the past discussions of the GCC on its purpose and its goal, it will be important for the Working Group to stay involved in the process.

Mariana Gomez-Vock (American Council of Life Insurers—ACLI) expressed appreciation for the recognition that confidentiality needs to be addressed in the GCC. She asked for clarification that the model law amendment process deals with the confidentiality and for the regulatory authority of filing the GCC.
Commissioner Altmaier responded that if the Working Group determines that authority is needed for the filing, the changes to the model can address such. He noted, however, that he is primarily focused on a very narrow change to the model since the primary purpose is the confidentiality.

Ms. Gomez-Vock stated it would be good to be mindful of the process for addressing other items. Commissioner Altmaier stated they would try to be mindful of such items as they began the process and simply reiterated his desire for the changes to be very narrow and related to the GCC only.

Mr. Hudson made a motion, seconded by Mr. Bruggeman, to adopt the Request for NAIC Model Law Development (see NAIC Proceedings – Fall 2019, Financial Condition (E) Committee, Attachment One-B). The motion passed unanimously.

3. **Discussed Other Matters**

Commissioner Altmaier asked NAIC staff to provide an update on the field testing.

Lou Felice (NAIC) reminded the Working Group of the multiple levels of testing debt within the GCC like the language in the revised memorandum previously adopted by the Working Group earlier in the conference call. He discussed that the testing criteria is being applied over regulatory capital and over regulatory capital plus debt. He discussed that restacked regulatory capital is being used to include all entities, permitted and prescribed practices, but it does not include the XXX/AXXX captive information as they would be considered separately. He also discussed the ongoing openness of considering other options offered by volunteers.

Mr. Felice described that they are working their way through the volunteer filings, noting one had dropped out. He stated that they have come in slower than desired. He stated that most of the filings had been reviewed by NAIC staff, with comments sent to the lead states for incorporation of the input from the lead state. He stated that once such input is added, a document would be shared with the volunteer and that companies are then allowed to have a written response and/or a final conference call. He said the greatest difficulty has been the coordinating of schedules for conference calls between each volunteer, their lead state and NAIC staff. They hope to have all completed by the end of November. However, he stated this will not change the summarizing charts that are expected to be provided in the open meeting where public feedback is provided.

Having no further business, the Group Capital Calculation (E) Working Group adjourned.

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MEMORANDUM

TO: Group Capital Calculation (E) Working Group

FROM: David Altmaier, Chair, Group Capital Calculation (E) Working Group

DATE: October 7, 2019

RE: Treatment of Senior Debt and Surplus Notes in the Group Capital Calculation

As part of the discussions related to the determination of available capital under an RBC aggregation approach to a group capital calculation (GCC), the issue of how to treat senior debt and surplus notes needs to be considered. As noted below, the treatment of Surplus Notes within the calculation is much more clearly guided by available accounting guidance. Less direction is found for the appropriate consideration of senior debt.

Background

Statement of Statutory Accounting Principles (SSAP) 41 establishes a strong State-based entity specific regulatory structure for surplus notes issued by insurers which is further supported by state receivership laws. SSAP 15 requires all types of debt, including senior debt to be recorded as a liability. However, SSAP 15 is based upon insurance legal entity principles that are not designed to consider the financial flexibility that senior debt issued by a non-insurer holding company can provide the insurance group. In addition, the current guidance does not consider any prohibitions / limitations on the investments of holding company debt instruments. Part of the reason for less regulatory guidance on holding company issuers of senior debt is related to the States’ focus on insurance legal entities (a bottom up approach) vs. a GAAP consolidated approach to available capital that views the group as a single economic construct and eliminates any intra-group double-counting (a top down approach). Further, current guidance does not apply an economic valuation approach which considers how such debt should be characterized when the insurance holding company receives assets that can be allocated to provide capital to the legal entity insurer(s). Surplus notes are generally issued by insurers or mutual holding companies in a holding company structure. They may be issued to insurers within the group or to outside investors. Senior debt is generally issued by non-operating holding companies and is issued to investors that are outside the group (or outside the definition of control within the group). Other issues related to these instruments include the manner in which “subordination” of debt (other than surplus notes) is established, the quality of capital generated, and what becomes of the capital generated via issuance of such debt.

Entity vs. Consolidated view:

In a consolidated calculation the value of intra-group surplus notes or loans are offset and eliminated (i.e. the asset held by the purchaser and the debt reported by the issuer are offset). When surplus notes (or any type of debt) are issued to entities outside the group, consolidated GAAP will treat them as a liability along with any associated accrued interest on the issuer’s balance sheet (See APB 15). Where the proceeds of other debt issued are held within the holding company structure, consolidated GAAP would offset that portion of debt issued against related capital that is held by affiliated entities or retained by the issuer. Any excess debt issues would be treated as a liability of the issuer.

By contrast, in the statutory entity-based calculation where surplus notes are issued intra-group to an affiliated insurer it creates capital value at the issuer level since such obligations are subordinated to policyholder claims, but is capital neutral to the purchaser at the entity level. In the group’s capital structure SSAP 97 eliminates the value from the purchaser’s surplus making the surplus note capital neutral at the group level. In addition, U.S. Risk-based Capital (RBC) assigns an asset risk charge (typically based on holding the note as a Schedule BA asset) to the purchaser. Therefore, the investment carried by the affiliate and any associated capital (e.g. RBC) charge to the affiliated purchaser(s) needs to be addressed in an aggregation approach. Under current SAP, senior or other debt instruments issued by a non-insurance holding company to the insurance company is
generally considered an asset if the purchase of the debt is approved by the domestic regulator and to the extent criteria demonstrating the financial strength of non-insurance holding company is met. Its value would be eliminated under GAAP consolidated statement, however, since the non-insurance holding company would treat it as a liability.

Nature of subordination
For surplus notes, the State-based regulatory framework applies “contractual subordination” in that the subordination provisions to restrict movement of funds from the licensed insurer to repay the note are contained within the language of the note itself. For senior debt issued by a holding company, the State-based regulatory system relies on what is referred to as “structural subordination”. In general, subordination ranks other creditors behind policyholders in priority of repayment. Structural subordination is achieved via regulation of movement of funds between insurers and other entities within the holding company structure. An example of how regulatory practices work under structural subordination is demonstrated in the regulatory review and oversight of stockholder dividends paid to the holding company. Dividends paid to the holding company are generally the primary source of income for holding companies which are then used to service their outside debt.

Treatment of Surplus Notes
Treatment of issuers of surplus notes and holders of surplus notes or capital notes is specified in SSAP #41 as follows:

3. Surplus notes issued by a reporting entity that are subject to strict control by the commissioner of the reporting entity’s state of domicile and have been approved as to form and content shall be reported as surplus and not as debt only if the surplus note contains the following provisions:
   a. Subordination to policyholders;
   b. Subordination to claimant and beneficiary claims;
   c. Subordination to all other classes of creditors other than surplus note holders; and
   d. Interest payments and principal repayments require prior approval of the commissioner of the state of domicile.

9. Investments in capital or surplus notes meet the definition of assets as defined in SSAP No. 4—Assets and Nonadmitted Assets and are admitted assets to the extent they conform to the requirements of this statement. Additionally, the amount admitted is specifically limited to the following two provisions:
   a. The admitted asset value of a capital or surplus note shall not exceed the amount that would be admitted if the instrument was considered an equity instrument and added to any other equity instruments in the issuer held directly or indirectly by the holder of the capital or surplus note.
   b. The surplus note shall be nonadmitted if issued by an entity that is subject to any order of liquidation, conservation, rehabilitation or any company action level event based on its risk-based capital. Subsequent to this nonadmittance, if any of the conditions described ceased to exist, the holder may admit the surplus note at the value determined under paragraph 11. If a surplus note was nonadmitted pursuant to this paragraph, and the surplus note was ultimately determined to be other-than-temporarily impaired, the reporting entity shall recognize a realized loss for the portion of the surplus note determined to be other-than-temporarily impaired, with elimination of a corresponding amount of the previously nonadmitted assets.

In addition, SSAP 97 is referenced in SSAP#41 as follows:

Holders of Capital or Surplus Notes
13. For surplus notes issued and held (directly or indirectly), between insurance reporting entities and subsidiary, controlled and affiliated entities, the guidance in SSAP No. 97 requires adjustment to prevent double-counting of surplus notes. For example, an insurance reporting entity is not permitted to report the issuance of a surplus note as an increase in surplus and have an asset representing an investment in the SCA that includes the issued surplus note (held by an SCA). Pursuant to SSAP No. 97, the “investment in the SCA” shall be adjusted to eliminate the surplus note issued by the direct or indirect parent insurance reporting entity. This treatment shall also apply for instances in which the SCA acquires any portion of outstanding surplus notes issued by the direct or indirect parent through any means (e.g., directly acquired from the parent, acquired through a third-party broker, or via the market.).

SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities
Investment in Preferred Stock or Surplus Notes of a Subsidiary, Controlled and Affiliated Entity
20. Any parent reporting entity that has issued a surplus note, which has been acquired by an SCA (held directly or indirectly), shall adjust the investment in the SCA to eliminate the issued surplus note to prevent double counting of the surplus note...
at the parent reporting entity. Without adjustment, the issued surplus note would be reported both as an increase in surplus by the parent reporting entity, as well as an admitted asset of the parent through the “investment in an SCA.” The surplus note shall also be eliminated for instances in which the SCA acquires any portion of outstanding surplus notes issued by the parent through any means (e.g., directly acquired from the parent, acquired through a third-party broker, or via the market.).

By operation of SSAP97 the value of the surplus note in an affiliate purchaser is eliminated in the RBC roll-up of that entity. However, in the GCC aggregation approach, the group is de-stacked and stand-alone entities are established at their specified accounting values. These stand-alone values will include an asset for the investment in surplus note(s). So in such cases that investment must be eliminated along with any regulatory capital charge where applicable. Thus, surplus notes issued to non-affiliated entities outside of the group create new capital for the group while those issued within the group do not create new capital at the group level.

**Treatment of Senior Debt**

While there is no specific SAP regulatory treatment (independent of GAAP treatment as a liability) for debt issued by a non-operating holding company, it is recognized that in an insurance-led holding company structure that funds needed to repay the holders of the debt may be generated and provided by the insurers in the group in the form of stockholder dividends. Therefore, it is reasonable to recognize the structural subordination described above in considering how to treat the debt for purposes of available capital. However, because the issuance of debt within a holding company structure makes assets available within the holding company system that could be used to help absorb losses originating from the insurer or another entity within the holding company structure for which the group capital calculation attempts to require capital, it may be appropriate to develop criteria within the GCC that permit some amount of subordinated senior debt to be added back to capital.

The Working Group will need to come to a consensus agreement on the most logical way to field test the impact of including structurally subordinated senior debt as additional group capital within the GCC. If this capital resource is to be included, why? If it is to be is to be constrained or capped, to what level and why?

If it can be demonstrated that higher amounts of the debt can be tied to the principle of structural subordination (e.g. a higher percentage of the proceeds were downstreamed to the insurers or entities under similar regulatory supervision as U.S. insurers), then a higher allowance could be considered consistent with the amount of proceeds that are downstreamed to insurers in the group.

It is also important to consider that the base for total available capital under the U.S. insurance regulatory structure is generally lower than what is recognized under consolidated GAAP rules. Therefore, if the addition of subordinated debt to be included as capital is deemed appropriate, a case for a slightly higher allowance, based on regulatory accounting rules combined with the strength of structural subordination may be considered.

**Quality of Capital**

Under SAP (or GAAP) there is no distinction in quality of capital (i.e. tiering) for assets that meet the definition of admitted assets such as surplus notes. Based on this, it seems logical that any other asset values allowed in an aggregation approach should be treated similarly. However, there is such a distinction under U.S. banking rules and there may be under other sectoral rules. So it seems logical to respect the available calculations of the regulators in those sectors.

**Recommendations for an aggregation approach to a GCC:**

1. Surplus Notes – In all cases, treat the assets transferred to the issuer of the surplus note as available capital. If the purchaser is an affiliate, eliminate the investment value from the affiliated purchaser of the surplus note. If the purchaser is an insurer or other regulated entity, eliminate the purchaser’s capital charge (e.g. RBC charge) on the Surplus note investment.

2. Subordinated Senior Debt issued – Recognize structurally subordinated debt as available capital to some degree and only to the extent funded (i.e. any receivables for non-paid-in amounts would not be included for purposes of calculating the allowance). For purposes of recognition both of the following criteria are required to be met:

   a. The instrument must have a fixed term (a minimum of five years at the date of issue or refinance, including any call options).
b. Supervisory approval is required for any extraordinary dividend or distribution from any insurance subsidiary to fund the repurchase or redemption of the instrument. There shall be no expectation, either implied or through the terms of the instrument, that such approval will be granted without supervisory review.

3. For initial field testing:
   a) Construct the initial field testing template so as to collect data on senior debt issued to be included as capital such that a range of caps relative to total available capital can be evaluated to assess the level. For purposes of testing a range of caps as a percentage of total available capital, the total available capital base should be defined as aggregated entity based capital (e.g. SAP available capital for U.S insurers) plus the outstanding value of the senior debt.
   b) In addition to 3a, construct the initial field testing template so as to collect data on debt that includes equity like features (so-called hybrids) and other subordinated debt issued, including the extent that the proceeds are downstreamed to the regulated entities or otherwise used for the benefit of those entities at the time of issuance of the debt instruments, such that an additional cap for these instruments can be evaluated. For purposes of testing an allowance as a percentage of total available capital, the total available capital base should be defined as aggregated entity based capital (e.g. SAP available capital for U.S insurers) plus the outstanding value of the senior debt and hybrids or other subordinated debt.
   c) As one option for field testing, a cap should be tested based on the amount of proceeds of the debt that is downstreamed to the regulated entities or otherwise used for the benefit of those entities at the time of issuance of the debt instruments.
   d) Recognize the proceeds of surplus notes and structurally subordinated senior debt as capital in line with the criteria described above, but respect quality of capital classifications defined by other U.S. sectoral regulators on their regulated entities’ available capital.

4. Other recommendations:
   a) Review and establish appropriate allowance criteria for hybrid debt that recognizes the instruments’ required equity features.
   b) Continue discussion, in consultation with NAIC international team, to maintain consistency on the boundaries of what constitutes structural subordination and how it should be measured.
Commissioner Altmaier stated the purpose of the conference call is to continue discussions about the confidentiality of the group capital calculation (GCC). He stated prior to the Summer National Meeting, he had previously asked NAIC staff to draft an initial memorandum on this topic to allow the Working Group to begin its discussions. He stated during that meeting, the Working Group discussed that initial memorandum briefly, and began some discussions with interested stakeholders. He noted that since that time, additional comment letters have been received on the topic.

Commissioner Altmaier reminded members about the previous discussions as the Summer National meeting, where he reiterated that during the development of the GCC, the Working Group had been clear that once completed, confidentiality would be needed. He stated there had been some discussions about the NAIC model to place such confidentiality provisions, and the Working Group has initially identified the Risk-Based Capital (RBC) for Insurers Model Act (#312) as a logical place to insert language. He stated another issue is preventing rating agencies and other third parties’ access to the GCC. He stated that during today’s conference call, he wants to focus on some of the comments received since the Summer National Meeting.

Michael Gugig (Transamerica), representing a coalition of 10 companies, summarized the basis for some of the more significant elements of their comments on this topic (Attachment Three-B1). He stated that from their vantage point, the need for robust confidentiality protections is absolutely critical to the ultimate success of the GCC in part because of the coalition’s views about deviating from legal entity rules with certain on-top adjustments, which he said they would continue to fight for at the appropriate times. He stated that a GCC for such companies with on-top adjustments will end up with a GCC ratio lower for those companies to which the on-top adjustments would apply than the stated capital in statutory reporting. Mr. Gugig said the coalition thinks the difference between the GCC ratio and the risk-based capital (RBC) ratio would be of significant concern to many stakeholders, not the least of which would be rating agencies or other regulators, or stockholders to the extent that the company has a stock company where policyholders would be confused if they are doing research on an RBC and the GCC ratio. He stated that if the GCC ratio is public information, it is likely to lead to consumer confusion about the actual financial position of the ensure that they have either purchased a policy from or are considering purchasing a policy from. He discussed how there is precedent in the current Insurance Holding Company System Regulatory Act (#440) and said in their draft proposal, the coalition included similar provisions. He stated that their initial view is that Model #440 is the appropriate placement for such protections.

Andrew Vedder (Northwestern Mutual), also representing New York Life and Travelers, summarized the basis for the more significant elements of their comments on the topic (Attachment Three-B2). He stated that while the confidentiality question is important, it should be viewed in the context of the other important decisions to be made about the GCC, including the regulatory filing mechanism that will be chosen. He stated that the NAIC draft memorandum suggests that Model #440 will be that mechanism and they do see merit to that, given that the #440 already addresses supervision of an insurance group, including insurance and non-insurance entities. He noted, however, that given the importance of the regulatory mechanism decision, they would recommend that there be some focus on that question and suggest that a logical next step might be for the Working Group to assess: 1) how it would serve the purposes of the GCC; 2) the relationship to existing regulatory tools; and 3) filing mechanisms under the act in the comparison of alternatives. He stated that their second point is that when it comes to defining the appropriate degree of confidentiality, the question should be viewed in the context of what the GCC is intended to be, which is a new regulatory tool to provide a group-level perspective on capital strength aggregated from legal entity RBC with the adjustments needed to make it a credible group-level measure done in a straightforward and transparent way. These considerations seem more important than how a company’s results may differ from an entity-level view. Commissioner
Altmaier asked for clarification. Mr. Vedder stated that they were operating under the expectation that there will be some regulatory attachment point for the GCC as a requirement and that where it fits in the regulatory toolkit needs to be considered before settling on the confidentiality language.

Bob Ridgeway (America’s Health Insurance Plans—AHIP) summarized AHIP’s comments on the topic (Attachment Three-B3). He noted that throughout the development of this GCC, Commissioner Altmaier has stated that it is more important to get this done right than quickly, and he stated his appreciation for that point. He stated this was particularly the case regarding the confidentiality. He stated that while AHIP cannot say that Model #440 is the perfect place to put language, it cannot think of a better place for it to be. He stated AHIP would also like to give at least a preliminary agreement or support to the coalition of 10 recommended revisions to section eight of Model #440 as the confidentiality language. He discussed that during a prior NAIC project, NAIC legal staff indicated that it was important to keep the confidentiality protections consistent from each NAIC model and from state to state, and AHIP believes that is still good advice for this topic.

Mariana Gomez-Vock (American Council of Life Insurers—ACLI) said the ACLI appreciates the Working Group’s recognition of the need for confidentiality of the GCC. She stated its members just met via conference call on this topic and that it wants to provide a summary of its views. First, the GCC should be a confidential regulatory filing, and the ACLI agrees with the NAIC’s view, as espoused in the May 29 “Proposed Group Capital Calculation” memorandum, that the GCC “will be a confidential regulatory filing” and that state insurance regulators will implement the appropriate confidentiality protections. Confidentiality should also be strictly observed while the GCC is under construction and before it is finalized in a version that stakeholders believe is fit for purpose.

Second, Ms. Gomez-Vock stated that strict confidentiality of the GCC results are necessary because if the GCC results are published by the NAIC or affected companies, the potential for misuse and abuse of the GCC ratio/data is high. Non-regulators who view the numbers will not have insight into the details of the calculation to be able to interpret and understand the GCC results. As a result, there is a strong likelihood the GCC would be misused to make comparisons between companies instead of being used as a sophisticated regulatory tool that is “intended to provide comprehensive accounting and transparency to state insurance regulators and facilitate earlier engagement with company management regarding potential business operations of concern and communication with other insurance regulators.” She noted that the NAIC has historically acknowledged and recognized the potential for the misuse of certain regulatory filings like non-public RBC reports or plans by limiting the ability of companies or state insurance regulators to disclose these reports. The GCC, as contemplated by the NAIC, will be a regulatory tool that helps state insurance regulators “better understand an insurance group’s financial risk profile for the purpose of enhancing policyholder protections.” A high degree of regulatory acumen will likely be necessary to ensure that the results, and the nuances contained within them, are understood in the appropriate context.

Finally, Ms. Gomez-Vock stated that the ACLI has a question. She said they appreciate that the Working Group is giving serious thoughts to the need for robust confidentiality protections and is considering using the Model #440 as a vehicle to incorporate those protections, but the ACLI has a question about the timing and implementation of the confidentiality protections and the timing and implementation of the calculation. Specifically, the NAIC has said it hopes to finalize the GCC in 2019 or early 2020 and begin implementation as soon as possible. The ACLI’s question is: How does the NAIC plan to handle the potential discrepancies between the two timelines? If the goal is to finalize the GCC and begin implementation in 2020, how does that affect the placement and implementation of the necessary confidentiality protections? Are we setting up a scenario where the GCC is ready to be implemented but the confidentiality protections have not been incorporated into Model #440 yet, much less adopted into state law yet? She stated the ACLI is not opposed to including the confidentiality protections in Model #440, but it believes it would be beneficial to have a discussion on the implementation of the GCC and confidentiality protections, and what the plan is to ensure that the protections are in place if the NAIC begins implementing the GCC prior to the adoption of Model #440 amendments. It may also be appropriate to consider a vehicle other than the HCA, and just in case, the ACLI wants the confidentiality and placement discussions to proceed hand in hand.

Commissioner Altmaier responded that it was a good question and stated he believes Mr. Slape touched upon this issue at the Summer National Meeting. He stated that there probably is a little bit of misalignment between the two timelines but that he sees a duel track approach to where progress is made on both during 2020 to where they become aligned once the GCC is completed. He also talked about how state insurance regulators have done things in the past with respect to, for example, the Own Risk and Solvency Assessment (ORSA) pilot project, where examination statutes were used in the interim.

Mr. Barlow stated he was confused by the comments from Mr. Vedder from the standpoint that the NAIC is not planning to create a model law with authority for the GCC. Commissioner Altmaier responded that he does not envision a group capital law like the RBC model law, which establishes thresholds under which regulatory regulators could act. He stated he believes
Mr. Vedder was suggesting that if the intent is for state insurance regulators to require all their insurers to provide a copy of their GCC, there might need to be somewhere in a model that that is a required filing. Mr. Slape agreed with Commissioner Altmaier and noted how certain ratios were developed using data supplied by annual statement filings required by law. He said the GCC would need a specific statutory framework on which to collect data. He also agreed that the work can be dual tracked in some respects as not to distract the GCC work. Commissioner Altmaier asked Mr. Vedder if he agrees with others on the non-disclosure issue; not only should the calculation be confidential when it was given to state insurance regulators, but also to have prohibition placed upon them so that insurers are not permitted to share their calculation with someone like a rating agency. Mr. Vedder responded that when it’s taken to something like rating agencies, it does get more complicated because rating agencies are going to have their own tools, and they do receive confidential information from insurers already. He stated he agrees with the idea that it is not something that companies should be advertising. However, he said he considers the GCC a relevant tool and rating agencies ask about relevant tools and including things like the Risk Management and Own Risk and Solvency Assessment Model Act (#505).

Mr. Gugig responded that Transamerica agrees with Mr. Slape but with respect to the rating agencies, those are exactly the type of entities that Transamerica referred to when it talked about the inability to understand. He stated that there are lots of nuances that state insurance regulators would understand that he does not think even rating agencies would. He said Transamerica thinks that rating agencies might use the information to publicly create winners and losers.

Commissioner Altmaier stated that he would work with NAIC staff to update the memorandum to reflect some of the conversations and bring back for discussion on a future conference call.

Having no further business, the Group Capital Calculation (E) Working Group adjourned.
July 30, 2019

Commissioner David Altmaier
Florida Office of Insurance Regulation
Chairman, NAIC Group Capital Calculation (E) Working Group
via email to  ddaveline@naic.org & Ifelice@naic.org

Re: August 3, 2019 Working Group Discussion of Group Capital Calculation Confidentiality

Dear Commissioner Altmaier:

On behalf of a coalition of ten companies (Athene Holding Ltd., Brighthouse Financial, Global Atlantic Financial Group, Jackson National, Lincoln Financial, National Life Group, Pacific Life, Protective Life, Reinsurance Group of America, and Transamerica; collectively “the Coalition”), we write in advance of the August 3, 2019 Group Capital Calculation Working Group (GCCWG) meeting to provide our Coalition’s initial thoughts on the need for significant confidentiality protections once the Group Capital Calculation (GCC) becomes final. The Coalition greatly appreciates the opportunity to engage with the GCCWG and interested stakeholders regarding the confidentiality issue.

Initially, we want to make clear that the Coalition continues to strenuously urge the GCCWG to create a GCC that is faithful to the legal entity rules that NAIC has itself adopted through rigorous processes, and which state legislatures have in large part adopted in law. State regulators should avoid creating a complex and costly “dual system,” with one set of solvency measures at the legal entity level and a somewhat different set of measures at the group level. Moreover, we believe that international regulators may misunderstand the import of a GCC that disregards current capital rules (such as those for XXX/AXXX captives). Some will likely ask why the NAIC feels the need to reassess capital measures that insurers hold in accordance with state laws.

A. Broad Confidentiality Protections Are Necessary

The GCC for each group should receive the highest level of confidentiality permitted by law. The GCCWG has repeatedly made clear that the GCC is not intended to create a new capital requirement or standard. Instead, it is merely designed to be “one tool in the toolbox” for regulators to assess how capital at the group level might impact regulated insurance companies. Thus, we see no legitimate reason for regulators, the NAIC, insurers or other entities to be able to disclose any particular group’s GCC for any non-regulatory purpose.

We believe that on-top adjustments being considered by the GCCWG increase the risk of harmful disclosure. As we have previously pointed out in comment letters and conversations with GCCWG members, on-top adjustments in the GCC create “winners” and “losers.” The “winners” would benefit from an optical windfall, while the perceived financial strength of the “losers” will be undermined.
“Winners” could then attempt to use the GCC as a competitive weapon by disclosing their own results, implicitly opening non-disclosing groups to criticism and scrutiny from interested parties. For example, if a company were to disclose its GCC to rating agencies, analysts, or the general public, it would likely prompt those entities to pressure other groups to disclose their own GCC ratios. This would be unfair to insurers that have done nothing untoward, but which are nonetheless among the “losers.”

Therefore, disclosure of any group’sGCC outside the regulatory community would foster a competitive imbalance, undermining the NAIC’s stated mission of “facilitating...an effective and efficient marketplace for insurance products.”\(^1\) We therefore urge the GCCWG to adopt strict confidentiality protections that would preclude disclosure of any group’s GCC outside the regulatory community, whether by regulators, insurers, insurance groups or others.

**B. Proposed Holding Company Act Amendments To Ensure GCC Confidentiality**

We believe that the NAIC Model Insurance Holding Company System Regulatory Act (“Holding Company Act”) is likely to be the preferred place to address GCC confidentiality as well as a prohibition on disclosure of the GCC and resulting Group Capital Ratio. Our reasons include that the Holding Company Act: (1) is referenced within the NAIC’s May 29, 2019 GCC report; (2) is the only model act that addresses both an insurer and other members of an insurance group; and (3) already includes authority for a regulator to examine non-insurer members of an insurance holding company system. To this end, we are providing our preliminary thoughts regarding possible changes to Section 8 (Confidentiality) of the Holding Company Act.

Our proposed language draws from and strengthens confidentiality provisions in other NAIC models. One such model is the RBC for Insurers Model Act, which includes a specific prohibition on public disclosure/advertising of RBC ratios. Because the NAIC describes the GCC as an “RBC aggregation methodology” and incorporates the RBC throughout the calculation, incorporating confidentiality provisions from the RBC Model Act seems logical.

Another model from which we propose to borrow language is the ORSA Model Act. Given the sensitivity of ORSA information, the ORSA model includes an enhanced level of confidentiality protection. The GCC is likely to be at least as commercially sensitive as ORSA.

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In conclusion, the Coalition respectfully submits that, because the GCC may deviate from how available and required capital is calculated under legal entity rules and thus would

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almost certainly lead to confusion and misunderstanding by non-regulatory stakeholders, the most robust possible confidentiality protections are warranted.

The Coalition appreciates the opportunity to provide a summary of its position on confidentiality in advance of the National Meeting. We look forward to engaging with the GCCWG on this important issue.

Sincerely,

Athene Holding Ltd.
Brighthouse Financial
Global Atlantic Financial Group
Jackson National
Lincoln Financial
National Life Group
Pacific Life
Protective Life
Reinsurance Group of America
Transamerica
Model 440 – Insurance Holding Company System Regulation Act

Recommended Revisions

Section 8. Confidential Treatment: Prohibition on Announcements

A. Documents, materials or other information in the possession or control of the Department of Insurance that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to Section 6 and all information reported or provided to the Department of Insurance pursuant to Section 3B(12) and (13), Section 4, Section 5 and Section 7.1 shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties, but shall seek to maintain the confidentiality of such documents during the course of any such regulatory or legal action. The commissioner shall maintain the confidentiality of the group capital calculation and Group Capital Ratio. With respect to all other documents, materials or other information covered by this paragraph, the commissioner will not otherwise make such the documents, materials or other information public without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part in such manner as may be deemed appropriate.

B. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to this Act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to Subsection A.

C. In order to assist in the performance of the commissioner's duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, with any third-party consultants, and with state, federal, and international law enforcement authorities, including members of any supervisory college described in Section 7, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information, and has verified in writing the legal authority to maintain confidentiality.

(2) Notwithstanding paragraph (1) above, the commissioner may only share confidential and privileged documents, material, or information reported pursuant to Section 4L with commissioners of states having statutes or regulations substantially similar to Subsection A and who have agreed in writing not to disclose such information.

(3) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of
the document, material or information; and

(4) Shall enter into written agreements with the NAIC and any third-party consultant governing sharing and use of information provided pursuant to this Act consistent with this subsection that shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC and its affiliates and subsidiaries or a third-party consultant pursuant to this Act, including procedures and protocols for sharing by the NAIC with other state, federal or international regulators. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileges status of the documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(ii) Specify that ownership of information shared with the NAIC and its affiliates and subsidiaries or a third-party consultant pursuant to this Act remains with the commissioner and the NAIC’s or a third-party consultant’s use of the information is subject to the direction of the commissioner:

(iii) Prohibit the NAIC or third-party consultant from storing the information shared pursuant to this Act in a permanent database after the underlying analysis is completed;

(iv) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant pursuant to this Act is subject to a request or subpoena to the NAIC or a third-party consultant for disclosure or production; and

(v) Require the NAIC and its affiliates and subsidiaries or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC and its affiliates and subsidiaries or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC and its affiliates and subsidiaries or a third-party consultant pursuant to this Act.

(vi) In the case of an agreement involving a third-party consultant, provide for the insurer’s written consent.

D. The sharing of information by the commissioner pursuant to this Act shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this Act.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection C.

F. Documents, materials or other information in the possession or control of the NAIC or third-party consultants pursuant to this Act shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

G. It is the judgment of the legislature that the group capital calculation and resulting Group Capital Ratio is a regulatory tool for assessing group risks and capital adequacy, and is not intended as a means to rank insurers or insurer groups generally. Therefore, except as otherwise may be required under the provisions of
this Act, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the group capital calculation or Group Capital Ratio of any insurer or any insurer group, or of any component derived in the calculation, by any insurer, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the group capital calculation or resulting Group Capital Ratio or an inappropriate comparison of any other amount to an insurer’s or insurance group’s group capital calculation or resulting Group Capital Ratio is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.
August 22, 2019

Via Electronic Delivery

Commissioner David Altmaier
Florida Office of Insurance Regulation
J. Edwin Larson Building
200 E. Gaines Street, Room 101A
Tallahassee, Florida 32399

Attention: Dan Daveline

Re: Confidentiality of GCC Results

Commissioner Altmaier:

The issue of confidentiality protection of the group capital calculation (“GCC”) has been presented for discussion by the Group Capital Calculation Working Group (the “Working Group”). Arriving at the appropriate answer to this question is integral to regulators receiving high quality information from insurance groups. As continued supporters of the NAIC’s development of a robust capital calculation, we appreciate the opportunity to comment on this issue. An appropriately designed GCC that promotes comparable and consistent approaches across companies will be a useful supervisory tool to assist lead states in analyzing the financial condition of insurance groups by complementing entity-based solvency requirements. While the issue of appropriate confidentiality should be considered with any new supervisory tool, a narrow or premature focus on confidentiality could distract from resolution of all the other important issues that need to be addressed to develop a credible capital standard. Confidentiality must be approached and sequenced within the broader development process, taking into consideration a variety of interdependent issues, including the supervisory purpose, the relationship to existing regulatory tools, the statute or regulation under which the filings would be made (i.e., the regulatory filing mechanism) and how confidentiality is provided within statutes or regulations.

We have reviewed the draft memorandum from the Working Group to the Group Solvency Issues Working Group (“GSIWG”), including its recommendation that the Insurance Holding Company System Regulatory Act (#440) be revised to incorporate appropriate confidentiality protections for the GCC. The memorandum alludes to other key decisions that remain with respect to the GCC, including several with respect to the filing mechanism. We believe that a determination as to the appropriate filing mechanism is a critical pre-condition that should be discussed and agreed upon before language regarding confidentiality can be developed. Different confidentiality considerations may apply depending on the regulatory framework that is ultimately chosen to facilitate filing of the GCC with regulators.
When the Working Group discusses the appropriate level of confidentiality protections, we would respectfully suggest that it consider the appropriate level of confidentiality for the results of a regulatory tool that provides insight into group-level risk, and how that should differ, if at all, from the confidentiality applied to other information provided under the Holding Company Act. One of the advantages of the GCC over consolidated group capital methods is that it aggregates existing entity-level RBC results, with appropriate adjustments, in a straightforward and transparent manner. The resulting GCC will be, as members of the Working Group have noted, another tool in the regulatory toolbox that assists with group-wide surveillance and solvency regulation. We view these considerations as more relevant to the determination of an appropriate degree of confidentiality than speculation as to whether and how the results will differ from a legal-entity view.

We understand that the Working Group may be concerned with ratings agencies seeking to access GCC results. Even if the Working Group were to draft confidentiality protections that would prevent groups from sharing their GCC results with ratings agencies, we would still expect that those agencies could conduct their own calculations that would approximate the GCC’s results or provide a similar group-level perspective on capital.

Our companies will be pleased to provide further input into this process as the Working Group completes the work necessary to establish a robust GCC, including resolving important issues such as the appropriate degree of confidentiality, as well as the related and equally important issue of the filing mechanism for GCC results.
We are grateful for your time and attention to our comments. If you would like to discuss this letter with us, please let us know.

Sincerely,

Douglas A. Wheeler  
Senior Vice President  
Office of Governmental Affairs  
New York Life Insurance Company

Andrew T. Vedder  
Vice President  
Solvency Policy & Risk Management  
The Northwestern Mutual Life Insurance Company

D. Keith Bell  
Senior Vice President  
Corporate Finance  
The Travelers Companies, Inc.
September 27, 2019

Commissioner David Altmaier  
Florida Office of Insurance Regulation  
Chair, Group Capital Calculation (EE) Working Group  
1100 Walnut, Suite 1500  
Kansas City, MO  64106-2197  

Via email to ddaveline@naic.org

Re: August 3, 2019 Discussion of Group Capital Calculation Confidentiality

Dear Commissioner Altmaier;

As several companies, including some of AHIP’s members, engage in the Group Capital Calculation Field Testing, AHIP and its members appreciate the continuing cooperation displayed by you and other regulators and staff on the Working Group, and we welcome the opportunity to offer comments to the proposal concerning confidentiality which has been set out as a draft memo to Justin Schrader, Chair of the Group Solvency Issues (E) Working Group.

We have reviewed the letter of July 30, 2019, from the Coalition, and generally support the views expressed there. Although we also believe that the confidentiality language should be consistent not only from NAIC Model to NAIC Model, and also from state to state in their enactments of those Models, we are open to discussing some changes to the confidentiality language in the Holding Company Act, not only to increase the consistency between it and the confidentiality protections in the ORSA Model, but also to address any specific gaps that have come to light in recent years.

What we cannot support, however, would be any initiative which could weaken or otherwise restrict the strongest possible confidentiality protections for the GCC’s calculations or any final figures resulting from them.

We look forward to continuing the cooperative atmosphere set by you and your fellow regulators as we continue working on this issue, and we hope you will let us know if there is further assistance we can offer.
Sincerely,

Bob Ridgeway
America’s Health Insurance Plans
NAIC GROUP CAPITAL CALCULATION FIELD TESTING
INITIAL REVIEW OBSERVATIONS AND DATA SUMMARIES
December 6, 2019

Status of Field Test

- 32 Submissions Reviewed by NAIC (1 Volunteer withdrew)
- 28 Review Summaries Provided to / Discussed with Lead—States
- 14 Submissions Presented and Discussed with Volunteer
- NAIC / Lead-States will Schedule Calls with Remaining Volunteers (est. completion before 1/15/2020)

Field Test Feedback (Template and Instructions)

- Comments and Observations Thus Far on:
  - Template
    - Additions / deletions
    - Formula revisions
  - Instructions:
    - Additions and clarifications

Schedule 1

- Instructions
  - Clarify required entries in Schedule 1B, Column 16 (Treatment of Entity for RBC purposes)
  - Clarify instructions or eliminate Section 1D, Column 4 (Notional Value of Contract)
  - Add / delete instructions for new data columns and delete for any that are removed
  - Clarify definition of regulated vs. non-regulated financial entity
  - Clarify Instructions for Tests in Schedule 1E
- Template
  - Add Columns in Schedule 1C to report stand-alone revenue and equity amounts for each entity (+ instructions). This will avoid double counting in the tests applied to non-insurance entities
  - Remove the following data:
    - Financial strength ratings?
    - Assumed and ceded premiums?
  - Add the following data:
    - Dividends Paid and Received
    - Capital Contributions Paid and Received
    - Inter-group reinsurance assumed and ceded
    - Income/other data for insurers as well (for trending/better picture of group)

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Inventory Tab

- Instructions
  - Enhance instructions regarding carrying values to be reported in Columns 1 and 2 of Inventory B (Parent and Local carrying values)
  - Clarify when values should be reported in Inventory C for non-insurance / non-financial entities including holding companies
  - Clarify where and which intercompany receivables and payables should be reported in Inventory C.
  - Clarify reporting of prescribed and permitted practices of subsidiaries in Inventory B and C, columns 9 and 10
  - Clarify handling of de-stacking of Schedule BA financial affiliates and intragroup surplus notes
- Template
  - Add columns (+ instructions) in Section 1B for GAAP to SAP (or other regulatory) adjustments
  - Address (+ instructions) cases where a foreign regulator does not impose an insurer entity capital requirement.
  - Add columns (+ instructions) in Section 1B and 1C for foreign currency adjustments to U.S. dollars (may be better to handle in Schedule 1)

Capital Instruments

- Instructions
  - Clarify what should be reported in Section A, column 9 ("Amount recognized or credited as capital in local regulatory regime")
  - Clarify what should be reported in Section A, column 10 ("Amount Down-streamed") and clarify criteria for “tracking”
  - Clarify instructions as relates to debt issued to affiliates (avoid double hit for captive adjustments)
- Template
  - Adjust formulas to bring the correct amount of outstanding debt into the calculation base in Section B.
  - Review allowance options for hybrid debt
  - Cleaner separation of intra-group debt vs. debt issued to parties outside the group
  - Include all debt and improve tie with Schedule 1C, Column 12

XXX / AXXX Assets and Liabilities

- Template
  - Very few comments on the template and instructions
    - Recommendation to delete tax affecting the calculation
  - Most comments suggested information should not be included in ratio, but more as FYI

Questions and Other Information

- Instructions
  - Materiality information TBD
  - Should there be a materiality threshold for non-insurance / non-financial Schedule BA affiliates (Similar to such entities in Schedule D)?
- Template
  - Add a description of debt instruments listed in the Capital Instruments Tab that are reported as other than senior debt or hybrid debt.
  - Add question on intangible assets held by positive value Hold Co’s + instructions
Scalors

- Instructions
  - TBD

- Template
  - Separate alternative charges for Hold Cos from other scaled values for foreign insurers

Test Options and Data Points Summary

- Base GCC Ratio
- Defining the Insurance Group
  - Materiality (include / exclude and thoughts on regulator discretion)
  - Treatment of Non-insurance / Non-financial entities
- Banks and Other Financial Entities
- Treatment of Hold Cos
- Permitted / Prescribed Practices
- Capital Instruments
- XXX / AXXX
- Scalars

Guide to Hi-Level Charts

Base GCC Ratio

- All Entities
- All Entities at Values Reported in the Inventory Tab
  - Trend test calibration for RBC filers and non-insurance / non-financial subsidiaries (300% x ACL)
  - Available capital from Inventory B, Column 8 (negative values included)
  - Capital calculation from Inventory C, Column 8 (floored at zero)
  - All permitted and prescribed practices allowed
  - All non-operating hold cos at zero capital calculation
  - All values foreign insurance values scaled at 100%
  - Captives at reported regulatory values
  - No additional allowance for senior / hybrid debt

Attach Chart A - Base GCC Ratios
Defining the Insurance Group

- Field Test includes the ultimate controlling party and all entities within the group.
  - Only non-insurance / non-financial entities without material risk that are outside the defined insurance group may be marked as ‘exclude’.
- Current Definition of Insurance Group

  An insurance Group is comprised of the head of the Insurance Group (insurer, mutual holding, or other holding company) and all entities under its direct or indirect control and includes all members of the Broader Group that exercise significant influence on the insurance entities and/or facilitate, finance, or exercise the insurance operations.

  An Insurance Group may be:
  - a substantial part of a bank-led or securities-led financial conglomerate; or
  - a subset of a wider group.

- Materiality and Excluding Non-insurance / Non-financial entities
  - No single suggestion for a threshold-led consensus from the volunteers
  - 17 volunteers excluded some amount for non-material entities (Range from <1% of Available Capital to 46%)
  - Range of results is shown in Chart B

- Treatment of Non-insurance / Non-financial Entities
  - Owned by insurers (may not be excluded) – consider not de-stacking due to coverage issues in RBC
  - Owned by non-insurers within defined group (may not be excluded)
  - Owned outside the defined insurance group (may be excluded based on materiality threshold)
  - Tested using 5 alternative equity and revenue-based measures – See Chart C

Included Business; Stock Companies Only [Chart B Hi-Level]

- Impact of removing ‘Excluded’ entities is small for most Volunteers but leads to a large reduction for a small number of them.

Range of NI Tests [Chart C Hi Level]

- Tests 2a is reported at 2 calibration levels (12% Scaled to RBC CAL & Revenue and 12% Scaled to RBC Trend Test & Revenue
- Treatment of Non-insurance / Non-Financial entities is material for three volunteers and not material for the rest.
- Of these three entities, one sees sizable benefit from the revenue-based tests (i.e. . 1a, . 7b and 2a) and
- The average impact is positive. Tests based on carrying value (i.e. . 25 and 3) have less impact on all.
Banks and Other Financial Entities

- Banks are valued at regulatory available capital and regulatory capital requirements (risk weighted assets calculation) [Chart D]
- Other Financial Entities (e.g., asset managers) were run through several equity and revenue-based tests
  - Chart E displays the range of results for the calculations that were tested

Chart D Bank

- There are 9 volunteers with banking operations. Of those, 5 have more than 1% of available capital in banking entities.
- Capital ratios for banking within these volunteers are in range of 100-300%.

Non-Bank Range of Fin Tests [Chart E Hi-Level]

- The revenue based tests tend to lead to higher charges than the BACV and notional value based test.

Treatment of Hold Cos

- Non-operating Hold Cos (Ungrouped)
  - Negative values included
  - Zero Capital charge
  - Alternative charge @ 22.5% x stand-alone value
  - Chart F indicates impact of 22.5% charge on the OCC ratio
- Operating Hold Cos
  - Treated based on operating activities (and included with data on applicable entity type)
  - Grouped Hold Cos (Excludes regulated insurance and bank entity Hold Cos)
    - Categorized based on entity type of grouped subsidiaries and included with data on applicable entity type
    - Must all conduct similar operating activities and reported under same basis of accounting

Impact on Capital Ratio of 22.5% Charge on HC (floored at 0)
Perm/ Prescribed Practices

- Permitted and prescribed practices can both increase and decrease capital ratios.
- In dollar terms, the bulk of the impact was in P&C entities. As a %, the entity category most impacted was Property & Casualty Insurers (not GAAP Captives)
  - Does not include asset adjustments for AGAII Captives that are shown separately.

Capital Instruments (1)

- 23 Volunteers Issued Debt other than Surplus Notes from either Top or Downstream Hold Cos
- Tested Allowances from 20% to 100% for Senior Debt and 10% to 100% for Other Debt
- Ratio Of All Listed and Qualifying (i.e. at least 5-year term) Debt to Equity Ranges was calculated in two ways
  - The straight debt to equity ratio ranges from 1% to 95%
  - When the qualifying debt is included in the denominator, the range is 1% to 48% (7 > 30% / 3 = 40%)
- Chart D shows the average ratio of debt to base available capital for the individual groups for debt adjusted (with debt included in the denominator)

Capital Instruments EXAMPLE (2)

- Some Volunteers’ Description of Debt Listed as “Other” or “Capital Instruments” is Still Required
- Chart H shows the impact on the GCC ratio for stock groups by Industry Segment using (i) expanded ratio definition and applying a sample allowance of 30% for senior debt and 15% of other debt and (ii) No limit on debt

Note: Allowing Senior Debt may require reconsideration of capital calculation for hold cos.

XXX / AXXX

- Test 3 generally considered most favorable
  - Uses economic reserve approved by regulator on captives
  - Uses factor approach as proxy for companies not modeling
- Test 1 factor for XXX considered somewhat reasonable
- Test 1 factor for AXXX less desired but at least recognizes reserve likely overstated
- Test 2 not able to be completed by many companies due to lack of data (would require estimations);
- Test 4-Despite some negative feedback on Test 1 factor approach, only 5 utilized a different factor, and none pushed it as being right for rest of industry
- Test 5-Only 5 companies provided (GAAP or GAAP based)
22 Volunteers Reported Insurance Entities Located in Non-U.S. Jurisdictions > 1% of Available Capital. The range was from 1.9% - 83.8%.
- 13 Volunteers Reported Insurance Entities Located in Non-U.S. Jurisdictions > 10% of Available Capital (9 reported > 30%).
- 4 scaling methods were tested – 2 at RBC Trend Test Level (300% x ACL) and 2 at RBC CAL.
- Over 90% of entities (as measured by available capital) were mapped to named entity category. Remainder were mapped to Region A, B, etc.
- Some of these regimes do not have req’d capital; in such cases suggestion made to set “calc capital” = “available capital.”

NOTE: One suggestion to use Group Specific (Rather than U.S. Industry) Average RBC Ratio and Excess Ratio compared to Jurisdiction Ratios to Scale.

- Chart above shows impact of scalar options for all volunteers and the subset that are likely IAIG’s.
- Main driver of the differences is calibration level: Premise 1 and Premise 2 are at “Trend Test” level (i.e. 300% of ACL) while Premise 3 and Premise 4 are at Company Action Level (i.e. 200% of ACL).
- Likely US ‘Internationaly Active Insurance Groups’ are actually less sensitive, on average, to scalars than other volunteers. This is mostly due to inclusion of non-US domiciled insurers in the sample.
Other Input Provided

- Consider Materiality Threshold for Schedule BA Non-financial Affiliates
- Do Not De-stack Non-insurance / Non-financial entities from RBC Filers
- RBC Equity Charges are Too High for Non-insurance / Non-financial Affiliates Outside the Defined Insurance Group.
- Consider Other Options for Non-RBC Filing U.S. Insurers
- Consider a capital charge on Des-stacked Hold Cos material positive values (Due to investment risk or holding of significant intangible assets)

Template Revisions Since Version 2

- Fixes / Changes to address data quality:
  - Added separate row to ‘Calc.2’ to allow adjustment to calculated capital due to permitted / prescribed practices
  - Several adjustments to fill in missing data: used ‘Revenue’ as proxy for ‘Revenue during year of greatest loss’ and ‘Average 3 yr. Revenue’; ‘Adj Carrying Value’ for Equity and BACV, etc.
  - Any capital instrument with blank/error in maturity date was assumed to be included
- Suggested improvements:
  - Req’d capital should be entered Company Action Level and then multiplied by 1.5 in the template
The Mortgage Guaranty Insurance (E) Working Group of the Financial Condition (E) Committee met in Austin, TX, Dec. 8, 2019. The following Working Group members participated: Kevin Conley, Chair and Rick Kohan (NC); Kurt Regner (AZ); Virginia Christy (FL); John Rehagen (MO); Joe DiMemmo and Melissa Greiner (PA); Miriam Fisk (TX); and Amy Malm (WI).

1. Exposed the Mortgage Guaranty Capital Model

Mr. Conley indicated that the goal of the mortgage guaranty capital model is to construct a counter-cyclical model similar to risk-based capital (RBC). Further, he indicated that the capital model is intended to help the state insurance regulator understand the relative capital position and strength of the mortgage insurer. He indicated that in late 2017, Milliman was brought on to audit the original work conducted by Oliver Wyman to determine if anything could be salvaged. He stated that by the summer of 2018, the Working Group moved ahead and asked Milliman to develop a new capital model. He commented that the Working Group asked Milliman to utilize the Oliver Wyman data set in order to summarize the data and drop it into an excel format so that North Carolina could follow along and build the capital model block by block, allowing for continuous state insurance regulator involvement, transparency and buy-in. He indicated that North Carolina initiated a lot of collaboration with Milliman to get to this point in the development process. He commented that he believes that the capital model predicts ultimate capital losses accurately on a book year and accurately across numerous years as determined through a testing process. He indicated that the Working Group was introduced to the concept of State Regulatory Mortgage Insurer Capital Standards (SRMICS) in September of this year. He indicated that the Working Group is implementing revisions to the capital model through the interaction with the industry trade group. Ed Hartman (Genworth Financial) commented that the original intention was to eliminate the 25:1 risk-to-capital standard and replace the contingency reserve. He stated that given the implementation of the new capital model, these two capital requirements should be evaluated to determine if they are still necessary. He commented that there is also a request for additional blanks reporting of sensitive data from a competitive perspective and would rather not have this data available to the public but make them prescribed schedules. Mr. Conley indicated that a letter was received from the industry trade group that addresses these concerns among other observations and suggestions by the industry trade group. He stated that the Working Group has not yet had time to review the letter and discuss.

Following the update on the capital model, Mr. Regner made a motion, seconded by Mr. DiMemmo, to expose the mortgage guaranty capital model and supporting documentation for a 45-day public comment period. The motion passed unanimously.

2. Exposed Model #630 and the Mortgage Guaranty Insurance Standards Manual

Ms. Malm commented that Wisconsin has submitted revisions to both the Mortgage Guaranty Insurance Model Act (#630) and the Mortgage Guaranty Insurance Standards Manual. She stated that there are four major areas of change:

- RBC standards were removed and replaced them with the SRMICS.
- Technical details, such as those related to underwriting standards, were removed from Model #630, due to the frequency of changes in best practices, and added to the Mortgage Guaranty Insurance Standards Manual.
- Reinsurance requirements were changed to make them compatible with the Credit for Reinsurance Model Act (#785).
- Dividend restrictions were rewritten to improve clarity and make them more enforceable.

Ms. Malm indicated that SRMICS establishes a capital requirement, based on a risk-modeled ultimate loss estimate, at the level of each insured mortgage loan based on the risk characteristics and economic conditions at origination. Further, she indicated that there are adjustments made at the book year level and the aggregate level of the calculation, but the foundation of the capital requirement is established at the loan level.

Ms. Malm stated that the economic factor that is applied at the individual mortgage loan level compares the rolling four-year change in state-level per capita income relative to the four-year change in state-level home prices at the time the mortgage loan...
is originated. By so doing, the capital requirement addresses geographic concentration risk and recognizes variations in market conditions across the U.S. Ms. Malm stated that this is far more effective in addressing geographic concentration risk than any fixed percentage limitation on the amounts of writings in any one state.

Ms. Malm commented that the SRMICS is economically countercyclical. She continued that the capital requirements rise as home prices become less affordable relative to per capita incomes, and very substantially so when there is indication of a housing market bubble. Further, she stated that this is intended to prompt mortgage insurers to become progressively more selective in their underwriting standards. Conversely, as home prices decline and become objectively more affordable relative to per capita incomes, capital requirements decline. She commented that while the viewpoints of members of this Working Group differed, a consensus was reached to maintain the 25:1 risk-to-capital ratio from the previous 1976 version of Model #630 as a floor below which the capital requirement could not go. She also stated that the reduction in capital requirements occasioned by a decline in home prices, which generally coincides with adverse economic conditions, is intended to encourage mortgage insurers to become prudently more expansive in their underwriting standards and thereby aid economic recovery.

Ms. Malm commented that the SRMICS Mandatory Control Level Event, which has been set at a ratio of total adjusted capital to SRMICS of 50% or less, is where the domiciliary commissioner must take actions necessary to place the company in receivership. She stated that this would not be the first option explored in such a circumstance. She indicated that a capital plan would be prepared by the company; the domiciliary commissioner would be either conducting an examination or an intensive analysis, and there is the likelihood of a corrective order being issued by the domiciliary commissioner. She concluded that the fact of the insurer’s failure to maintain its capital above the SRMICS is by itself sufficient grounds for receivership.

Ms. Malm commented that the SRMICS is a capital requirement with definite consequences. Although the domiciliary commissioner is not mandated to do so, a mortgage insurer whose capital falls below its SRMICS could be placed into receivership. She stated that this would not be the first option explored in such a circumstance. She indicated that a capital plan would be prepared by the company; the domiciliary commissioner would be either conducting an examination or an intensive analysis, and there is the likelihood of a corrective order being issued by the domiciliary commissioner. She concluded that the fact of the insurer’s failure to maintain its capital above the SRMICS is by itself sufficient grounds for receivership.

Ms. Malm commented that by the time a mortgage insurer were to fail its SRMICS, the domiciliary commissioner should have assembled a team to assist insurance department staff in the assessment of the company’s financial condition, risk exposures, and remediation plans, so that the company’s financial condition is either restored or there can be an orderly run-off, whether that is with or without a receivership proceeding. She stated that given the lead times required under responsible government contracting practices, Model #630 authorizes the domiciliary commissioner to retain consultants once the ratio of total adjusted capital to SRMICS is 125% or less. She indicated that consultants could also be retained by the domiciliary commissioner if an examination or investigation has indicated material deficiencies in underwriting procedures or in the Mortgage Guaranty Quality Control Program.

Ms. Malm commented that the SRMICS Mandatory Control Level Event, which has been set at a ratio of total adjusted capital to SRMICS of 50% or less, is where the domiciliary commissioner must take actions necessary to place the company in receivership. She stated that as with the Mandatory Control Level under the RBC structure, there is provision to allow the domiciliary commissioner to forego actions for up to one year after a SRMICS Mandatory Control Level Event if there is a reasonable expectation that the capital deficiency could be eliminated in a reasonable period of time. She countered, as a practical matter, that this would effectively require broad acceptance from commissioners throughout the U.S. She stated that the insurer must stop writing new business following an SRMICS Mandatory Control Level Event.

Ms. Malm indicated that SRMICS is a capital requirement with definite consequences. Although the domiciliary commissioner is not mandated to do so, a mortgage insurer whose capital falls below its SRMICS could be placed into receivership. She stated that this would not be the first option explored in such a circumstance. She indicated that a capital plan would be prepared by the company; the domiciliary commissioner would be either conducting an examination or an intensive analysis, and there is the likelihood of a corrective order being issued by the domiciliary commissioner. She concluded that the fact of the insurer’s failure to maintain its capital above the SRMICS is by itself sufficient grounds for receivership.

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Ms. Malm commented that by the time a mortgage insurer were to fail its SRMICS, the domiciliary commissioner should have assembled a team to assist insurance department staff in the assessment of the company’s financial condition, risk exposures, and remediation plans, so that the company’s financial condition is either restored or there can be an orderly run-off, whether that is with or without a receivership proceeding. She stated that given the lead times required under responsible government contracting practices, Model #630 authorizes the domiciliary commissioner to retain consultants once the ratio of total adjusted capital to SRMICS is 125% or less. She indicated that consultants could also be retained by the domiciliary commissioner if an examination or investigation has indicated material deficiencies in underwriting procedures or in the Mortgage Guaranty Quality Control Program.

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Control Level Event. She closed by stating that having a set of common parameters for this financial projection would allow for comparability if adverse economic circumstances were to affect all or most of the mortgage guaranty insurance industry.

Ms. Malm indicated that there are four major revisions to the reinsurance requirements within Model #630:

- Prior regulatory approval is required for all reinsurance agreements.
- There is a limit for aggregate concentration of mortgage guaranty risk in a multiline reinsurer, which is 15% of the assuming reinsurer’s gross written premium in the prior calendar year, and its aggregate maximum loss exposure to mortgage guaranty insurance risk should not exceed 30% of its capital and surplus as of the end of the immediately preceding calendar year.
- Subterfuge in reinsurance is prohibited. Under any reinsurance agreement, the unearned premium reserve, loss reserve, and contingency reserve must be established and maintained by the original insurer or by the assuming reinsurer so that the aggregate reserves of both shall be equal to or greater than the reserves required by Section 8 -Contingency Reserves of the Model Act.
- There are specific standards for a domiciliary commissioner disapproving a reinsurance agreement.

Ms. Malm stated that the section on dividend restrictions was revised to prohibit a mortgage insurer whose total adjusted capital is below its SRMICS from paying dividends. She stated that an insurer that has made releases from its contingency reserve at any time in the preceding 12 calendar months could only pay dividends if its domiciliary commissioner does not disapprove. She indicated that this rewrite presumes that contingency reserves will remain at the same level they are now, but an insurer would be allowed to make contingency reserve withdrawals, with domiciliary commissioner approval, to the extent that aggregate contingency reserves exceed the dollar equivalent of its SRMICS.

Following the update, Ms. Malm made a motion, seconded by Mr. Regner, to expose Model #630 and the Mortgage Guaranty Insurance Standards Manual for a 45-day public comment period. The motion passed unanimously.

3. Exposed the Draft Blanks Proposal Regarding a Mortgage Guaranty Insurance Exhibit

Mr. Conley commented that in order to get a better understanding of the mortgage guaranty business, better financial reporting is needed. As result, the Working Group proposes an exhibit that collects 20 years of data triangle experience and includes risk-in-force, earned premiums, paid loss and other elements.

Following the update, Mr. DiMemmo made a motion, seconded by Ms. Malm, to expose the mortgage guaranty capital model and supporting documentation for a 45-day public comment period. The motion passed unanimously.

Having no further business, the Mortgage Guaranty Insurance (E) Working Group adjourned.
The National Treatment and Coordination (E) Working Group of the Financial Condition (E) Committee met via conference call Nov. 6, 2019. The following Working Group members participated: Joel Sander, Co-Chair, and Cuc Nguyen (OK); Linda Johnson, Co-Chair (WY); Cindy Hathaway (CO); Maura Welch and Joan Nakano (CT); Carolyn Morgan (FL); Mike Boutwell and Stewart Guerin (LA); Debbie Doggett (MO); Ursula Almada (NM); Cameron Piatt (OH); Greg Lathrop and Ryan Keeling (OR); Robert Rudnai (TX); Jay Sueoka (UT); and Jason Carr and Susan Baker (WA). Also participating were: Cary Cook (AZ); and Michelle Scaccia (MT).

1. Adopted its Sept. 12 Minutes

The Working Group met Sept. 12 and took the following action: 1) adopted proposal 2019-06, Form 12 Consent Service for Service of Process, clarifying language to include “statutory” for the reference to the home address and regulated state in addition to the state where it was organized; 2) exposed two proposals—2019-07, expansion and corporate amendment instructions, and the Form 11 biographical affidavit—for a 30-day public comment period ending Oct. 11; and 3) adopted revisions to the Company Licensing Best Practices Handbook (Best Practices Handbook).

Mr. Piatt made a motion, seconded by Mr. Guerin, to adopt the Working Group’s Sept. 12 minutes with the modification to include Mr. Lathrop as a participating member during the conference call (Attachment Five-A). The motion passed unanimously.

2. Adopted Proposal 2019-05

Mr. Sander said that proposal 2019-05 was previously exposed for a 30-day public comment period for changes to the biographical affidavit (Form 11). No comments were received during the comment period. Crystal Brown (NAIC) said that addendum pages were incorporated into the proposal as a friendly amendment to be used for additional responses that will carry over from the questions on the biographical affidavit. Ms. Brown explained that these pages were added in response to formatting constraints within the fillable portable document format (PDF) version of the form. For uniformity purposes, the addendum pages were also included in the word version of the form. Ms. Brown noted that responses included on the addendum pages should be labeled and each page signed, or pages labeled as 1 of X and the last page signed.

Gina Hudson (Liberty Mutual Insurance) asked what option should be checked in the Purpose for Completion section for a new officer or director. Ms. Brown said the annual update option would be selected. Mr. Boutwell said he had a similar question and suggested removing “Annual” and having it listed just as “Update.” Ms. Brown suggested that a Frequently Asked Questions (FAQ) document could be drafted to clarify that the “Update” option would be checked for promotions, new officers/directors, changes and annual updates. Ms. Doggett said if the affiant is a new officer or director, it would be the first time they are filing a biographical affidavit, and it would not necessarily be an update. She agreed that drafting an FAQ could clarify that. Ms. Scaccia suggested changing it to “Other Updates.” Ms. Brown suggested removing “update” and include it only as “Other” as this would capture all updates and new officer/director options. Ms. Scaccia, Ms. Doggett and Ms. Johnson agreed.

Mr. Rudnai made a motion, seconded by Mr. Lathrop, to adopt proposal 2019-05 – Biographical Affidavit (Attachment Five-B) with an effective date of Jan. 1, 2020, that included a friendly amendment to include the addendum pages, modify the “Purpose for Completion” reference from “Annual Update” to “Other,” and draft an FAQ for when the “Other” option should be selected. The motion passed unanimously.

The Working Group unanimously agreed via email to an editorial change to add the word “specify” before “purpose for completion” and move “Specify Purpose for Completion” as the heading. In addition, the Uniform Certificate of Authority Application (UCAA) will include the word “type” to make it clear to the user that a check mark is not acceptable and to include a response on the blank. Examples will be provided on the FAQs.
3. **Adopted Proposal 2019-07**

Ms. Johnson said one comment was received from Montana on proposal 2019-07 for the lines of business instructions. Montana suggested clarifying the first statement of the tracked changes to include the words “to transact” to the corporate amendment instructions so that the sentence would read: “The application must identify all lines of insurance that the Applicant Company is currently authorized to transact and specify the lines of authority to add or delete from an existing Certificate of Authority, as identified in the plan of operation.”

Ms. Doggett made a motion, seconded by Mr. Sueoka, to adopt proposal 2019-07 (Attachment Five-C) with the friendly amendment to incorporate the words “to transact” into corporate amendment instructions. The motion passed unanimously.

4. **Discussed Other Matters**

Mr. Boutwell said that Louisiana requires biographical affidavits for certain new officers or directors that are appointed or elected to a company and that it is not uncommon for an officer or director to be named as an officer or director for multiple companies within a holding company group. He said that Louisiana is receiving multiple copies of biographies for the same officer because the company has been instructed to submit separate biographies for each company that the affiant is an officer of. Mr. Boutwell said that since the information contained in the biographical affidavit is about the individual, Louisiana does not require separate biographical affidavits for each company that the affiant is an officer or director of and will allow the affiant to list multiple company names on page 1 and page 7 of the biographical affidavit. Mr. Boutwell asked if a state-specific chart could be created to list which states will allow for multiple company names to be listed on the biographical affidavit and which states require a separate biographical affidavit for each company the affiant is an officer or director of.

Ms. Brown said that the UCAA FAQ instruct that the biographical affidavit should only list one company name and that the third-party vendors have been notified that only one company name should be listed on the biographical affidavit. Mr. Boutwell said he understands the concern of having multiple companies listed on a biographical affidavit for a UCAA application or a Form A filing. He said Louisiana’s concern arises from its statutorily mandated filing of biographical affidavits when a new officer or director is named because it is creating a large number of unnecessary and redundant filings of the biographical affidavits, which would be under the new category of “Other.” He said he was under the impression that Louisiana was not the only state that discourages multiple filings of the biographical affidavits under those circumstances.

Mr. Boutwell said that Louisiana’s approach for the biographical affidavit is that is for the individual, and the information contained within the biographical affidavit is about that person, even if it is filed in conjunction with a UCAA application. Mr. Piatt asked if Louisiana defined in its statute that the UCAA forms were required. Mr. Boutwell said that administratively, Louisiana always requires the UCAA form. Mr. Piatt said that the UCAA form instructions were defined more specifically for a UCAA application and not necessarily in the scenario of changes in officers. Ms. Brown said that other changes were made to the biographical affidavit under proposal 2019-05 that specifically break out the company name, address and phone number with regard to the requirement that only one company name should be listed on each biographical affidavit and in conjunction with changes in the future on the biographical database. Ms. Brown said that the NAIC has a current chart that shows what states require an updated biographical affidavit after licensure.

Mr. Boutwell said he is not suggesting a change to the biographical affidavit form, but rather a change to the FAQ to allow for multiple company names to be listed. He asked how many states will accept a “see attached” on the officer position and company name. Ms. Scaccia suggested modifying the FAQ rather than creating a state chart. Ms. Brown said that there is an FAQ that currently states that the biographical affidavit is not to have multiple companies listed. She said that the third-party vendors also verify that only one company is listed per affidavit and that if this was a change, they would need to be notified as well. Mr. Piatt suggested that the Biographical Third-Party Review (E) Subgroup review this issue further. The Working Group agreed to have the Subgroup look into this issue further.

In regard to multiple applications being submitted to various states within a short time period, Ms. Brown asked if the states had any concerns with separate applications being submitted rather than one application submitted to all the states at the same time. Liane Birchler (Westmont Associates) said that they may submit them in separate batches based on the state’s requirements. Mr. Boutwell said he has seen this before and would prefer to see them as one filing, but if they are filed separately for business reasons, the company should make them aware of the pending applications.

Having no further business, the National Treatment and Coordination (E) Working Group adjourned.
The National Treatment and Coordination (E) Working Group of the Financial Condition (E) Committee met via conference call Sept. 12, 2019. The following Working Group members participated: Joel Sander, Co-Chair (OK); Linda Johnson, Co-Chair (WY); Cindy Hathaway (CO); Maura Welch and Joan Nakano (CT); Alison Sterett (FL); Stewart Guerin (LA); Debbie Doggett (MO); Victoria Baca (NM); Cameron Piatt (OH); Greg Lathrop (OR); Cressinda Bybee (PA); Robert Rudnai (TX); Jay Sueoka (UT); and Ron Pastuch (WA). Also participating was: Pat Mulvihill (KS); Carol Anderson (ID); Laurelyn Cooper (ME); and James B. Ware (VA).

1. **Reviewed its July 17 Minutes**

Mr. Sander said the Financial Condition (E) Committee adopted the Working Group’s July 17 minutes during the Summer National Meeting. There were no questions or concerns with the July 17 minutes.

2. **Adopted Proposal 2019-04**

Mr. Sander said the purpose of this proposal is to add the word “statutory” in front of the home office address listing and to add an additional requirement for the state where the company is regulated if different from the state where the company was organized. He added that this proposal was exposed for a 30-day public comment period, and no comments were received.

Ms. Baca made a motion, seconded by Mr. Lathrop, to adopt proposal 2019-04; clarification to Form 12, Uniform Consent to Service of Process (Attachment Five-A1). The motion passed unanimously.

3. **Disposed Proposal 2019-06**

Mr. Sander explained that when Form 8, Questionnaire was modified in 2012, several questions were moved and reworded, and during this update, a question was inadvertently deleted. It was suggested during the review of the *Company Licensing Best Practices Handbook* (Best Practices Handbook) updates that this question be moved and renumbered as question 31 and made as an optional question for expansion applications.

Mr. Sander added that this proposal was exposed for a 30-day public comment period specifically asking the state to respond: 1) that this question be placed back into the questionnaire and that subpart b be optional; or 2) that this question not be placed back into the questionnaire because this information is already located in the general interrogatories of the annual financial statement.

Ms. Doggett reiterated that this question has not been noticed as missing by the states in the past five years and deemed it not necessary to add back to the application since this information is provided in the annual financial statement. She added that the application already contains so much information and that licensing should be more risk-focused. She said if the information is necessary, states can request additional information.

Ms. Doggett made a motion, seconded by Mr. Guerin, to dispose proposal 2019-06, with no action to add the question back to the questionnaire (Attachment Five-A2). The motion passed unanimously.

4. **Received Comments on Edits to the Best Practices Handbook – Appendix D**

Ms. Johnson summarized that this proposal was exposed separately from the Best Practices Handbook. He said the additional items added to the Form A review checklist were in response to a referral from the Financial Analysis (E) Working Group regarding caution to state insurance regulators when reviewing applications to not place reliance on parental guarantees to resolve capital issues with the insurer. No comments were submitted opposing the edits.
5. **Adopted Proposal 2019-03**

Ms. Johnson said the Best Practices Handbook was exposed for a public comment period and that the proposal brought before the Working Group includes suggested edits to the Best Practices Handbook based on the comments received. She noted that page 46 will remove the reference to the questionnaire that the Working Group agreed could be eliminated.

Mr. Lathrop made a motion, seconded by Mr. Pastuch, to adopt proposal 2019-03; revisions to the Best Practices Handbook (Attachment Five-A3). The motion passed unanimously.

6. **Exposed Proposal 2019-07**

Ms. Johnson summarized the purpose of this proposal is to clarify in the instructions that Form 3, Lines of Business must include all lines where the applicant company is authorized to transact business. She added that NAIC staff have recently received inquiries asking for clarification and noted that the current wording was causing confusion.

Ms. Johnson suggested, and the Working Group agreed, to expose proposal 2019-17 for a 30-day public comment period ending Oct. 11.

7. **Exposed Proposal 2019-05**

Mr. Piatt said the purpose of edits to the biographical affidavit are to: 1) identify the reason for submitting a biographical affidavit; 2) include space for multiple government identification numbers and the country of origin; and 3) provide separate fields for address information and applicant name.

Jane Barr (NAIC) added that this will be the last update to this form until the electronic database is available in production.

Gina Hudson (Liberty Mutual Insurance) asked when the database would be available. Ms. Barr said the projected date is 2022.

Ms. Johnson suggested, and the Working Group agreed, to expose proposal 2019-05 for a 30-day public comment period ending Oct. 11.

8. **Discussed Other Matters**

Ms. Barr summarized a concern she received from Ms. Bybee regarding state-specific requests from expansion states when the information requested is already provided on the Uniform Certificate of Authority Application (UCAA) forms.

Ms. Bybee asked if the Working Group could reach out to those states regarding uniformity and the need for additional duplicative information or meet via conference call in regulator-to-regulator session to discuss state uniformity.

Ms. Doggett concurred that Missouri receives additional requests for retaliatory fee information when that information is already provided on the UCAA website.

Mr. Mulvihill asked if there were any states on the conference call with a seasoning requirement that considers the length of time that management has been overseeing the company with regards to seasoning requirements and if they would consider new management as a new company with regard to seasoning or if states are only looking at the length of time the company has been writing the line, regardless of how long the management has been in place, and would that be applicable for their conditions for waiver.

Mr. Ware said Virginia’s seasoning requirement is an administrative policy that gives the state some leeway on the interpretation of seasoning. For this example, if the applicant had new management that would void their seasoning, the next step would be to look for affiliates in the state that would serve for a waiver of the seasoning requirement.

Ms. Anderson said Idaho would also look at this example as a new company; its seasoning looks at five years.

Ms. Welch said Connecticut would look at new management as a red flag and would look for affiliates. She added that seasoning is on a line-by-line basis. She said seasoning requirements are covered in the Best Practices Handbook on page 16.
Ms. Cooper said Maine would also look at the company in this example as a new company based on new leadership of the company.

Ms. Johnson said Wyoming statute looks at the insurer and how long it has been conducting business. She added that under other areas of review, management would be looked at, but not as a seasoning requirement.

Mr. Pastuch said Washington’s requirement is similar to Wyoming, in that its statute also looks at the length of business by the insurer by line. He added that new products would not fall under the seasoning requirement and that new management would be reviewed in other areas of the application review process.

Ms. Johnson suggested that quarterly regulator-to-regulator conference calls be scheduled to discuss issues with uniformity, applications or requirements and asked if there would be any interest from the company licensing regulators.

Ms. Anderson agreed that would be useful.

Ms. Barr said a state shared an issue with an expansion application that was submitted in hardcopy, and there were several noted errors on the biographical affidavits, such as old forms, missing information, signature dates, etc. Their concern was whether the other applicant states would accept the application without requesting that the applicant company resubmit a corrected form. She added that uniformity is a concern and whether the states would adhere to the application instructions and requirements.

Ms. Cooper said Maine is the state that was going to send the affidavits back because they were sloppy and incomplete.

Ms. Johnson said Wyoming received a similar application and that was the reason that prompted the request to meet quarterly via conference call in regulator-to-regulator session.

Ms. Barr asked if she would like the first call scheduled as early as October.

Ms. Cooper said she has reached out to the company and has not heard a response.

The Working Group plans to meet Nov. 6 via conference call.

Having no further business, the National Treatment and Coordination (E) Working Group adjourned.
National Treatment and Coordination (E) Working Group
Company Licensing Proposal Form

DATE: 2-1-19

CONTACT PERSON: Jane Barr

TELEPHONE: 

EMAIL ADDRESS: jbarr@naic.org

ON BEHALF OF: National Treatment & Coordination WG

NAME: Linda Johnson

TITLE: Chief Examiner

AFFILIATION: Wyoming Insurance Department

ADDRESS: 

FOR NAIC USE ONLY

Agenda Item # 2019-04

Year 2019

DISPOSITION

[ ] ADOPTED 9-12-19

[ ] REJECTED

[ ] DEFERRED TO

[ ] REFERRED TO OTHER NAIC GROUP

[ x ] EXPOSED Due Aug. 16

[ ] OTHER (SPECIFY) 

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

[X ] UCAA Forms [ ] UCAA Instructions [ X ] Enhancement to the Electronic Application Process

[ ] Company Licensing Best Practices HB

Forms:

[ ] Form 1 – Checklist [ ] Form 2 - Application [ ] Form 3 – Lines of Business

[ ] Form 6- Certificate of Compliance [ ] Form 7 – Certificate of Deposit [ ] Form 8 - Questionnaire

[ ] Form 8C- Corporate Amendment Questionnaire [ ] Form 11-Biographical Affidavit [ x ] Form 12-Uniform Consent to Service of Process [ ] Form 13- ProForma [ ] Form 14- Change of Address/Contact Notification

[ ] Form 15 – Affidavit of Lost C of A [ ] Form 16 – Voluntary Dissolution [ ] Form 17 – Statement of Withdrawal

DESCRIPTION OF CHANGE(S)

Insert the word “Statutory” before “Home Office Address” on page 1 of the Uniform Consent to Service of Process. Include the state where the company is regulated if different than the state where it was organized.

REASON OR JUSTIFICATION FOR CHANGE **

This change would clarify that the address to be listed is the statutory home office address. Further clarification to include the state where the company is regulated if different than the state where it is organized.

Additional Staff Comments:

6/12/19-jdb NAIC staff added further clarification for companies that are organized in one state and domiciled (regulated) in another.

7-17-19-cgb NTCWG exposed proposal 2019-04 for 30-day comment period.

9/12/19-cgb No comments were received. NTCWG adopted proposal 2019-04.

** This section must be completed on all forms. Revised 01-2019
Applicant Company Name: ___________________________ 
NAIC No. ___________________________ 
FEIN: ___________________________

Uniform Certificate of Authority Application (UCAA)

Uniform Consent to Service of Process

_____ Original Designation   _____ Amended Designation

Applicant Company Name: ___________________________

Previous Name (if applicable): ___________________________

Statutory: ___________________________

Home Office Address: ___________________________

City, State, Zip: ___________________________ NAIC CoCode: ___________________________

The Applicant Company named above, organized under the laws of ___________________________, and regulated under the laws of ___________________________ for purposes of complying with the laws of the State(s) designate hereunder relating to the holding of a certificate of authority or the conduct of an insurance business within said State(s), pursuant to a resolution adopted by its board of directors or other governing body, hereby irrevocably appoints the officers of the State(s) and their successors identified in Exhibit A, or where applicable appoints the required agent so designated in Exhibit A hereunder as its attorney in such State(s) upon whom may be served any notice, process or pleading as required by law as reflected on Exhibit A in any action or proceeding against it in the State(s) so designated; and does hereby consent that any lawful action or proceeding against it may be commenced in any court of competent jurisdiction and proper venue within the State(s) so designated; and agrees that any lawful process against it which is served under this appointment shall be of the same legal force and validity as if served on the entity directly. This appointment shall be binding upon any successor to the above named entity that acquires the entity’s assets or assumes its liabilities by merger, consolidation or otherwise; and shall be binding as long as there is a contract in force or liability of the entity outstanding in the State. The entity hereby waives all claims of error by reason of such service. The entity named above agrees to submit an amended designation form upon a change in any of the information provided on this power of attorney.

Applicant Company Officers’ Certification and Attestation

One of the two Officers (listed below) of the Applicant Company must read the following very carefully and sign:

1. I acknowledge that I am authorized to execute and am executing this document on behalf of the Applicant Company.

2. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing is true and correct, executed at ___________________________.

Date ___________________________ Signature of President ___________________________

Full Legal Name of President ___________________________

Date ___________________________ Signature of Secretary ___________________________

Full Legal Name of Secretary ___________________________
National Treatment and Coordination (E) Working Group
Company Licensing Proposal Form

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

[X] UCAA Forms  [ ] UCAA Instructions  [ X ] Enhancement to the Electronic Application Process
[ ] Company Licensing Best Practices HB

Forms:
[ ] Form 1 – Checklist  [ ] Form 2 - Application  [ ] Form 3 – Lines of Business
[ ] Form 6- Certificate of Compliance  [ ] Form 7 – Certificate of Deposit  [ X ] Form 8 - Questionnaire
[ ] Form 8C- Corporate Amendment Questionnaire  [ ] Form 11-Biographical Affidavit  [ ] Form 12-Uniform Consent to Service of Process  [ ] Form 13- ProForma  [ ] Form 14- Change of Address/Contact Notification
[ ] Form 15 – Affidavit of Lost C of A  [ ] Form 16 – Voluntary Dissolution  [ ] Form 17 – Statement of Withdrawal

DESCRIPTION OF CHANGE(S)
To clarify that the following question must be answered for Expansion applications and Sub-section “B” would be optional, per the state’s discretion.

31. Does the Applicant Company use a third party (affiliated or unaffiliated) to manage the Applicant Company’s investments?
   Yes ____  No ____
   A. If yes, provide detailed information as to the compensation that will be paid for management of the Applicant Company’s investments.
   B. Provide copies of the Applicant Company’s investment management agreements and any investment guidelines.

REASON OR JUSTIFICATION FOR CHANGE **
In 2010 some Form 8 questions were revised, combined and/or reorganized. During these revisions Q23 (worded above as Q31) was inadvertently removed from the questionnaire. Discussions during the July 17 conference call clarified that this information is located in the Annual Statement Interrogatories and may not be necessary for inclusion on the Questionnaire.

Additional Staff Comments:
5/15/19- Discussions during the May 15, 2019 conference call suggests this question would be better located after Q30, as optional for expansion (electronic) applications. Questions 1-30 are required to be completed for both Primary and Expansion applications.
7/17/2019-Discussions during the July 17, 2019 conference call suggest that this question does NOT need to be placed back on the Questionnaire or if it is placed back on the Questionnaire then sub-section “B” could be at the state’s discretion if copies are required. This proposal will be exposed for a 30-day comment period asking which option to proceed with. 
9/12/19 cgb – NTCWG agreed to dispose of proposal 2019-06 with no action to add the question back to the questionnaire.

** This section must be completed on all forms.  

Revised 01-2019
Applicant Company Name: ___________________________ NAIC No. ________________
FEIN: ___________________________

Uniform Certificate of Authority Application
QUESTIONNAIRE

Directions: Each "Yes" or "No" question is to be answered by marking an "X" in the appropriate space. All questions should be answered. If the Applicant Company denotes a question as "Not Applicable" (N/A) an explanation must be provided. Other answers and additional explanations or details may be provided in writing attached to the questionnaire. Please complete this form and file it with the Applicant Company's application for a Certificate of Authority.

1. I hold the position(s) of ___________________________ with the Applicant Company.

Eliminated To Conserve Space  Detail

30. Does the Applicant Company pay, directly or indirectly, any commission to any officer, director, actuary, medical director or any other physician charged with the duty of examining risks or applications?

Yes____ No ____ Not Applicable____

If yes, provide the details in writing and attach to the Questionnaire.

The following question pertains if the Applicant Company is filing a Primary Application, the application state may request this question be answered for an expansion application.

31. Does the Applicant Company use a third party (affiliated or unaffiliated) to manage the Applicant Company’s investments?

Yes ____ No ____

A. If yes, provide detailed information as to the compensation that will be paid for management of the Applicant Company’s investments.

B. Provide copies of the Applicant Company’s investment management agreements and any investment guidelines.

The following questions are to be completed only if the Applicant Company is redomiciliating to another state.

32. Does the Applicant Company have any permitted practices allowed by its current state of domicile?

Yes____ No ____ Not Applicable____

If yes, provide the details in writing and attach a copy of the state of domicile’s approval to the Questionnaire.
National Treatment and Coordination (E) Working Group
Company Licensing Proposal Form

| CONTACT PERSON: | Jane Barr |
| TELEPHONE: | 816-783-8413 |
| EMAIL ADDRESS: | jbarr@naic.org |
| ON BEHALF OF: | National Treatment and Coordination WG |
| NAME: | Jeff Hunt and Joel Sander |
| TITLE: | co-chairs |
| AFFILIATION: | |
| ADDRESS: | |

DATE: 4/22/2019
FOR NAIC USE ONLY
Agenda Item # 2019-03
Year 2019
DISPOSITION
[ ] ADOPTED
[ ] REJECTED
[ ] DEFERRED TO
[ ] REFERRED TO OTHER NAIC GROUP
[ X ] EXPOSED June 14, 2019
[ ] OTHER (SPECIFY)

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED
[ ] UCAA Forms  [ ] UCAA Instructions  [ ] Enhancement to the Electronic Application Process
[ X ] Company Licensing Best Practices HB

Forms:
[ ] Form 1 – Checklist  [ ] Form 2 - Application  [ ] Form 3 – Lines of Business
[ ] Form 6- Certificate of Compliance  [ ] Form 7 – Certificate of Deposit  [ ] Form 8 - Questionnaire
[ ] Form 8C- Corporate Amendment Questionnaire  [ ] Form 11-Biographical Affidavit  [ ] Form 12-Uniform Consent to Service of Process  [ ] Form 13- ProForma  [ ] Form 14- Change of Address/Contact Notification
[ ] Form 15 – Affidavit of Lost C of A  [ ] Form 16 – Voluntary Dissolution  [ ] Form 17 – Statement of Withdrawal

DESCRIPTION OF CHANGE(S)
Updates to the Best Practices included changes for the Risk-Based prioritization to align with the Financial Analysis Handbook. Updates to align with recent changes to the Part D Organization Licensing Standards; Updates to include information for states that have adopted the NAIC Insurance Data Security Model Law (#668) Updates to the biographical affidavit review process, addition of corporate amendment change type Statement of Withdrawal/Complete Surrender and the addition of Appendix E – Speed to Market.

REASON OR JUSTIFICATION FOR CHANGE **
The Company Licensing Best Practices Handbook was developed in 2005 and has only been updated for changes to the UCAA without the entire handbook being evaluated for content and updates to outside sources.

Additional Staff Comments:
5/15/2019 jdb- The Working Group agreed to expose the Best Practices for a 30-day comment period.
7/15/19 jdb – The Working Group exposed Appendix D for a 30-day comment period.
9-12-19 cgb – The Working Group received comments on Appendix D and adopted the revisions to the BP Handbook.

** This section must be completed on all forms.
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Appendix D – Form A Review Best Practices

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  Communication and Record Maintenance ...........................................................
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NAIC Company Licensing Best Practices Handbook

Introduction

BACKGROUND

In conjunction with the NAIC, the various states, as a part of the former Accelerated Licensing Evaluation Review Technique (ALERT) Subgroup, have worked toward the goal of streamlining and achieving uniformity in the insurer licensing process. To that end, a Uniform Certificate of Authority Application (UCAA) was developed by the former Accelerated Licensing Evaluation Review Technique (ALERT) Subgroup and is currently in use. However, the implementation of UCAA requirements and the standards and procedures involved in the reviewing of applications has not proven to be consistent among the members of the NAIC.

The objective of the Company Licensing Best Practices Handbook (Best Practices Handbook) is to provide a framework that, while not preempting a state’s authority, promotes consistent decisions while reviewing the standardized UCAA and improves the efficiency of the review process. This Best Practices Handbook is not intended to constitute a comprehensive company licensing procedures manual. Each state must assess its ability, within the confines of existing statutes, regulations and resource constraints, to implement the recommendations contained herein.

UCAA INSTRUCTIONS vs. BEST PRACTICES HANDBOOK

The ALERT Subgroup performed a monumental task in bringing order to the various state rules, regulations, requirements and forms facing an applicant. That work is thoroughly documented on the UCAA website. This Best Practices Handbook contains numerous references to the forms and processes described on the UCAA website.

This Best Practices Handbook deals primarily with the qualitative processes involved in reviewing an application. The concepts and recommended processes and procedures described herein were developed through interviews with various state regulatory personnel involved in the company licensing process and a compilation of the observed best practices. During those interviews several “best practices” concepts became evident. They were:

- **LICENSING PROCESSES**: The company licensing function can be viewed in light of its component processes:
  - Administrative Filings: Receipt and processing of certain corporate documents that are needed to establish a corporate existence, but are not subject to qualitative review.
  - Analysis of Current Financial Condition: Documentation of the current operating condition of the company.
  - Analysis of Business Plan: Review of the company’s explanation for the proposed expansion and/or change in its operations and how those changes will affect the company’s operating condition.
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- INTERSTATE COMMUNICATION: The licensing process in many states involved the re-determination of the current financial condition of the company. This information should already be known by the domestic state and can be conveyed to the applicant state. The effort saved by not reanalyzing company condition in the company license process can be used to communicate financial condition information to other states when requested.

- PRIORITIZATION FRAMEWORK: Several states incorporated more or less sophisticated prioritization systems as a part of the licensing function. The scope of the financial review may be adjusted based upon the prioritization of the insurer. The resources saved by reducing effort in reviewing companies on the top and bottom of the scale can be better spent performing a more thorough review of those companies where the effect of an expansion or amendment of the business plan is not so easily evident.

In addition to gathering information necessary to evaluate an applicant, the UCAA was developed to incorporate the majority of state’s rules, regulations and requirements relative to company licensing. The goals of this Best Practices Handbook are uniformity and efficiency in the review of company licensing applications. In some instances, those goals conflict with filing requirements noted in the UCAA. Therefore, it is acknowledged that there may be inconsistencies between this Best Practices Handbook and any specific state’s filing requirements.

DESCRIPTION OF THE BEST PRACTICES HANDBOOK

The Company Licensing Function
This chapter provides an overview of the role of the company licensing function as the initial step in state regulatory oversight. The goals of the company licensing function and the risk-based approach to achieving them are described.

Interstate Communication
This chapter discusses a framework for communication and cooperation between an applicant state, the state of domicile and other stakeholder states (if any).

Best Practices

Conceptual Framework
This chapter presents a risk-based framework for the processes involved in analyzing the application.

Review of Forms
This chapter presents a summation of best practices compiled as guidance relative to the analysis and decision making regarding the application.
NAIC Company Licensing Best Practices Handbook
Introduction

Appendix A – The Uniform Certificate of Authority Application (UCAA)
This appendix presents a brief overview of the UCAA and how it is referenced in the “Best Practices: Application Review” chapter.

Appendix B – Use of Electronic Documents
This appendix presents a description of UCAA contents that are available in electronic media.

Appendix C – Review of Electronic Application Coordination and Processing (REACAP)
This appendix presents the criteria for requesting the National Treatment and Coordination (E) Working Group to monitor the timing, technology and substantive issues regarding the insurers’ electronic UCAA filings.

Appendix D – Form A Review Best Practices
This appendix presents a guide for regulatory review and analysis of Form A acquisitions, recognizing that this list may not be comprehensive and not all items will apply to every acquisition.

Appendix E – Speed to Market
This appendix presents the criteria for requesting the National Treatment and Coordination (E) Working Group to monitor the timing and coordination of expansion applications for insurers in good standing with their state of domicile (lead state).
The company licensing function stands at the threshold of an insurance department’s oversight of an applicant’s future operations within the state. The function encompasses virtually all areas of regulatory oversight, from solvency surveillance to market conduct, to rates and forms and producers’ licensing — and not only within the applicant state insurance department, but also within the insurance department of the domiciliary state. The most difficult stages of regulatory oversight occur at the very beginning and at the very end of an insurer’s regulatory life cycle. Never is a more comprehensive understanding of an insurer and its potential for success more critical than when a regulator must grant authority to conduct business and in those even more difficult circumstances when the regulator must withdraw the authority to conduct business.

In developing this Handbook, a great deal of consideration was given to the assessment of risk in the review of a company license application. All of the current NAIC guidance provided to insurance department personnel relative to insurance company surveillance deals with the assessment of risk present in the individual insurers comprising the population to be regulated. That risk, the risk of financial failure or risk of marketplace improprieties is to be measured and graded. Current guidance defines procedures in such a manner that regulators maximize the effectiveness of the surveillance process by concentrating on the areas, or companies, of greatest risk. This approach by its nature, forgoes the idea of “zero” risk. The cost of obtaining zero risk is prohibitive and the effort expended in its pursuit is better spent in other endeavors.

Similarly, regulators involved in reviewing company licensing applications must adhere to the same goals. The review of the company licensing application should be structured so that applicants’ risks of financial failure or marketplace impropriety are identified and addressed. Procedures exist in the Financial Analysis Handbook, the Financial Condition Examiners Handbook and the Market Regulation Handbook for monitoring companies subsequent to admission. Company licensing personnel should concentrate on those issues that indicate an applicant may harm the citizens of their state, either through financial failure or marketplace improprieties, as a result of granting or amending a certificate of authority.

Therefore, the procedures described herein represent a departure from the conventional approach to the review of a company license application. In some instances, it is recommended that documents submitted with an application should be subject to minimal review. Those documents, although necessary to establish an applicant as a legal entity, do not provide significant insight into the risk profile of a company. By accepting the risk of a minor compliance violation (that, after all, will still be the subject of ongoing monitoring), the regulator will maximize the effectiveness of their department and better fulfill their responsibilities to the citizens of their state.
NAIC Company Licensing Best Practices Handbook
Interstate Communication

INITIATING INTERSTATE COMMUNICATION

The expansion and/or alteration of a company’s operations are of equal importance to the regulators in both the expansion states and the domestic state. The results of unsuccessful expansion plans cut across state boundaries — a troubled company is “troubled” in all states. It follows that the analysis of a company’s condition and business plan should be accomplished through a coordinated effort. Ultimately, each state operates under its own statutory authority and is responsible for the protection of its own policyholders. Interstate communication and cooperation is not intended to relinquish the authority of any state or to disadvantage any state; rather, it is intended to facilitate efficiencies that will be achieved when applicant states coordinate the company licensing process with all states involved, including, most importantly, the domestic state.

The NAIC Financial Regulation Standards and Accreditation Program requires states to provide for the sharing of otherwise confidential information, administrative or judicial orders, or other action, with other state regulatory officials, provided that those officials are required under their law to maintain its confidentiality. The NAIC “Master Information Sharing and Confidentiality Agreement” allows signatory states to share confidential information with other signatory states. As of this writing, 50 states and the District of Columbia have signed the agreement. Current information can be accessed through the NAIC I-SITE application under StateNet or https://i-site-state.naic.org/cgi-bin/statenet.

Prior to submitting an application in a foreign state, the insurer should inform the state of domicile of its plans in the foreign state(s). If the state of domicile holds important concerns regarding the applicant’s plans, such concerns should be communicated to the senior financial regulator in the applicant state(s). Similarly, after receipt and an initial review of an application, the applicant state may contact the senior financial regulator in the domiciliary state to open a dialogue regarding the applicant. Preferably, this communication should occur as early in the application process as possible to allow consideration of the information within an appropriate timeframe. The dialogue should include:

- Is the Applicant Company concurrently applying to additional states?
  - If so, contact other states to coordinate information available from the domiciliary state.
  - If so, and the applicant is part of a holding company structure, contact the “Lead State” to coordinate information sharing.
  - If the Applicant Company does the majority of its business in a state other than the domiciliary state, the Applicant Company and domiciliary states may consider communication with a “Key State” as discussed below. However, even if a key state is identified, the domiciliary state will remain the primary regulator.

- Domiciliary (and key) state’s analysis of current condition of the applicant.
  - Has the domiciliary state performed a risk analysis of the applicant?
  - If the risk analysis performed by the domiciliary state is understandable to the applicant state and is substantially similar to the prioritization system defined in this Handbook, the...
applicant state should consider accepting the analysis in lieu of performing an additional financial analysis of the Applicant Company.

- Analysis of Business Plan by Applicant State(s)
  - Are the operations described in the business plan consistent with the demonstrated experience and expertise of the Applicant Company?
  - Does the business plan have the potential to significantly alter the condition of the Applicant Company?
  - After consideration of the Applicant Company’s condition, business plan and any other relevant information, has the domiciliary state transmitted any information having a bearing on the application?

LEAD STATE

Lead state(s) or designee assumes the role of coordinator and communication facilitator. The lead state(s) serves as the facilitator and central point of contact for purposes of gathering and distributing information to all regulators involved.

KEY STATE

In some instances other states may have information pertinent to the application. In those instances, a “Key State” may be considered for consultation in addition to the domiciliary state. The Key State may emerge based on the state with the largest premium volume, the state of domicile of the parent of the holding company, or other reasons. The “Key State” should not assume the responsibilities of either the applicant state or the domiciliary state. A “Key State” should be identified solely as an additional source of information regarding the applicant.

COMMUNICATIONS AND THE DOMICILIARY STATE

As previously stated, the Applicant Company should inform the domiciliary state of its plans to file company licensing applications in foreign states. In addition, communications between the applicant state(s) and the insurer may contain information regarding specifics of the applicant state’s marketplace that may significantly impact the insurer’s proposed business plan. The use of the electronic UCAA provides a mechanism for tracking such correspondence. This will allow the domiciliary state to remain cognizant of these communications and the relevant information, while the decision on the expansion remains with the expansion state.
NAIC Company Licensing Best Practices Handbook
Best Practices: Conceptual Framework of Processes and Procedures

CHAPTER OVERVIEW

This chapter will discuss a framework for the process flows that occur within the Company Licensing Function. The significant procedures within those process flows are discussed in detail, although guidance on the review of specific UCAA forms is contained in the “Best Practices: Application Review” chapter.

COMPONENTS OF THE COMPANY LICENSING FUNCTION

Depending on the type of application, the processing of a company license application can be broken down into one or more of the following components as shown in the graphic below.

![Diagram showing the components of the company licensing function]

**Administrative**

**Coordination:** This component begins with the receipt and recording of an application and its supporting documentation. The application should be reviewed to determine that a response exists for all inquiries. Supporting documents should then be reviewed to determine that they are, in fact, responsive to the UCAA requirement. The degree of the completeness and/or responsiveness of the application must be assessed to determine if processing of the application can proceed without further input from the Applicant Company. It is recommended that the state issue a letter to the Applicant Company acknowledging receipt of the application.
NAIC Company Licensing Best Practices Handbook
Best Practices: Conceptual Framework of Processes and Procedures

**Timeliness:** If processing can commence, an “application coordinator” should employ a spreadsheet, database, TeamMate file, or other mechanism (if the application was not received via the NAIC electronic UCAA utility) to record the assignment of application review responsibilities and the progress of the review against the Department or UCAA timelines:

- The Department should have a policy that establishes timing requirements for the review of applications for primary licensure of new companies and redomestications and Form A filings. If not, then the following guidelines are acceptable.
- Fourteen days to review an application for completeness.
- The goal is to notify the Applicant Company of supplemental information required from the Applicant Company within 30 days of applications. However, there may be situations where supplemental information provided requires clarification or a second review of the application requires requesting additional information.
- It should be noted, if additional information is needed to complete the review of an application, the review may also take longer to complete. Once a request for additional information has been made, the 60-day or 90-day goal is suspended until the requested information is received.
- Ninety days to process a primary application. Effective January 1, 2012, company licensing will be part of the accreditation program, Part D of the NAIC Policy Statement on Financial Regulation Standards, which provides that if a state does not have timing requirements in statute or regulation, the state will be expected to meet the 90-day goal for accreditation purposes.
- Sixty days to process all other types of applications.

It is recommended that the state send the company regular correspondence regarding the progress of the application.

**Administrative Filing:** This component consists of the review and filing of administrative documentation, which, while critical to the establishment of the Applicant Company as an operating business organization, is generally not subject to substantial qualitative analysis. This includes receipt of filing fees, articles of incorporation and bylaws, statutory deposits, membership in mandatory associations, consent to service of process, as well as other state-specific requirements. (See discussion of specific forms in “Best Practices: Application Review” chapter.)

**Analytical Review**

**Analysis of Current Condition:** The financial condition and management practices of the Applicant Company must be ascertained to determine they are of sufficient quality to permit the applicant to sell insurance products to the citizens of the state.

Except for a primary application, the analysis of the Applicant Company’s current condition should begin with contact to the domiciliary (and key) state as described in the “Interstate Communications” chapter. Company licensing analysts should confer with financial analysts in the domiciliary (and key) state to determine the overall operating condition of the Applicant Company based on a prioritization system and plan the scope of review activities accordingly.
Prioritization Framework

The utilization of a prioritization framework is the key to the efficient analysis of an Applicant Company’s current condition. The Financial Analysis Handbook suggests that domestic insurers be “prioritized” or ranked according to each insurer’s “relative stability.”

The Financial Analysis Handbook provides general guidance regarding the framework, but leaves the determination of specific prioritization metrics up to the domiciliary state. Tools currently available for use in reviewing the financial condition include: Insurance Regulatory Information System (IRIS) ratios, Analyst Team System results and Financial Analysis Solvency Tools (FAST). In addition to the financial review, any market conduct information available from the market analysis chief or collaborative action designee in the state’s market analysis department should be considered along with data available in the following market analysis tools and systems that are available on I-SITE: Complaints Database System (CDS), Examination Tracking System (ETS), Market Analysis Profile (MAP), Market Analysis Review System (MARS), Market Initiative Tracking System (MITS), Regulatory Information Retrieval System (RIRS), Market Conduct Annual Statement (MCAS), Producer Database (PDB), and 1033 State Decision Repository (SDR)-Data Entry Tool. The analyst should note any unusual items that translate into financial risks or indicate further review or communication is needed with the insurance department’s market analysis staff.

Other initiatives have been undertaken to more specifically define a broad-based system of prioritizing insurers based on operational practices as well as financial condition. During the development of this Handbook, it was noted that several states have developed such holistic models. The use of these models is clearly the best practice for determining the current overall condition of an insurer, and then assigning a prioritization that can be used to determine the appropriate scope of analytical review for a specific application. However, in each case, the specifics of the model are considered confidential.

Therefore, for the purpose of this Handbook, a prioritization framework will be discussed, and the general characteristics of each prioritization category will be described.

Use of Prioritization Framework in Application Review

The use of prioritization in the application review process carries the same risks and benefits inherent in any prioritization evaluation system. The goal of all such systems are to eschew the costly practice of reducing risk to zero, and instead to define a level of acceptable risk. The use of prioritization means that, in some instances, all the documents included with an application will not be reviewed in detail. However, the risk of not reviewing those documents in detail is mitigated by a company’s low risk of financial failure and by providing additional time to review the company’s business plan.
NAIC Company Licensing Best Practices Handbook
Best Practices: Conceptual Framework of Processes and Procedures

During the development of this Handbook, almost all company licensing personnel interviewed indicated that they were able to quickly, even if only informally, identify companies whose applications were likely to be approved. States that utilized prioritization systems were able to more formally document those applicants. Through the use of a formal prioritization system, company licensing analysts can reduce the scope of their review of strong applicants, thus conserving effort better served in the review of marginal applicants. The following guidance provides a recommended scope of review for each prioritization category.

Priority 1

Insurers included in Priority 1 are considered troubled and subject to comprehensive annual and quarterly analysis procedures, detailed considerations outlined with the Troubled Insurance Company Handbook, and a significantly elevated level of ongoing regulatory monitoring and oversight. Upon designating an insurer as a Priority 1, the domestic state should follow required procedures for troubled companies in communicating with other state insurance regulators. Insurers prioritized at this level would also be considered priority insurers for accreditation timeliness purposes and should generally be analyzed ahead of Priority 2, Priority 3, and Priority 4 insurers.

Insurers in this group generally are not capable of withstanding even moderate business fluctuations. There may be significant noncompliance with laws and regulations. Risk-management practices are generally unacceptable relative to the insurer’s size, complexity and risk profile. Corporate and group structures or framework may be of a nature that is not conductive to effective regulation. Close regulatory attention is required, which means formal action is necessary in most cases to address the problems. Insurers in this group pose a risk to the state guaranty fund. Failure of the insurer is probable if the problems and weaknesses are not satisfactorily addressed and resolved. Priority 1 companies should not be considered for expansion.

Priority 2

Insurers in Priority 2 are – high-priority insurers that are not yet considered troubled but may become so if recent trends or unfavorable metrics are not addressed. High-priority insurers may also include those subject to heightened monitoring for reasons other than financial solvency risks, as determined by the department. Insurers prioritized at this level may be subject to full quarterly analysis procedures and are subject to comprehensive annual analysis and an elevated level of ongoing regulatory monitoring and oversight. Insurers prioritized at this level would also be considered priority insurers for accreditation timeliness purposes and should generally be analyzed ahead of Priority 3 and Priority 4 insurers. Priority 2 companies are generally not considered good candidates for expansion. However, senior-level department personnel should contact their counterparts in the domiciliary state to determine if there is any reason to perform further analysis in consideration of approval of the application. In certain unique circumstances, based on the line of business offered and the market conditions in the expansion state, it may be appropriate to pursue licensure under heavily monitored criteria.
NAIC Company Licensing Best Practices Handbook  
Best Practices: Conceptual Framework of Processes and Procedures

These insurers, or their holding company groups, have a combination of moderate to severe weaknesses that may exhibit unsafe and unsound practices or conditions. The insurer is moving toward meeting criteria indicative that it is operating in a manner that is financially hazardous to policyholders and/or the public. They have serious financial or managerial deficiencies that result in unsatisfactory performance and problems are not being satisfactorily addressed or resolved by the board of directors and management.

Priority 3

Insurers in Priority 3 are considered moderate priority insurers that indicate some need for additional monitoring. Insurers prioritized at this level should be subject to comprehensive annual analysis procedures, should generally be analyzed ahead of Priority 4 insurers, and may be subject to an enhanced level of ongoing regulatory monitoring and oversight.

Priority 3 companies present the greatest challenge to the company licensing analyst. They are neither an obvious candidate for approval nor for denial, based on their current overall condition. Insurers in Priority 3 appear fundamentally sound, but may exhibit some degree of regulatory concern in one or more areas. These insurers and their parent and other members of the holding company group are relatively stable, could withstand moderate business fluctuations, and are in substantial compliance with laws and regulations. While the overall, risk-management practices are satisfactory relative to the insurer’s size, complexity, and risk profile, these companies exhibit certain notable adverse risk characteristics. There are no current material supervisory concerns and, as a result, the regulatory response is informal and limited. The risk to policyholders and/or guaranty funds is currently viewed as remote, however significant factors exist that may result in financial stress in the longer term.

In this instance the company licensing analyst should re-analyze the financial information provided with the application in order to better understand the exact nature of the Applicant Company’s weaknesses. However, it is important that communication between senior-level department personnel in the domiciliary (and key) state remains active. The domiciliary state can provide insight into the resolution of adverse financial or market conduct examination findings and the extent to which the company has remediated the deficiencies. Once the analyst has gained comfort with his/her knowledge of the Applicant Company’s current operational condition, the business plan should be diligently reviewed in order to determine whether:

- The Applicant Company has a demonstrated history (e.g., five years) with the lines of business for which it is applying.
  - If the Applicant Company is applying for lines of business for which it has less than five years of history, the analyst should review the business plan to identify, and/or request additional information regarding, key managerial personnel responsible for administering the new lines of business.
- Key personnel have been in place for a sufficient period of time to demonstrate their insurance management expertise.
- The scope of the expanded operations is not imprudent relative to the financial strength of the Applicant Company, its parent and other members of the holding company group. If the
NAIC Company Licensing Best Practices Handbook
Best Practices: Conceptual Framework of Processes and Procedures

expanded operations are in new lines of business, more stringent standards should be applied when assessing the potential effect of expanded operations on the condition of the Applicant Company.
- The domiciliary state noted any operational or compliance deficiencies in lines of business similar to those planned for the expanded operations.

Priority 4

Priority 4 are lower priority insurers that do not currently indicate a need for additional monitoring. These insurers should be subject to a basic level of regulatory monitoring and oversight, including annual analysis.

For these companies, the analysts should consider foregoing an in-depth review of information relevant to the Applicant Company’s current operating condition (e.g., financial documents included with public records package or the holding company statements). Rather, the company licensing analyst should focus on the quality and assumptions of the business plan to determine whether:
- The Applicant Company has a demonstrated history (e.g., three years) with the lines of business for which it is applying.
  - If the Applicant Company is applying for lines of business for which it has less than three years of history, the analyst should review the business plan to identify, and/or request additional information regarding, key managerial personnel responsible for administering the new lines of business.
- Key personnel have been in place for a sufficient period of time to demonstrate their insurance management expertise.
- The scope of the expanded operations is not imprudent relative to the financial strength of the company and its parent and other members of the holding company group.

Analysis of Business Plan

The Applicant Company’s plan for conducting business in new jurisdictions must be evaluated to determine if the plan is consistent with the Applicant Company’s demonstrated capabilities and the state’s marketplace. Further guidance for the analysis of business plans is included in the “Best Practices: Application Review” chapter.

Intrafdepartmental Communications

In addition to communications with other jurisdictions, it is important that the company licensing coordinator convey information regarding pending applications to other divisions within the insurance department. The licensing of a new entity or expansion of authority will impact other divisions once the new or amended certificate of authority is issued.

Actuarial: This section should understand the business plan filed with an application in order to adequately monitor any future reserving issues or other actuarial concerns.
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Financial Analysis: Once a new or amended certificate of authority has been issued the financial analysis division of the insurance department will assume monitoring responsibilities. The financial analysis section should understand the business plan filed with an application in order to monitor future results against that plan.

Market Conduct and/or Analysis (including consumer complaints and enforcement): The Market Conduct/Analysis section should understand the business plan to anticipate any issues and to monitor future results against the plan.

Policy Approval: Although policy forms are not a required component of the company license application, they are one of the most significant indicators of an Applicant Company’s actual business intentions. The financial analysis section should coordinate with the policy approval section to monitor policy filings from the newly licensed company to determine that they are consistent with the filed business plan.
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Producer Licensing: Similar to policy approval, the appointment of producers must be consistent with the scope of the new company’s business plan. The financial analysis section should similarly coordinate with the producer licensing section to monitor producer appointments by the new company.

Timeliness of Review

Perhaps no issue surrounding the company licensing process creates greater interest than that of timeliness. The UCAA website contains suggested guidance for the processing of various types of applications, including interim timelines. Although regulators should not sacrifice an appropriate level of review solely in the pursuit of expediency, it is imperative that every effort be made to adhere to the processing times recommended on the UCAA website when reviewing Priority 4 companies:

- Fourteen days to review an application for completeness.
- The goal is to notify the company of supplemental information required from the applicant within 30 days of applications. However, there may be situations where supplemental information provided requires clarification or a second review of the application requires requesting additional information.
- It should be noted, if additional information is needed to complete the review of an application, the review may also take longer to complete. Once a request for additional information has been made, the 60-day or 90-day goal is suspended until the requested information is received.
- Ninety days to process a primary application.
- Sixty days to process all other types of applications.
- Complexities involved with the review of Priority 2 and Priority 3 companies may adversely affect a state’s ability to meet these timelines recommendations. Notwithstanding these complexities, the regulator should make all reasonable efforts to maintain timely communication with the applicant companies.
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Introduction

In this chapter, recommendations for the review of each type of application are presented. The recommendations are based on the concepts of prioritization framework and interstate communications presented in the previous sections of this Handbook.

Within each application type, the review recommendations are presented in the following format:

- Application Type:
  - Chart Illustrating the UCAA sections of the application.
  - Recommendations for reviewing the “Administrative Filings” sections of an application.
  - Recommendations for reviewing the “Analysis of Current Condition” sections of an application.
    - Depending on the type of application, there may be subsections based on the risk profile of the Applicant Company.
  - Recommendations for reviewing the “Analysis of Business Plan” sections of an application.
    - Depending on the type of application, there may be subsections based on the risk profile of the Applicant Company.

Confidentiality and Safeguarding of Biographical Affidavit Information

The insurance department shall implement a written information security program that includes administrative, technical, and physical safeguards to protect the security and confidentiality of the biographical affidavit, fingerprint card (where applicable), independent third-party background report, and all associated notes, emails or work papers (collectively referred to hereafter as “documents or records”).

Given: (i) the size and complexity of the insurance department and the nature and scope of its activities; (ii) the variations in state laws; and (iii) the sensitive and personal information it maintains, the insurance department is referred to the NAIC Standards for Safeguarding Customer Information Model Regulation (#673) for further guidance with respect to an information security program. In addition, the insurance department should be aware that there may be other state-specific and federal laws and regulations regarding record retention and confidentiality, including the federal Fair Credit Reporting Act and the Federal Trade Commission regulations.

The following actions and procedures are recommended to the insurance department in implementing a written information security program.

Administrative Safeguards

- Identify reasonably foreseeable internal or external threats, assess the risk of harm from these threats, and develop and implement written procedures and policies that will safeguard the information and minimize the threats.

- Annually assess the sufficiency of current practices and adjust the written program as necessary to adapt to new threats and technologies.
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- Train employees on the policies and procedures developed to safeguard documents or records and personal information contained therein. Periodically review the training process and refresh employees on old and new processes. Provide training and training materials relevant to the safeguards to employees outside the company licensing division that may handle a public records request for the documents or records. Educate employees on any state enforcement rules and/or polices regarding their failure to abide by the training they receive.

- Develop procedures to search for Social Security numbers imbedded in licensure or registration numbers provided. Licenses or registrations from prior years may have included Social Security numbers within the number.

- Develop procedures and policies specific to the security of laptops and other portable devices that may contain personal information from the documents or records.

- Prohibit the sale of personal information, including names and addresses of any affiant for any purpose.

- Exercise appropriate due diligence in selecting service providers, and require thorough appropriate confidentiality agreements, that they implement measures to meet the relevant objectives of the security program.

Technical Safeguards

- Maintain personal information in a secure manner that is appropriate to the size and complexity of the insurance department and the nature and scope of its activities.

- Transmit documents or records and personal information between the third-party vendor and insurance department in a secure manner.

Physical Safeguards

- Develop policies and procedures to address retention and destruction of paper and electronic documents or records.

- Place access controls to the documents or records, whether in paper or electronic form, only to those individuals that need to know the information contained therein to complete a company’s review for licensure or to investigate a response to an open records or Freedom of Information Act (FOIA) request.

- Keep the documents or records out of public view and secure when not being utilized.
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- Maintain and secure all electronic and paper documents or records in accordance with state laws or record retention policies. The insurance department must comply with its written information security program when responding to the public records request for biographical information that is outdated or for which the authorization has been revoked by the affiant. In addition, the Department should include a statement with the documents that notifies the individual requesting disclosure through a public records request that the information contained therein may be outdated. (According to the UCAA Instructions, a biographical affidavit is only good for 6 months after executed, and an affiant may revoke authorization at any time.)

- Destroy documents or records in a manner that renders the information unreadable and undecipherable; document and maintain those procedures for secure disposal of Nonpublic information.

- Develop standards for notifying the affiant and affiant’s employer in the event of a security breach.

- Store the electronic and hardcopies of these documents or records in a secure manner. (Examples include storage in a cabinet or room accessible only by individuals that need the information for permitted purposes.)

For the states that have enacted the **NAIC Insurance Data Security Model Law (#668)** refer to the guidance provided in the Financial Examiners Handbook.
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Primary Application

A Primary Application is to be used for domestic insurers. See Appendix A for the Primary Application Review Checklist.

The classification of the application instruction items is illustrated in the following chart:

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Administrative Filing

Application Instruction Items

Item 1. Application Form and Attachments
- Form 1P “Checklist” – The coordinator should review the checklist for completeness and that all described documents are included in the application.
- Form 2P “Primary Application” – The coordinator should review the form for completeness.
- Form 3 “Lines of Insurance” – Only the applied for lines will be required for a newly formed company. The entire Form 3 will be required for a redomestication.

Item 2. Filing Fee
- Review check submitted in payment of fees for correct amount. In some instances, the check may be held by another section of the insurance department. In that case, review the description of the check received.
- Forward check for deposit or provide information for proper processing of check.
- Filing fees range from $0 to in excess of $5,000 and are generally retaliatory.
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Item 4. Statutory Deposit Requirements
- Form 7 “Certificate of Deposit” – The coordinator should review the form and compare the amount of the deposit to the state’s requirement.
- These funds are deposited with the commissioner, generally through a safekeeping or trust receipt, to be held for the benefit and protection of, and as security for, all policyholders and, in some instances, creditors of the insurer making the deposit. Additional deposits are generally required of those insurers applying to write lines of business not covered under state insurance guaranty funds (e.g., guaranty, fidelity, surety, and bond business) or otherwise (e.g., workers’ compensation). The ultimate purpose of these funds is to ensure that liquid assets are unencumbered and available for use by the commissioner, or his/her designee, for the administration of the insurer’s estate should it become insolvent.

Item 5. Name Approval
- The coordinator should determine that a name approval request consistent with the state’s requirements has been filed. If state requirements dictate, the request should be forwarded to the appropriate area for processing.
- Typically, state insurance departments incorporate insurers, but some states require the involvement of the secretary of state or the attorney general. Names are submitted for preapproval because the public has the right to know with whom it is dealing and, therefore, someone must determine that the name is not so similar to another as to be likely to deceive or mislead. The name should be such as to show that the company is engaged in the insurance business and preferably to show the type of business. Some states provide for publication and subsequent hearing to ensure that any objections are addressed.

Item 8. Statutory Memberships
- The coordinator should compare the application to the state requirements for statutory memberships and determine that appropriate documentation supporting the membership application is included.
- Some states require a positive application and confirmation regarding membership in state-mandated risk pools or other organizations. In other words, an insurer may not automatically be a member by virtue of its certificate of authority, but may be required to join outside the jurisdiction of the insurance department.

Item 12. Public Records Package
- The coordinator should compare the contents of the public records package with state requirements. Financial documents should be forwarded to the areas expected to utilize the documents. Operational documents (other than the application form) should be filed as required.
Analysis of Current Condition

Note: Generally, the scope of the analysis of current condition would depend on the prioritization of the Applicant Company. With a primary application (not a redomestication):

i. If it is a stand-alone company, there is no information upon which to establish a prioritization and the use of that technique is inapplicable.

ii. However, if the Applicant Company is part of a holding company structure, the reviewer may want to consider the strengths, structure, ratings, etc. of the holding company.

Application Instruction Items

Item 3. Minimum Capital and Surplus Requirements

- This document should make it clear that the Applicant Company understands state law with respect to the amount of capital and surplus that must be maintained at a minimum. In some states, the minimum capital and surplus requirements are determined by the classes of insurance that the applicant is requesting authority to transact and the classes of insurance the applicant is authorized to transact in all other jurisdictions. The analyst should determine the level of surplus required after considering the Applicant Company’s plan of operation. Compliance with the statutorily prescribed minimum surplus requirement may not be sufficient for all applicants.

Item 7. Holding Company Act Filings

If the Applicant Company is a member of a holding company system, the application must include either the most recent Holding Company Act (HCA) filings, including the annual Form B registration statement and related Form F, or a statement substantially similar to the Insurance Holding Company System Regulatory Act (#440). Holding Company Act filing information should be considered to determine the role of the Applicant Company within the holding company structure, enterprise risk, the financial capacity of the parent to support an insurance operation and the existence of relevant insurance operations experience in the proposed parent or affiliates. Affiliates are identified along with a description of any transactions between the insurer and an affiliate currently outstanding or during the last calendar year. Copies of all advisory, management and service agreements and other attachments need be reviewed for fair and equitable terms. Refer to the Form A Review Best Practices located under Appendix D.

- The applicant state should bear in mind that Holding Company Act filings, including the Holding Company Form F, are highly confidential, but that state laws providing confidentiality protections may vary from those of the applicant state. A state that has not enacted language specified under HCA Item 8 in its entirety will not have the same confidentiality protections afforded in a state where the language has been enacted. State confidentiality statutes applicable to HCA filings should be reviewed by Regulators of each state before any information is exchanged and where an apparent inconsistency is noted, the state’s legal division should be contacted. Regulators should treat all such materials with the highest level of protections afforded by any relevant state, in order to preserve the confidentiality of such materials and to encourage candor and openness in company discussions and disclosures.
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Item 9. SEC Filings or Consolidated GAAP Financial Statement
- If the Applicant Company, its parent or its ultimate holding company has made a filing or registration with the U.S. Securities and Exchange Commission (SEC) in connection with a public offering within the past three years, or filed an 8K, 10K or 10Q within the past 12 months, the filing, including any supplements or amendments, is available electronically from the SEC. If the applicant, its parent or its ultimate holding company is not publicly traded, the application must include a copy of the Applicant Company’s most recent consolidated generally accepted accounting principles (GAAP) financial statement.
- Similar to the Holding Company Act filings, these filings will provide insight into the financial capacity of the parent to support an insurance operation and the existence of relevant insurance operations experience in the proposed parent or affiliates, as well as information regarding control, enterprise risk, and corporate governance.

Item 10. Debt-to-Equity Ratio Statement
- The debt-to-equity ratio statement should be reviewed to determine the debt service burden that is likely to be placed upon the Applicant Company. Debt service should only be provided through earnings not needed by the insurer to service its own operations.

Item 13. NAIC Biographical Affidavits
- These documents are used to perform a background check (if required by the state) to evaluate the suitability, competency, character and integrity of those persons ultimately responsible for the operations of the insurer. Persons to be reviewed are the controlling owners, officers, directors and key managerial personnel with the ultimate authority over the financial and operational decisions of the insurer, such as the chief executive officer (CEO), chief operating officer (COO), chief financial officer (CFO), secretary, chief marketing officer and treasurer.
- Independent third-party background reports are used to identify discrepancies in the biographical affidavit and evaluate the suitability of the controlling owners, officers, directors or key managerial personnel of the Applicant Company and competency to perform the responsibilities of the position held with the company. Issues regarding competency, character and integrity may be self-evident from the information provided in the affidavit or may be determined from the related background review or criminal background check.
  - Regulators will review the biographical affidavit for completeness – each question should have a response. The affiant must use the most current form available and posted on the UCAA website. Insufficient affidavits or affidavits where signature dates are more than six months from the application submit date should not be accepted.
  - Regulators will review the comparison of information provided on the biographical affidavit and the results of the independent third-party background reports.
  - Regulators will note any discrepancies found in the independent third-party background reports and follow up with the Applicant Company.
  - Any key concerns will be addressed with the Applicant Company.
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Fingerprint data, if available, can be used to validate the identity of personnel and check for criminal background. Information in the biographical affidavit can then be utilized to verify employment and educational background.

Analysis of Business Plan

Note: Generally, the scope of the analysis of current condition would depend on the prioritization of the Applicant Company. With a primary application (not a redomestication):

i. If it is a stand-alone company, there is no information upon which to establish a prioritization and the use of that technique is inapplicable.

ii. However, if the Applicant Company is part of a holding company structure, the reviewer may want to consider the strengths, structure, ratings, etc. of the holding company.

Application Instruction Items

Item 6. Plan of Operation

- Business plans are written descriptions of expected market conditions, company operations, and related forecasted financial results. The plan of operation section of the UCAA refers to three components: a brief narrative, proforma financial statements/projections and a completed questionnaire (Form 8).
- Overly rapid growth in premium volume, inappropriate pricing, inappropriate underwriting, and product mix are important areas of concern when reviewing a business plan.
- The pricing of insurance products is a difficult task. The premium is established based on estimates of a number of unknown future events. The effects of a failure to accurately estimate the cost of those events or to provide a sufficient margin for adverse deviation from the estimate may not be apparent for a long time. The types of business written by an insurer affect the ability of the insurer to estimate future costs. Certain lines of business are, by their nature, more volatile than others in claim cost experience. Also, the long-tail nature of some lines of business increases the level of uncertainty in estimating future costs. Setting premium rates solely on the basis of rates charged by competitors, without consideration for possible differences in the quality of the business that the insurer and its competitors are writing, should be a concern. The description of pricing should indicate the coordination between the Applicant Company’s actuarial and underwriting and marketing departments.
- The proforma financials should be reviewed for consistency with the stated business plan and reasonableness with respect to assumptions. Projections should be based upon well-described and defensible assumptions that are attainable under the circumstances described in the business plan. The department should consider a review of the business plan and proforma financials by department actuaries and/or other experts.
- The insurance department should consider obtaining a pledge from the Applicant Company to notify the insurance department if any deviations from the filed plan of operation are initiated by the Applicant Company within three years of admission.
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The depth of the review will depend on the complexity and financial strength as well as known risks of the insurer(s). Therefore, the analyst may consider a tailored set of procedures that addresses the specific risks of the insurer(s). The following best practices are presented as a guide for regulatory review and analysis of the plan of operations and financial projections related to UCAA primary and expansion applications, recognizing that this is not an all-inclusive list and not all items on this list will apply to each and every application. This list is intended to be a regulatory tool only. The analyst may find it useful to utilize the Financial Analysis Handbook in conjunction to this checklist during their financial review.

1. Background Analysis
   - Request the Applicant Company’s Insurer Profile Summary (IPS) from the lead state. Upon receipt and review of the IPS, document your findings related to the following:
     - State’s Priority Designation
     - Scoring System Result
     - IRIS Ratio Result
     - Analyst Team System Validation Level
     - RBC Ratio
     - Trend Test
     - Review any material issues or concerns of prospective risks noted in the IPS
     - Review the Applicant Company’s most recent Annual Financial Statement, General Interrogatories, Part 1:
       - #5.1 and #5.2 in order to ascertain if the insurer has been a party to a merger or consolidation; and #6.1 and #6.2 in order to ascertain if the insurer had any certificate of authority, licenses or registrations suspended or revoked by any governmental entity during the reporting period
     - Review the most recent report from a credit rating provider in order to ascertain the current financial strength and credit rating of the insurer
     - Document assessment.

2. Management Assessment
   - Review the entity’s biographical affidavits and third-party verifications
   - Note any areas of concern that would indicate further review is necessary. In conducting such review, also consider whether officers, directors and trustees are suitable (e.g. does the individual have the appropriate background and experience to perform the duties expected) for the positions within the insurer. The analyst could also reference the Best Practices for Background Investigations, Background Guidelines and Red Flags on StateNet.
   - Review of the Applicant Company’s Corporate Governance
   - Review the NAIC Form A and Market Action Tracking System (MATS) databases for related information about the primary applicant and other key persons
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- Document assessment.

3. Capital and Surplus Assessment
- Review the proposed Financial Projections, request assumptions used if not provided
- For HMO’s, determine the minimum capital and surplus requirements based on projections
- Review and verify if the following are at or above the statutory minimum requirement for each of the projected years for:
  - Capital
  - Surplus
- Review and verify if the RBC ratio is adequate for each of the projected years
- Review for indications if any surplus notes will be issued as part of the funding component
- Review and assess the surplus note’s impact on overall capitalization
- Review for indications if any capital contributions are contemplated as part of the projections
- Review and assess the capital contributions’ impact on overall capitalization
- Review for indications if any dividend distributions are contemplated as part of the projections
- Review and assess the dividend distributions’ impact on overall capitalization
- Document assessment.

4. Operations Assessment
- Review the projected Statement of Income
- Assess if the company appears to be overleveraged based on the NPW to C&S or RBC ratios
- Review and assess if the combined ratio exceeds 100% for any of the projected years
- For each year projecting net losses, assess the Applicant Company’s ability to absorb and recover from such losses
- For each year projecting negative cash flow from operations, assess the Applicant Company’s ability to absorb and recover from such negative cash flows
- Review the Applicant Company’s most recent audited financial statement to identify any unusual items or areas that indicate additional review is required
- Document assessment.

5. Ultimate Controlling Party (UCP) Financials
- Review the most recent audited financial statements or SEC reports of the UCP
- Assess whether or not the UCP is capable of providing adequate financial support and management experience in operating the Applicant Company
- Calculate the UCP’s total debt to equity ratio and assess the impact of this ratio on Applicant Company’s overall operations and future solvency
- Review lead state Group Profile Summary
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- Determine if financial projections are needed for the immediate parent or UCP
- Document assessment.

6. Business Plan
- Review the Business Plan
- Review the Business Plan narrative including the types of products to be sold or lines of business and how they will be distributed
- Review the Applicant Company’s geographic service area and the marketing plan
- Review and explain the insurer’s processes for claim processing and claim payments
- Assess reasonableness of Officer/Director compensation information
- Identify if Managing General Agents (MGA) and Third-Party Administrator (TPA) are properly licensed or registered in the state
  - Review the items related to MGA’s and TPA’s as appropriate
    - Contract
    - Oversight
    - Subcontracting provisions
    - Financials
    - Control
    - Delegation
    - Fees
- Review the Applicant Company’s investment policy and investment management of the applicant
- Review custodial agreements and compliance with statutory deposit safekeeping requirements in accordance with the Financial Condition Examiners Handbook
- Review any financial guarantees involved with this transaction
- Document assessment.

7. Reinsurance
- Review and assess the Applicant Company’s reinsurance program and activities; including the impact of assumed and ceded premiums, retention and limitation levels
- Review the financial condition and AM Best ratings of reinsurers with material reinsurance arrangements
  - Consider separately affiliated and non-affiliated reinsurers, which may require separate financial review
  - Consider financial requirements for licensed, authorized or unauthorized material reinsurance arrangements
- Document assessment.

8. Market Share Report
- Review market share reports
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- Assess the impact of the Applicant Company’s projected premiums on the state’s market share and whether there are any areas of concern regarding market share percentages for any of the proposed lines of business
- Determine if a Form E filing is required
- Document assessment.

9. Summary
- Develop and document an overall summary of findings based on the analysis and all other factors that are relevant to evaluating the Applicant Company’s plan of operation and overall financial condition
- Itemize each issue that warrants a company inquiry or resolution
- Send correspondence to Applicant Company.

10. Follow-up
- Upon receipt of the Applicant Company’s response to the inquiry, review and assess the status of each outstanding issue
- Determine if additional company correspondence is required.

Item 11. Custody Agreements
- Custody agreements should be reviewed to determine that the proposed insurer will actually possess its proposed start-up funding. Also, because invested assets make up a significant portion of the asset side of the balance sheet, control of those assets are of utmost importance. The Financial Condition Examiners Handbook provides excellent guidance in reviewing this item.
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Primary Application – Redomestication

The redomestication of an insurer presents unique challenges. It is the only licensing-related transaction in which a foreign insurer becomes a domestic insurer of the applicant state. As such, the applicant state will assume primary regulatory oversight of the applicant. Therefore, it is important that the applicant state obtain a level of understanding of the insurer’s condition and operations equivalent to that of its other domestic companies.

The department should effectively communicate with the domestic state to gain an understanding of the reason for redomestication and any concerns of the domestic state. Any concerns raised should be assessed and documented with rationale to support the conclusion.

It is recommended that both the current and proposed domiciliary states have a thorough understanding of the underlying reasons for redomestication. To that end, a meeting with company representatives should be held prior to the filing of an application. See Appendix A for the Primary Application Review Checklist.

The classification of the of the application instruction items is illustrated in the following chart.

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<td>20. Certificate of Compliance</td>
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Application Instruction Items

The information provided in the application instruction items noted in the primary application should be viewed in conjunction with the items above. The department should assess the redomestication application and accompanying information to effectively reach the appropriate conclusions regarding whether the application is approved or denied. The department should document each assessment for the items listed above.

Item 15. Annual Statements with Attachments

- The Level 1 review as outlined in the Financial Analysis Handbook should be performed.
- Management’s Discussion and Analysis
  - The narrative should be reviewed for explanations of fluctuations in areas such as losses and premium income. Significant events such as expansion into a new line of business or territory will be explained along with other changes that will have been noticed in
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the review of the annual statement. The information provided in this document should be consistent with the plan of operations.

- Actuarial Opinion
  - The actuarial opinion is reviewed for any qualifications or unusual comments along with any explanation of material risk factors.

Item 16. Quarterly Statements
- The quarterly statements are reviewed for any unexplained inconsistencies or fluctuations from the annual statement.

Item 17. Risk-Based Capital (RBC) Report
- The RBC report should be reviewed for significant risk components such as reserves, premium, reinsurance recoverables and investments. The support for those significant risk components should be reviewed for appropriateness. In addition to comparing the action and control levels to the total adjusted capital, the business plan and other information should be reviewed to ensure all risks are adequately addressed.

Item 18. Independent CPA Audit Report
- The statutory audited financial statement should be reviewed for any differences with the annual statement. The opinion should be non-qualified. The notes should be read for a better understanding of the Applicant Company along with any comments or concerns.

Item 19. Reports of Examination
- The financial examination report provides an understanding of the insurer, addresses the accuracy of the filed financial statements and identifies any issues noted with respect to corporate governance. Review of this document should concentrate on compliance issues, comments and recommendations. The Applicant Company should provide follow-up documentation regarding any concerns noted by the domestic state.
- The applicant state should consider contacting the domiciliary state if concerns exist regarding the insurer’s complaint levels, response times, etc.
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The department should meet with the domestic regulator to obtain, discuss and conclude on, at a minimum, the items listed below. The meeting should be held via conference call; an email exchange is not considered sufficient.

- Most recent Insurer Profile Summary (IPS) and supervisory plan, including supporting analysis detail for significant risks
- Reason for redomestication
- Concerns identified with the insurer/group
- History of communication with the insurer/group
- History of regulatory actions
- Results of recent examinations (financial and market conduct), including findings and resolutions
- Status of and responsibilities for annual financial analysis and group analysis, if applicable
- Status of and responsibilities for financial examinations

The department should notify the lead state of the insurance holding company group on receipt of a redomestication application and obtain a copy of the most recent Group Profile Summary (GPS), if applicable.
Expansion Application

The classification of the application instruction items is illustrated in the following chart.

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Administrative Filing

Overall Responsibilities

One person in the insurance department should be assigned as the key administrative coordinator for company licensing applications. This person will be responsible for maintaining a record of applications received, correspondence regarding the application, information received relative to an application, distribution of application materials and the monitoring of time frames regarding the processing of the application. It is recommended that the coordinator utilize a method for tracking the progress of the application; whether it is through the use of the electronic UCAA filing status updates, a database, a word processing document, a spreadsheet or even a TeamMate file.

The completeness of an application is expected prior to the official initiation of the review process and the corresponding start of the “clock.” However, the absence of certain items should not preclude the initial contact with the state of domicile and the start of the review of the significant aspects of the application. For example, the absence of corporate documents such as the current articles of incorporation or an incomplete response on a form should not preclude the contact with the domestic state and a preliminary review of the plan of operations and the biographical affidavits and background reports (if applicable).
Application Instruction Items

The prioritization of the Applicant Company has no effect on the administrative filings processes.

Item 1. Expansion Application Form
- Form 1E “Checklist” – The coordinator should review the checklist for completeness and that all described documents are included in the application.
- Form 2E “Expansion Application” – The coordinator should review the form for completeness.
- Form 3 “Lines of Insurance” – The coordinator should utilize the Lines of Business Matrix to compare the lines of business authorized in the Applicant Company’s domiciliary state (per the certificate of compliance) with the applied for lines of business.

Item 2. Filing Fee
- Review check submitted in payment of fees for correct amount. In some instances, the check may be held by another section of the insurance department. In that case, review the description of the check received.
- Forward check for deposit or provide information for proper processing of check.

Item 4. Statutory Deposit Requirements
- Form 7 “Certificate of Deposit” – The coordinator should review the form and compare the amount of the deposit to the state’s requirement.
- These funds are deposited with the commissioner, generally through a safekeeping or trust receipt, to be held for the benefit and protection of, and as security for, all policyholders and, in some instances, creditors of the insurer making the deposit. Additional deposits are generally required of those insurers applying to write lines of business not covered under state insurance guaranty funds (e.g., guaranty, fidelity, surety, and bond business) or otherwise (e.g., workers’ compensation). The ultimate purpose of these funds is to ensure that liquid assets are unencumbered and available for use by the commissioner, or his/her designee, for the administration of the insurer’s estate should it become insolvent.

Item 5. Name Approval
- The coordinator should determine that a name approval request consistent with the state’s requirements has been filed. If state requirements dictate, the request should be forwarded to the appropriate area for processing.
- Typically, state insurance departments incorporate insurers, but some states require the involvement of the secretary of state or the attorney general. Names are submitted for preapproval because the public has the right to know with whom it is dealing and therefore, someone must determine that the name is not so similar to another as to be likely to deceive or mislead. The name should be such as to show that the company is engaged in the insurance business and preferably to show the type of business. Some states provide for publication and subsequent hearing to ensure that any objections are addressed.

Item 10. Statutory Memberships
The coordinator should compare the application to the state requirements for statutory memberships and determine that appropriate documentation supporting the membership application is included.

Some states require a positive application and confirmation regarding membership in state-mandated risk pools or other organizations. In other words, an insurer may not automatically be a member by virtue of its certificate of authority, but may be required to join outside the jurisdiction of the insurance department.

Item 11. Public Records Package
- The coordinator should compare the contents of the public records package with state requirements. Financial documents should be forwarded to the areas expected to utilize the documents. Operational documents (other than the application form) should be filed as required.

Item 13. Consent to Service of Process
- Form 12 “Consent to Service of Process” – The coordinator should review the form for completeness and file as appropriate.
- This document designates the commissioner or a resident of the state to receive consent to service of process on behalf of the company. Persons or entities to receive forwarded consent to service of process from the commissioner are also provided.

Analysis of Current Condition

Priority 4

The expansion state should determine the prioritization category of the Applicant Company based upon its analysis. For applicants prioritized as Priority 4, the applicant state should contact the domiciliary state if there are any questions or concerns.

Priority 3

If, after discussion with the domiciliary state it is determined the Applicant Company is a Priority 3 company, the expansion state should perform sufficient analysis to fully understand the financial condition and operating practices of the insurer in order to assess the effect of the proposed business plan.

Item 3. Minimum Capital and Surplus Requirements
- This document should make it clear that the Applicant Company understands the expansion state law with respect to the amount of capital and surplus that must be maintained at a minimum. The expansion state processor or analyst can easily determine the Applicant Company’s capital and surplus position by looking at the filed financial statement. The requirement for this document should make it clear that the insurer has read and understands the underlying surplus requirements. The amount required varies from stated capital and free surplus of specific dollar amounts based on lines of authority to a percentage of RBC.
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Item 7. Holding Company Act Filings
- The current registration statement will provide the insurer’s capital structure, general financial condition, ownership and management, along with that of any person controlling the insurer. Affiliates are identified along with a description of any transactions between the Applicant Company and an affiliate that is currently outstanding or was incurred during the last calendar year. A review of this document by an expansion state provides insight into the operations of the insurer and its relationships with its affiliates. Attachments and agreements should only be requested for transactions or items material to the business plan for that state. For additional guidance refer to the Form A Review Best Practices located in Appendix D.

Item 9. Reports of Examination
- As the record of periodic on-site examinations of the Applicant Company’s compliance and accuracy of its financial statements, review of this document should concentrate on compliance issues, comments and recommendations. The Applicant Company should provide follow-up documentation regarding any concerns noted by the domestic state.
- The applicant state may consider contacting the domiciliary state if concerns exist regarding the insurer’s complaint levels, response times, etc.

Item 11. Public Records Package
- The items included in the Public Records Package are familiar to all financial analysts and can be utilized to complete the reviews described in the Financial Analysis Handbook. Unusual results should be discussed with the domiciliary state.

Item 12. NAIC Biographical Affidavits
- These documents are used to perform a background check (if required by the state) to evaluate the suitability, competency, character and integrity of those persons ultimately responsible for the operations of the insurer. Persons to be reviewed are the controlling owners, officers, directors and key managerial personnel with the ultimate authority over the financial and operational decisions of the insurer, such as the chief executive officer (CEO), chief operating officer (COO), chief financial officer (CFO), secretary, chief marketing officer and treasurer.
- Independent third-party background reports are used to identify discrepancies in the biographical affidavit and evaluate the suitability of the controlling owners, officers, directors or key managerial personnel of the Applicant Company and competency to perform the responsibilities of the position held with the company. Issues regarding competency, character and integrity may be self-evident from the information provided in the affidavit or may be determined from the related background review or criminal background check.
  o Regulators will review the biographical affidavit for completeness – each question should have a response. The affiant must use the most current form available and posted on the UCAA website. Insufficient affidavits or affidavits where signature dates are more than six months from application submit date should not be accepted.
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- Regulators will review the comparison of information provided on the biographical affidavit and the results of the independent third-party background reports.
- Regulators will note any discrepancies found in the independent third-party background reports and follow up with the Applicant Company or domestic regulator for further clarification.
- Any key concerns will be addressed with the Applicant Company or domestic regulator for further clarification.

Fingerprint data, if available, can be used to validate the identity of personnel and check for criminal background. Information in the biographical affidavit can then be utilized to verify employment and educational background, if necessary.

Priority 1 and Priority 2

Priority 1 and 2 companies are generally not considered good candidates for expansion. There is little to be gained from the processing of the administrative filing sections of the application that is destined to be rejected once the analytical review is conducted. If, after discussion with the domiciliary state, it is determined the applicant is a Priority 1 or 2, the expansion state should determine if there is a reason to further analyze the financial condition of the company.

Based on the business plan there may be a reason to further analyze the financial condition of the company (see Analysis of Business Plan: Priority 2, below). The expansion state should communicate with the domiciliary state to understand the circumstances under which expansion may be advisable. In such situations, the expansion state must perform sufficient analysis (at least those required of a Priority 2 company) of the Applicant Company’s financial condition and operating practices to determine that the risks associated with the proposed business plan are within the Applicant Company’s expertise and financial capacity to assume.

Analysis of Business Plan

Priority 4

Item 6. Plan of Operation

- The plan of operation should be reviewed to ensure that the proposed business plan is consistent with the Applicant Company’s demonstrated experience. See Priority 3 Best Practices—Review of Plan of Operations (Proforma Financial Statements, Narrative/Business Plan and Questionnaire).

Priority 3

Item 6. Plan of Operation

- Business plans are written descriptions of expected market conditions, company operations, and related forecasted financial results. The plan of operation section of the UCAA refers to three components: a brief narrative, pro-forma financial statements/projections and a completed questionnaire (Form 8).
By virtue of the filing of the UCAA, the applicant is notifying the state insurance department of recent or planned changes in the insurer’s operations. One recurring factor that appears in many troubled insurance company situations is a recent change in operations, management or ownership. Therefore, overly rapid growth in premium volume, expansion into new geographic areas or new lines of business, inappropriate pricing, inappropriate underwriting, and product mix are important areas of concern when reviewing a business plan.

Geographic growth can lead to less control by the insurer over new producers, underwriting operations, and claims administration. The insurance laws and regulations in the expansion state and the nature of the various operational risks may differ from those of jurisdictions to which the business was previously limited. Similarly, rapid expansion into new lines of business can lead to difficulties if the insurer’s management and personnel lack an adequate knowledge and understanding of the characteristics and risks of the business proposed to be written. Extremely rapid geographic or product line expansion may cause the insurer’s training of new producers, underwriters, and claims personnel to trail growth of the business. A change to specialized lines of business should be accompanied by concurrently obtaining the additional specialized expertise or qualified personnel required to understand and administer that specialized business. Additionally, a rapidly growing insurer may fail to add enough experienced personnel to keep up with its expanding operations. Existing personnel may not have sufficient skills to manage the additional growth.

The pricing of insurance products is a difficult task. The premium is established based on estimates of a number of unknown future events. The effects of a failure to accurately estimate the cost of those events or to provide a sufficient margin for adverse deviation from the estimate may not be apparent for a long time. The types of business written by an insurer affect the ability of the insurer to estimate future costs. Certain lines of business are, by their nature, more volatile than others in claim cost experience. Also, the long-tail nature of some lines of business increases the level of uncertainty in estimating future costs. Setting premium rates solely on the basis of rates charged by competitors, without consideration for possible differences in the quality of the business that the insurer and its competitors are writing, should be a concern. The description of pricing should indicate coordination between the Applicant Company’s actuarial and underwriting and marketing departments.

Concern should be noted when management of the insurer has focused excessively on the agency or marketing aspects of the business. Management may have a tendency to measure success by the volume of business written and ignore the underwriting aspects. Also, while most insurers may establish production or profit goals, these goals may be deemed so important by certain management groups that producers and underwriters may be allowed to relax underwriting standards to permit the acceptance of additional business so as to meet the insurer’s production goals.

The proforma financials should be reviewed for consistency with the stated business plan and reasonableness with respect to assumptions. Projections should be based upon well described and defensible assumptions that are attainable under the circumstances described in the business plan. The insurance department should consider a review of the business plan and proforma financials by department actuaries and/or other experts.
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- The insurance department should consider obtaining a pledge from the Applicant Company to notify the insurance department if any deviations from the filed plan of operation are initiated by the entity within three years of admission.


The depth of the review will depend on the complexity and financial strength as well as known risks of the insurer(s). Therefore, the analyst may consider a tailored set of procedures that addresses the specific risks of the insurer(s). The following best practices are presented as a guide for regulatory review and analysis of the plan of operations and financial projections related to UCAA primary and expansion applications, recognizing that this is not an all-inclusive list and not all items on this list will apply to each and every application. This list is intended to be a regulatory tool only. The analyst may find it useful to utilize the Financial Analysis Handbook in conjunction to this checklist during their financial review.

1. **Background Analysis**
   - Request the applicant’s Insurer Profile Summary (IPS) from the lead state. Upon receipt and review of the IPS, document your findings related to the following:
     - State’s Priority Designation
     - Scoring System Result
     - IRIS Ratio Result
     - Analyst Team System Validation Level
     - RBC Ratio
     - Trend Test
     - Review any material issues or concerns of prospective risks noted in the IPS
     - Review the applicant’s most recent Annual Financial Statement, General Interrogatories, Part 1:
       - #5.1 and #5.2 in order to ascertain if the insurer has been a party to a merger or consolidation; and #6.1 and #6.2 in order to ascertain if the insurer had any certificate of authority, licenses or registrations suspended or revoked by any governmental entity during the reporting period
     - Review the most recent report from a credit rating provider in order to ascertain the current financial strength and credit rating of the insurer.

2. **Management Assessment**
   - Review the entity’s biographical affidavits and third-party verifications
   - Note any areas of concern that would indicate further review is necessary. In conducting such review, also consider whether officers, directors and trustees are suitable (e.g. does the individual have the appropriate background and experience to perform the duties expected) for the positions within the insurer. The analyst could also reference the Best Practices for Background Investigations, Background Guidelines and Red Flags on StateNet.
   - Review of the Applicant Company’s Corporate Governance.
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3. **Capital and Surplus Assessment**
   - Review the proposed Financial Projections, request assumptions used if not provided
   - For HMO’s, determine the minimum capital and surplus requirements based on projections
   - Review and verify if the following are at or above the statutory minimum requirement for each of the projected years for:
     - Capital
     - Surplus
   - Review and verify if the RBC ratio is adequate for each of the projected years
   - Review for indications if any surplus notes will be issued as part of the funding component
   - Review and assess the surplus note’s impact on overall capitalization
   - Review for indications if any capital contributions are contemplated as part of the projections
   - Review and assess the capital contributions’ impact on overall capitalization
   - Review for indications if any dividend distributions are contemplated as part of the projections
   - Review and assess the dividend distributions’ impact on overall capitalization.

4. **Operations Assessment**
   - Review the projected Statement of Income
   - Assess if the company appears to be overleveraged based on the NPW to C&S or RBC ratios
   - Review and assess if the combined ratio exceeds 100% for any of the projected years
   - For each year projecting net losses, assess the Applicant Company’s ability to absorb and recover from such losses
   - For each year projecting negative cash flow from operations, assess the company’s ability to absorb and recover from such negative cash flows
   - Review the company’s most recent audited financial statement to identify any unusual items or areas that indicate additional review is required.

5. **Ultimate Controlling Party (UCP) Financials**
   - Review the most recent audited financial statements or SEC reports of the UCP
   - Assess whether or not the UCP is capable of providing adequate financial support and management experience in operating the Applicant Company
   - Calculate the UCP’s total debt to equity ratio and assess the impact of this ratio on Applicant Company’s overall operations and future solvency
   - Review lead state Group Profile Summary
   - Determine if financial projections are needed for the immediate parent or UCP.

6. **Business Plan**
   - Review the Business Plan
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- Review the Business Plan narrative including the types of products to be sold or lines of business and how they will be distributed
- Review the applicant’s geographic service area and the marketing plan
- Review and explain the insurer’s processes for claim processing and claim payments
- Assess reasonableness of Officer/Director compensation information
- Identify if Managing General Agents (MGA) and Third-Party Administrator (TPA) are properly licensed or registered in the state
  - Review the items related to MGA’s and TPA’s as appropriate
    - Contract
    - Oversight
    - Subcontracting provisions
    - Financials
    - Control
    - Delegation
    - Fees
- Review the Applicant Company’s investment policy and investment management of the applicant
- Review custodial agreements and compliance with statutory deposit safekeeping requirements in accordance with the Financial Condition Examiners Handbook
- Review any financial guarantees involved with this transaction.

7. Reinsurance
   - Review and assess the Applicant Company’s reinsurance program and activities; including the impact of assumed and ceded premiums, retention and limitation levels
   - Review the financial condition and AM Best ratings of reinsurers with material reinsurance arrangements
     - Consider separately affiliated and non-affiliated reinsurers, which may require separate financial review
     - Consider financial requirements for licensed, authorized or unauthorized material reinsurance arrangements.

8. Market Share Report
   - Review market share reports
   - Assess the impact of the applicant projected premiums on the state’s market share and whether there are any areas of concern regarding market share percentages for any of the proposed lines of business
   - Determine if a Form E filing is required.

9. Summary
   - Develop and document an overall summary of findings based on the analysis and all other factors that are relevant to evaluating the Applicant Company’s plan of operation and overall financial condition
Best Practices: Application Review

- Itemize each issue that warrants a company inquiry or resolution
- Send correspondence to Applicant Company.

10. Follow-up
- Upon receipt of the Applicant Company’s response to the inquiry, review and assess the status of each outstanding issue
- Determine if additional company correspondence is required.
NAIC Company Licensing Best Practices Handbook
Best Practices: Application Review

Form 8 – Interrogatories from Form 8 that provide insight into the Applicant Company’s business plan are discussed below.

Interrogatory 2: Encumbered assets must be explored for propriety; Pledged capital stock is a sign of borrowing and repayment terms and conditions must be investigated; Merger or consolidation might explain significant fluctuations in a historical financial analysis.

Interrogatory 4: Historical information in order to do further research, if necessary. An explanation is adequate. The initial request of copies of documentation is unnecessary unless questions arise concerning the veracity of the Applicant Company’s response to this and other questions.

Interrogatory 5: A change in management or control may have a significant impact on operations.

Interrogatory 6: The most recent Holding Company Filings should suffice to explain the holding company structure and intercompany relationships. If no holding corporation, then an explanation should suffice initially.

Interrogatory 8: Revocation of a certificate of authority or denial of licensure should be discussed with the domiciliary state to determine if the proximate causes for such actions are still in existence.

Interrogatory 9: Positive responses to this interrogatory should be discussed with the domiciliary state. All responses should be compared to the results of criminal background checks.

Interrogatory 10: Such dispute may affect the financial condition and may be an indication of inappropriate business practices.

Interrogatory 11: Such legal action may affect the financial condition and may be an indication of inappropriate business practices.

Interrogatory 12: Conflicts of interest can detrimentally affect the operations of an insurer.

Interrogatory 13: Positive responses to this interrogatory may affect the manner in which the company’s products are marketed. Additionally, the Applicant Company’s parent or affiliates will be subject to regulatory restrictions.

Interrogatory 14: Conflicts of interest can detrimentally affect the operations of an insurer.

Interrogatory 15: The organizational flow chart should depict the day-to-day management and internal controls within the company. The map or narrative depicting the location(s) of the office(s) should also contain the approximate number of employees for each location. Copies of agreements should be attached.

Interrogatories 16 and 17: The marketing plan is the core of the applicant’s business plan narrative. The use, oversight, and compensation of producers are important aspects of product delivery. Since each state or region inherently may have unique market conditions related to products, distribution systems, or competition, serious thought must be put into these areas. Copies of agreements should initially be required with the primary application.

Interrogatory 18: The applicant should be able to provide benefits to the citizens that do not already exist.
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Interrogatory 19: One of the state’s responsibilities is to prevent unfair trade practices. Deceptive advertising and sales are prohibited.

Interrogatories 20 and 21: Product administration should be included in the narrative of the business plan. Knowledge, experience and capacity are necessary ingredients. Service agreements and personnel oversight need only be initially provided in the primary application.

Interrogatory 22: Affiliated agreements for tax allocation, services and facilities are necessary to be reviewed with the primary application to ensure fairness and equity. Rates should be on an actual cost basis, but should be no less than market rates.

Interrogatory 24: Conflicts of interest can detrimentally affect the operations of an insurer.

Interrogatory 25: The expense of the options can affect the financial condition. The exercising of those options can affect control of the insurer. The existence of those options can affect the insurer’s ability to raise other capital.

Interrogatories 26-29: Review the responses to these interrogatories if specific state laws address these issues.

Interrogatory 30: Conflicts of interest can detrimentally affect the operations of an insurer.

The following questions apply only if the Applicant Company is filing a primary redomestication application.

Interrogatories 31 and 32c: It is important to understand the effect of prescribed or permitted practices on the reported financial condition of the company.

Interrogatories 32 and 33: It is important for both the applicant and the state of redomestication to know and address any regulatory differences.

Interrogatory 34: Interest and principal payment restrictions need to be clearly understood and agreed upon.
Priority 2

Priority 2 companies are generally not considered good candidates for expansion. There is little to be gained from the processing of the administrative filing sections of the application that is destined to be rejected once the analytical review is conducted.

However, in certain unique circumstances, based on the line of business offered and the market conditions in the expansion state, it may be appropriate to pursue licensure under heavily monitored criteria. For example, a small, specialty insurer (such as a captive insurer) may not demonstrate the qualities of a Priority 4 or Priority 3 company. Such a company may have a commercial policyholder with operations located in a state where it is not licensed. In order to continue to provide coverage to the policyholder, the insurer must seek licensure in the additional state. In this circumstance, the expansion state may grant a certificate of authority with additional restrictions that only identified risks be written.

In such situations, the expansion and domiciliary state must perform sufficient analysis (at least those required of a Priority 2 company) of the company’s financial condition and business plan to determine that such risks are within the company’s expertise and financial capacity to assume. The reasons why the proposed expansion would be tolerable should then be delineated.

Priority 1

Insurers included in Priority 1 are considered troubled and subject to comprehensive annual and quarterly analysis procedures, detailed considerations outlined with the Troubled Insurance Company Handbook, and a significantly elevated level of ongoing regulatory monitoring and oversight.

Insurers in this group generally are not capable of withstanding even moderate business fluctuations. There may be significant noncompliance with laws and regulations. Risk-management practices are generally unacceptable relative to the insurer’s size, complexity and risk profile. Corporate and group structures or framework may be of a nature that is not conducive to effective regulation. Close regulatory attention is required, which means formal action is necessary in most cases to address the problems. Insurers in this group pose a risk to the state guaranty fund. Priority 1 companies should not be considered for expansion.
Corporate Amendment Application – Adding and Deleting Lines of Business

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**Administrative Items**

**Item 1. Application Form and Attachments**
- Form 1C “Corporate Amendments Application Checklist” – The coordinator should review the checklist for completeness and that all described documents are included in the application. As stated on the checklist form, this document is simply a guide. It is a reminder of what should initially be included in the application package in order for it to be considered complete. This form is all-inclusive but should be completed with due consideration to the specific amendment(s) requested. Items required are dependent upon the request of the applicant.
- Form 2C “Corporate Amendments Application” – The coordinator should review the form for completeness. This form contains minimum required information.
- Form 3 “Lines of Insurance” – The coordinator should utilize the [Lines of Business Matrix](#) to compare the lines of business authorized in the company’s domiciliary state (per the certificate of compliance) with the applied for lines of business.

**Item 2. Filing Fee**
- Review check submitted in payment of fees for correct amount. In some instances, the check may be held by another section of the insurance department. In that case, review the description of the check received.
- Forward check for deposit or provide information for proper processing of check.
- Filing fees range from $0 to in excess of $500 and are generally retaliatory.
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Item 3. Articles of Incorporation
• In some instances, the articles of incorporation contain specific references to the lines of business the entity is authorized to engage. Such language should be consistent with the proposed changes to the certificate of authority.

Item 4. Bylaws
• The bylaws generally should not have to be reviewed in connection with the addition or deletion of a line of business.

Item 6. Statutory Deposit Requirements
• These funds are deposited with the commissioner, generally through a safekeeping or trust receipt, to be held for the benefit and protection of, and as security for, all policyholders and, in some instances, creditors of the insurer making the deposit. Additional deposits are generally required of those insurers applying to write lines of business not covered under state insurance guaranty funds (e.g., guaranty, fidelity, surety, and bond business) or otherwise (e.g., workers’ compensation). The ultimate purpose of these funds is to ensure that liquid assets are unencumbered and available for use by the commissioner, or his/her designee, for the administration of the insurer’s estate should it become insolvent. Unless a line of business is being applied for that is not protected by a guaranty fund, the domestic state should hold the deposit in an aggregate amount of no less than the minimum required capital.

Item 8. Statutory Memberships
• May be required, dependent upon line of business requested.
• Some states require a positive application and confirmation regarding membership in state-mandated risk pools or other organizations. In other words, an insurer may not automatically be a member by virtue of its certificate of authority, but may be required to join outside the jurisdiction of the insurance department.

Analysis of Current Condition

Priority 4

If the company is prioritized as 4, then typically only the certificate of compliance need be reviewed by the applicant state. However, some circumstances may exist that would warrant additional analysis by the applicant state. For example, differing capital and surplus requirements in the states may require some consideration by a particular applicant state. In addition, permitted practices granted to an applicant insurer by its domiciliary state may account for a significant amount of the insurer’s surplus, in which case the applicant state may need to perform a bit more analysis than just reviewing the comment.
Priority 3

If the company is prioritized as 3, then the following review of application documents is suggested:

Item 5. Minimum Capital and Surplus Requirements
  • This document should make it clear that the Applicant Company understands the state law with respect to the amount of capital and surplus that must be maintained at a minimum with respect to the line of business to be added. The analyst can easily determine the Applicant Company’s capital and surplus position by looking at the filed financial statement. The requirement for this document should make it clear that the insurer has read and understands the underlying surplus requirements. The amount required varies from stated capital and of specific dollar amounts based on lines of authority to a percentage of risk-based capital.

Priority 2

If the company is prioritized as Priority 2, then the Applicant Company state should discuss with the domiciliary state whether there exists any extraordinary circumstance that might outweigh the Applicant Company’s operating condition.

Analysis of Business Plan

Priority 4

If the Applicant Company is prioritized as Priority 4, then Item 7, Plan of Operation, should be reviewed to determine that the company has experience with the requested new line of business. Regardless of risk category, a line of business should not be deleted unless all liabilities in that line are extinguished. See Corporate Amendment – Adding and Deleting Lines of Business, Priority 3, Plan of Operation for Best Practices – Review of Plan of Operations (Proforma Financial Statements, Narrative/Business Plan and Questionnaire).

Priority 3

If the Applicant Company is prioritized as 3, then the following review of application documents is suggested.

Item 7. Plan of Operation
  • The narrative business plan including the rationale for adding lines of business and the sales and administration of that business along with the accompanying pro-forma financial statements/projections should provide the information initially required in this section. Dependent upon the prioritization of the Applicant Company and the specific line of business requested, along with the experience in that line of the insurer, Form 8C may be required.
NAIC Company Licensing Best Practices Handbook
Best Practices: Application Review


The depth of the review will depend on the complexity and financial strength as well as known risks of the insurer(s). Therefore, the analyst may consider a tailored set of procedures that addresses the specific risks of the insurer(s). The following best practices are presented as a guide for regulatory review and analysis of the plan of operations and financial projections related to UCAA primary and expansion applications, recognizing that this is not an all-inclusive list and not all items on this list will apply to each and every application. This list is intended to be a regulatory tool only. The analyst may find it useful to utilize the Financial Analysis Handbook in conjunction to this checklist during their financial review.

1. Background Analysis
   • Request the applicant’s Insurer Profile Summary (IPS) from the lead state. Upon receipt and review of the IPS, document your findings related to the following:
     • State’s Priority Designation
     • Scoring System Result
     • IRIS Ratio Result
     • Analyst Team System Validation Level
     • RBC Ratio
     • Trend Test
   • Review any material issues or concerns of prospective risks noted in the IPS
   • Review the applicant’s most recent Annual Financial Statement, General Interrogatories, Part 1:
     o #5.1 and #5.2 in order to ascertain if the insurer has been a party to a merger or consolidation; and #6.1 and #6.2 in order to ascertain if the insurer had any certificate of authority, licenses or registrations suspended or revoked by any governmental entity during the reporting period
   • Review the most recent report from a credit rating provider in order to ascertain the current financial strength and credit rating of the insurer.

2. Management Assessment
   • Review the entity’s biographical affidavits and third-party verifications
   • Note any areas of concern that would indicate further review is necessary. In conducting such review, also consider whether officers, directors and trustees are suitable (e.g. does the individual have the appropriate background and experience to perform the duties expected) for the positions within the insurer. The analyst could also reference the Best Practices for Background Investigations, Background Guidelines and Red Flags on StateNet.
   • Review of the Applicant Company’s Corporate Governance.

3. Capital and Surplus Assessment
   • Review the proposed Financial Projections, request assumptions used if not provided
NAIC Company Licensing Best Practices Handbook
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- For HMO’s, determine the minimum capital and surplus requirements based on projections
- Review and verify if the following are at or above the statutory minimum requirement for each of the projected years for:
  - Capital
  - Surplus
- Review and verify if the RBC ratio is adequate for each of the projected years
- Review for indications if any surplus notes will be issued as part of the funding component
- Review and assess the surplus note’s impact on overall capitalization
- Review for indications if any capital contributions are contemplated as part of the projections
- Review and assess the capital contributions’ impact on overall capitalization
- Review for indications if any dividend distributions are contemplated as part of the projections
- Review and assess the dividend distributions’ impact on overall capitalization.

4. Operations Assessment
- Review the projected Statement of Income
- Assess if the Applicant Company appears to be overleveraged based on the NPW to C&S or RBC ratios
- Review and assess if the combined ratio exceeds 100% for any of the projected years
- For each year projecting net losses, assess the Applicant Company’s ability to absorb and recover from such losses
- For each year projecting negative cash flow from operations, assess the company’s ability to absorb and recover from such negative cash flows
- Review the Applicant Company’s most recent audited financial statement to identify any unusual items or areas that indicate additional review is required.

5. Ultimate Controlling Party (UCP) Financials
- Review the most recent audited financial statements or SEC reports of the UCP
- Assess whether or not the UCP is capable of providing adequate financial support and management experience in operating the Applicant Company
- Calculate the UCP’s total debt to equity ratio and assess the impact of this ratio on Applicant Company’s overall operations and future solvency
- Review lead state Group Profile Summary
- Determine if financial projections are needed for the immediate parent or UCP.

6. Business Plan
- Review the Business Plan
- Review the Business Plan narrative including the types of products to be sold or lines of business and how they will be distributed
- Review the insurer’s geographic service area and the marketing plan
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- Review and explain the insurer’s processes for claim processing and claim payments
- Assess reasonableness of Officer/Director compensation information
- Identify if Managing General Agents (MGA) and Third-Party Administrator (TPA) are properly licensed or registered in the state
  o Review the items related to MGA’s and TPA’s as appropriate
    - Contract
    - Oversight
    - Subcontracting provisions
    - Financials
    - Control
    - Delegation
    - Fees
- Review the Applicant Company’s investment policy and investment management of the insurer
- Review custodial agreements and compliance with statutory deposit safekeeping requirements in accordance with the Financial Condition Examiners Handbook
- Review any financial guarantees involved with this transaction.

7. Reinsurance
   - Review and assess the Applicant Company’s reinsurance program and activities; including the impact of assumed and ceded premiums, retention and limitation levels
   - Review the financial condition and AM Best ratings of reinsurers with material reinsurance arrangements
     o Consider separately affiliated and non-affiliated reinsurers, which may require separate financial review
     o Consider financial requirements for licensed, authorized or unauthorized material reinsurance arrangements.

8. Market Share Report
   - Review market share reports
   - Assess the impact of the Applicant Company’s projected premiums on the state’s market share and whether there are any areas of concern regarding market share percentages for any of the proposed lines of business
   - Determine if a Form E filing is required.

9. Summary
   - Develop and document an overall summary of findings based on the analysis and all other factors that are relevant to evaluating the Applicant Company’s plan of operation and overall financial condition
   - Itemize each issue that warrants a company inquiry or resolution
   - Send correspondence to Applicant Company.
10. Follow-up

- Upon receipt of the Applicant Company’s response to the inquiry, review and assess the status of each outstanding issue
- Determine if additional company correspondence is required.

Item 11. Deleting Lines of Business

- Deletion of a line of business requires notification and adequate establishment or extinguishment of liabilities. A line of business should not be deleted unless all liabilities in that line are extinguished.

Priority 2

If the company is prioritized as 2, then the applicant state should discuss with the domiciliary state whether there exists any extraordinary circumstance that might outweigh the Applicant Company’s operating condition. In certain instances the proposed plan of operation might provide for a limited expansion of authority in order to maintain its current policyholder base. Should approval be granted, the business plan should be carefully reviewed and closely monitored. See Corporate Amendment – Adding and Deleting Lines of Business, Priority 2, Plan of Operation for Best Practices – Review of Plan of Operations (Proforma Financial Statements, Narrative/Business Plan and Questionnaire).
NAIC Company Licensing Best Practices Handbook
Best Practices: Application Review

Corporate Amendment Application – Name Change – For Filing with Non-Domiciliary States

Corporate amendment applications involving a change of name or location of the insurer are often accompanied by related policy form approval filings reflecting the change in name or location. In some instances, the company license application process is held in abeyance until a complete review of policy forms has been completed. It is recommended that in such instances a policy form endorsement be approved for only the change in name or location, in lieu of a complete policy form review.

The classification of the application instruction items is illustrated in the following chart.

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<th>Application Instruction Items</th>
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<td>8. Name Approval</td>
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Administrative Filing

Application Instruction Items

Item 1. Application Form and Attachments
- Form 1C “Checklist” – The coordinator should review the checklist for completeness and that all described documents are included in the application.
- Form 2C “Corporate Amendment Application” – The coordinator should review the form for completeness.

Item 2. Filing Fee
- Review check submitted in payment of fees for correct amount. In some instances the check may be held by another section of the insurance department. In that case, review the description of the check received.
- Forward check for deposit or provide information for proper processing of check.
- Filing fees range from $0 to in excess of $200 and are generally retaliatory.

Item 3. Articles of Incorporation
- The amended articles of incorporation should be reviewed to determine that the new name is reflected.
NAIC Company Licensing Best Practices Handbook
Best Practices: Application Review

Item 4. Bylaws
  • The amended bylaws should be reviewed to determine that the new name is reflected.

Item 5. Consent to Service of Process
  • The amended consent to service of process should be reviewed to determine that the new
  name is reflected.

Item 6. State of Domicile Approval
  • The domiciliary state should have already approved the name change.

Item 8. Name Approval
  • Typically state insurance departments incorporate insurers, but some states require the
    involvement of the secretary of state or the attorney general. Names are submitted for
    preapproval because the public has the right to know with whom it is dealing and therefore,
    someone must determine that the name is not so similar to another as to be likely to deceive
    or mislead. The name should be such as to show that the company is engaged in the
    insurance business and preferably to show the type of business. Some states provide for
    publication and subsequent hearing to ensure that any objections are addressed.
  • The coordinator should determine that a name approval request consistent with the state’s
    requirements has been filed. If state requirements dictate, the request should be forwarded
    to the appropriate area for processing.
Corporate Amendment Application – Redomestication of a Foreign Insurer

The classification of the application instruction items is illustrated in the following chart.

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<td>7. State of Domicile Approval</td>
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Administrative Filing

Application Instruction Items

Item 1. Application Form and Attachments
- Form 1P “Checklist” – The coordinator should review the checklist for completeness and that all described documents are included in the application.
- Form 2C “Corporate Amendment Application” – The coordinator should review the form for completeness.
- The coordinator should utilize the Lines of Business Matrix to compare the lines of business in the Applicant Company’s new domicile state with the authorized lines of business in the applicant state.

Item 2. Filing Fee
- Review check submitted in payment of fees for correct amount. In some instances the check may be held by another section of the insurance department. In that case, review the description of the check received.
- Forward check for deposit or provide information for proper processing of check.
- Filing fees range from $0 to in excess of $200 and are generally retaliatory.

Item 3. Articles of Incorporation
- The amended articles of incorporation should be reviewed to determine that the new state of domicile is reflected.

Item 4. Bylaws
- The amended bylaws should be reviewed to determine that the new state of domicile is reflected.
NAIC Company Licensing Best Practices Handbook
Best Practices: Application Review

Item 5. Statutory Deposit Requirements
- Form 7 – The Certificate of Deposit should be reviewed to determine that the new state of domicile is reflected and compare the amount of the deposit of the new state of domicile to the state’s requirement.

Item 6. Consent to Service of Process
- The amended consent to service of process should be reviewed to determine that the new state of domicile is reflected.

Item 7. State of Domicile Approval
- The domiciliary state should have already approved the redomestication.
**Corporate Amendment Application – Change of Statutory Home Office Address**

The classification of the application instruction items is illustrated in the following chart.

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**Administrative Filing**

**Application Instruction Items**

**Item 1. Application Form and Attachments**
- Form 1C “Checklist” – The coordinator should review the checklist for completeness and that all described documents are included in the application.
- Form 2C “Corporate Amendment Application” – The coordinator should review the form for completeness.
- Old Certificate of Authority – The Applicant Company should have surrendered the old certificate of authority or filed an affidavit of a lost certificate of authority.

**Item 2. Filing Fee**
- Review check submitted in payment of fees for correct amount. In some instances the check may be held by another section of the insurance Department. In that case, review the description of the check received.
- Forward check for deposit or provide information for proper processing of check.
- Filing fees range from $0 to in excess of $200 and are generally retaliatory.

**Item 3. Articles of Incorporation**
- The amended articles of incorporation or other documentation required or permitted by the domiciliary state should be reviewed to determine that the new location is reflected.

**Item 4. Bylaws**
- The amended bylaws should be reviewed to determine that if a location for the insurer is stated, the bylaws have been updated to reflect the new location.
NAIC Company Licensing Best Practices Handbook

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Item 5. Consent to Service of Process
- The amended consent to service of process should be reviewed to determine that the new location is reflected.

Item 6. State of Domicile Approval
- The domiciliary state (if the applicant is a foreign company) should have already approved the location change.
NAIC Company Licensing Best Practices Handbook
Best Practices: Application Review

Corporate Amendment Application – Merger of Two or More Foreign Insurers – For Filing with Non-Domiciliary States

Prior to a corporate amendment filing, the Form A should be approved. Refer to Appendix D for detailed information regarding the review of a Form A filing.

The classification of the application instruction items is illustrated in the following chart.

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Administrative Items

A merger requires notification to all states in which the Applicant Company is licensed. Corporate documents must be amended to incorporate the new address along with other requirements that may be state-specific.

Item 1. Application Form and Attachments
- Form 1C “Corporate Amendments Application Checklist” – The coordinator should review the checklist for completeness and that all described documents are included in the application. As stated on the checklist form, this document is simply a guide. It is a reminder of what should initially be included in the application package in order for it to be considered complete. This form is all-inclusive, but should be completed with due consideration to the specific amendment(s) requested. Items required are dependent upon the request of the applicant.
- Form 2C “Corporate Amendments Application” – The coordinator should review the form for completeness. This form contains minimum required information.
- Form 3 “Lines of Insurance” – The coordinator should verify if the Applicant Company is authorized to write all lines of business, including variable products in the state. If the Applicant Company is not authorized to write all lines of business in the state, then the Applicant Company should also complete Section I (Adding and Deleting Lines of Business) in the UCAA Corporate Amendment Application.
Item 2. Filing Fee
- Review check submitted in payment of fees for correct amount. In some instances the check may be held by another section of the insurance department. In that case, review the description of the check received.
- Forward check for deposit or provide information for proper processing of check.
- Filing fees range from $0 to in excess of $200 and are generally retaliatory.

Item 3. Articles of Incorporation/Articles of Merger
- The certificate of merger from the domestic state of the surviving entity serves as the “marriage license” and notes the approval of that state. The articles of merger serve as the “marriage contract” and specify the terms of the merger. These documents should be retained as permanent corporate records as part of the articles of incorporation.

Item 4. Bylaws
- The bylaws need only be reviewed if they have been amended.

Item 6. Statutory Deposit Requirements
- Form 7 “Certificate of Deposit” – The coordinator should review the form and compare the amount of the deposit to the state’s requirement.
- These funds are deposited with the commissioner, generally through a safekeeping or trust receipt, to be held for the benefit and protection of, and as security for, all policyholders and, in some instances, creditors of the insurer making the deposit. Additional deposits are generally required of those insurers applying to write lines of business not covered under state insurance guaranty funds (such as guaranty, fidelity, surety, and bond business) or otherwise (e.g., workers’ compensation). The ultimate purpose of these funds is to ensure that liquid assets are unencumbered and available for use by the commissioner, or his/her designee, for the administration of the insurer’s estate should it become insolvent.

Item 8. Statutory Memberships
- This item may be applicable depending on any new lines of business added.
- Some states require a positive application and confirmation regarding membership in state-mandated risk pools or other organizations. In other words, an insurer may not automatically be a member by virtue of its certificate of authority, but may be required to join outside the jurisdiction of the insurance department.

Item 10. Consent to Service of Process
- This document designates the commissioner or a resident of the state to receive consent to service of process on behalf of the entity. Persons or entities to receive forwarded consent to service of process from the commissioner are also provided.

Item 11. State of Domicile Approval
- The certificate of merger is the approval of the domestic state of the surviving entity. It should be accompanied by a certificate of compliance from the other state involved, if applicable.
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Best Practices: Application Review

Analysis of Current Condition

Item 5. Minimum Capital and Surplus Requirements
- This item may be applicable depending on any new lines of business added.

Item 9. NAIC Biographical Affidavits
- A review of biographical affidavits is only necessary if there is a change in officers, directors or ownership.
- These documents are used to perform a background check (if required by the state) to evaluate the suitability, competency, character and integrity of those persons ultimately responsible for the operations of the insurer. Persons to be reviewed are the controlling owners, officers, directors and key managerial personnel with the ultimate authority over the financial and operational decisions of the insurer, such as the chief executive officer (CEO), chief operating officer (COO), chief financial officer (CFO), secretary, chief marketing officer and treasurer.
- Independent third-party background reports are used to identify discrepancies in the biographical affidavit and evaluate the suitability of the controlling owners, officers, directors or key managerial personnel of the applicant and competency to perform the responsibilities of the position held with the company. Issues regarding competency, character and integrity may be self-evident from the information provided in the affidavit or may be determined from the related background review or criminal background check.
  - Regulators will review the biographical affidavit for completeness- each question should have a response. The affiant must use the most current form available and posted on the UCAA website. Insufficient affidavits or affidavits where signature dates are more than six months from application submit date should not be accepted.
  - Regulators will review the comparison of information provided on the biographical affidavit and the results of the independent third-party background reports.
  - Regulators will note any discrepancies found in the independent third-party background reports and follow up with the Applicant Company or domestic regulator for further clarification.
  - Any key concerns will be addressed with the Applicant Company or domestic regulator for further clarification.

Analysis of Business Plan

Item 7. Plan of Operation
- The articles of merger and/or the accompanying business plan of the surviving entity should be reviewed for informational purposes. See Corporate Amendment – Adding and Deleting Lines of Business. Plan of Operation for Best Practices – Review of Plan of Operations (Proforma Financial Statements, Narrative/Business Plan and Questionnaire).
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Corporate Amendment Application – Proposed/Completed Change of Control of Foreign Insurers

The classification of the of the application instruction items is illustrated in the following chart.

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Administrative Items

Proposed change of control transaction information (proposed transaction) and a second filing of actual information after the change of control are complete (completed transaction). This application is not applicable for filing in a state if the insurer is a domestic insurer in that state.

Item 1. Application Form and Attachments

- Form 1C “Corporate Amendments Application Checklist” – The coordinator should review the checklist for completeness and that all described documents are included in the application. As stated on the checklist form, this document is simply a guide. It is a reminder of what should initially be included in the application package in order for it to be considered complete. This form is all-inclusive, but should be completed with due consideration to the specific amendment(s) requested. Items required are dependent upon the request of the Applicant Company.
- Form 2C “Corporate Amendments Application” – The coordinator should review the form for completeness. This form contains minimum required information.

Item 2. Filing Fee

- Review check submitted in payment of fees for correct amount. In some instances the check may be held by another section of the insurance department. In that case, review the description of the check received.
- Forward check for deposit or provide information for proper processing of check.
- Filing fees range from $0 to in excess of $200 and are generally retaliatory.
NAIC Company Licensing Best Practices Handbook
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Item 3. Articles of Incorporation
- If the Articles of Incorporation have changed as a result of the change of control, file the amended Articles. If the most recently filed (in the state for which you are applying) Articles of Incorporation have not changed, do not file the Articles of Incorporation. Simply state that the current articles are already on file with the state to which this application relates. If it is expected that revised Articles of Incorporation will be submitted in the completed transaction filing, indicate that in the proposed transaction filing.

Item 4. Bylaws
- The bylaws need only be submitted if they have been amended. If it is expected that revised bylaws will be submitted in the completed transaction filing, indicate that in the proposed transaction filing.

Item 7. Consent to Service of Process
- This document designates the commissioner or a resident of the state to receive consent to service of process on behalf of the company. Persons or entities to receive forwarded consent to service of process from the commissioner are also provided.

Item 8. State of Domicile Approval
- Verify that the domiciliary state approved the change of control.
- Refer to Appendix D, Form A Review Best Practices for additional guidance.

Item 9. State-Specific Information
- Some jurisdictions may have additional requirements that must be met before a proposed change of control can be completed. For example, some states require the filing of a Form E (Pre-Acquisition Notification Form Regarding the Potential Competitive Impact of a Proposed Merger or Acquisition by a Non-Domestic Insurer Doing Business in this State or by a Domestic Insurer) at least 30 days before the completion of a change of control transaction. In addition, some states may require a Form B amended statement, in accordance with the Insurance Holding Company System Regulatory Act (#440), after completion of the change of control transaction. Before completing a UCAA Corporate Amendments Application the applicant should review a listing of requirements for the state to which you are applying. State-specific information is listed on the state-specific chart.

Analysis of Current Condition

Item 6. NAIC Biographical Affidavits
- A review of biographical affidavits is only necessary if there is a change in officers, directors or ownership.
- These documents are used to perform a background check (if required by the state) to evaluate the suitability, competency, character and integrity of those persons ultimately responsible for the operations of the insurer. Persons to be reviewed are the controlling owners, officers, directors and key managerial personnel with the ultimate authority over the financial and operational decisions of the insurer, such as the chief executive officer.
NAIC Company Licensing Best Practices Handbook
Best Practices: Application Review

(CEO), chief operating officer (COO), chief financial officer (CFO), secretary, chief marketing officer and treasurer.

- Independent third-party background reports are used to identify discrepancies in the biographical affidavit and evaluate the suitability of the controlling owners, officers, directors or key managerial personnel of the Applicant Company and competency to perform the responsibilities of the position held with the entity. Issues regarding competency, character and integrity may be self-evident from the information provided in the affidavit or may be determined from the related background review or criminal background check.
  - Regulators will review the biographical affidavit for completeness- each question should have a response. The affiant must use the most current form available and posted on the UCAA website. Insufficient affidavits or affidavits where signature dates are more than six months from application submit date should not be accepted.
  - Regulators will review the comparison of information provided on the biographical affidavit and the results of the independent third-party background reports.
  - Regulators will note any discrepancies found in the independent third-party background reports and follow up with the Applicant Company or domestic regulator for further clarification.
  - Any key concerns will be addressed with the Applicant Company or domestic regulator for further clarification.

Analysis of Business Plan

Item 5. Plan of Operation

- If the business plan of the insurer will change as a result of the change of control transaction, a plan of operation must be submitted; otherwise, a statement that the business plan will not change will suffice and should be submitted. The plan of operation is made up of two components: a brief narrative and proforma financial statements/projections (Form 13). The narrative should include significant information in support of the application. Projections must support all aspects of the proposed plan of operation, including reinsurance arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections. See Corporate Amendment – Adding and Deleting Lines of Business. Plan of Operation for Best Practices – Review of Plan of Operations (Proforma Financial Statements, Narrative/Business Plan and Questionnaire).
Corporate Amendment Application – Amended Articles of Incorporation

The classification of the of the application instruction items is illustrated in the following chart.

<table>
<thead>
<tr>
<th>Application Instruction Items</th>
<th>Administrative Filing</th>
<th>Analysis of Current Condition</th>
<th>Analysis of Business Plan</th>
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<tbody>
<tr>
<td>1. Application Form and Attachments</td>
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<td>2. Filing Fee</td>
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<td>3. Articles of Incorporation</td>
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<td>4. Bylaws</td>
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<td>5. State of Domicile Approval</td>
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<tr>
<td>6. State-Specific Information</td>
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</table>

Administrative Items

Amended articles of incorporation require notification to all states in which the Applicant Company is licensed. This application is not applicable for filing in a state if the insurer is a domestic insurer in that state.

Item 1. Application Form and Attachments
- Form 1C “Corporate Amendments Application Checklist” – The coordinator should review the Checklist for completeness and that all described documents are included in the application. As stated on the checklist form, this document is simply a guide. It is a reminder of what should initially be included in the application package in order for it to be considered complete. This form is all-inclusive, but should be completed with due consideration to the specific amendment(s) requested. Items required are dependent upon the request of the applicant.
- Form 2C “Corporate Amendments Application” – The coordinator should review the form for completeness. This form contains minimum required information.

Item 2. Filing Fee
- Review check submitted in payment of fees for correct amount. In some instances the check may be held by another section of the insurance department. In that case, review the description of the check received.
- Forward check for deposit or provide information for proper processing of check.
- Filing fees range from $0 to in excess of $200 and are generally retaliatory.

Item 3. Articles of Incorporation
- Indicate the location of the language within the articles of incorporation that reflects the change. (Page number, section number, etc., of the articles of incorporation).
Item 4. Bylaws
- The bylaws need only be submitted if they have been amended.

Item 5. State of Domicile Approval
- Provide a copy of the amended articles of incorporation approval from the Applicant Company’s state of domicile.

Item 6. State-Specific Information
- Some jurisdictions may have additional requirements that must be met before articles of incorporation can be amended. Before completing a UCAA Corporate Amendments Application the Applicant Company should review a listing of requirements for the state to which you are applying.
Corporation Amendment Application – Amended Bylaws

The classification of the of the application instruction items is illustrated in the following chart.

<table>
<thead>
<tr>
<th>Application Instruction Items</th>
<th>Administrative Filing</th>
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<td>1. Application Form and Attachments</td>
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<td>2. Filing Fee</td>
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<td>3. Bylaws</td>
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<tr>
<td>5. State-Specific Information</td>
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</table>

Administrative Items

Amended bylaws that are not a result of changes addressed in other areas of the corporate amendment application require notification to all states in which the Applicant Company is licensed. This application is not applicable for filing in a state if the insurer is a domestic insurer in that state.

Item 1. Application Form and Attachments
- Form 1C “Corporate Amendments Application Checklist” – The coordinator should review the checklist for completeness and that all described documents are included in the application. As stated on the checklist form, this document is simply a guide. It is a reminder of what should initially be included in the application package in order for it to be considered complete. This form is all-inclusive, but should be completed with due consideration to the specific amendment(s) requested. Items required are dependent upon the request of the Applicant Company.
- Form 2C “Corporate Amendments Application” – The coordinator should review the form for completeness. This form contains minimum required information.

Item 2. Filing Fee
- Review check submitted in payment of fees for correct amount. In some instances the check may be held by another section of the insurance department. In that case, review the description of the check received.
- Forward check for deposit or provide information for proper processing of check.
- Filing fees range from $0 to in excess of $200 and are generally retaliatory.

Item 3. Bylaws
- Indicate the location of the language within the bylaws that reflects the change (page number, section number, etc., of the bylaws).

Item 4. State of Domicile Approval
- Provide a copy of the amended bylaws approval from the Applicant Company’s state of domicile.
NAIC Company Licensing Best Practices Handbook
Best Practices: Application Review

Item 5. State-Specific Information
- Some jurisdictions may have additional requirements that must be met before the bylaws can be amended. Before completing a UCAA Corporate Amendments Application, the applicant should review a listing of requirements for the state to which you are applying.
NAIC Company Licensing Best Practices Handbook
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Corporate Amendment Application – Change of Mailing Address/Contact Notification

The classification of the application instruction items is illustrated in the following chart.

<table>
<thead>
<tr>
<th>Application Instruction Items</th>
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<tbody>
<tr>
<td>1. Application Form and Attachments</td>
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</tbody>
</table>

Administrative Items

Item 1. Application Form and Attachments
- Change of mailing address that do not involve corporate record amendments, such as moving from one building to another or contact person changes, are filed on Form14 – Change of Mailing Address/Contact Notification Form.
NAIC Company Licensing Best Practices Handbook
Best Practices: Application Review

Corporate Amendment Application – Consent to Service of Process

The classification of the application instruction items is illustrated in the following chart.

<table>
<thead>
<tr>
<th>Application Instruction Items</th>
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<tbody>
<tr>
<td>1. Consent to Service of Process Application</td>
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<td>2. Filing Fee</td>
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</table>

Administrative Items

Item 1. Consent to Service of Process
- The amended consent to service of process should be reviewed to determine that the resident agent or forwarding address is reflected.
- **If the application was submitted electronically**, the state may utilize the UCAA email system to contact or notify the company if there are questions regarding the resident agent or forwarding address. Refer to the Corporate Amendment User Guide for additional instructions.

Item 2. Filing Fee
- Review check submitted in payment of fees for correct amount. In some instances the check may be held by another section of the insurance department. In that case, review the description of the check received.
- Forward check for deposit or provide information for proper processing of check.
- Filing fees vary from state to state. Refer to the State Retaliatory Information link on the UCAA website for additional state information.
- **If the application was submitted electronically**, the state may utilize the UCAA email system to contact or notify the Applicant Company of filing fee requirements. Refer to the Corporate Amendment User Guide for additional instructions.
Corporate Amendment Application - Statement of Withdrawal, Complete Surrender of Certificate of Authority

<table>
<thead>
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<tr>
<td>3. Statement of Withdrawal and Attachments</td>
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<tr>
<td>4. State-Specific Information</td>
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Item 1. Application Form and Attachments
- Form 1C “Corporate Amendments Application Checklist” – The coordinator should review the checklist for completeness and that all described documents are included in the application. As stated on the checklist form, this document is simply a guide. It is a reminder of what should initially be included in the application package in order for it to be considered complete. This form is all-inclusive, but should be completed with due consideration to the specific amendment(s) requested. Items required are dependent upon the request of the applicant. If the Applicant Company cannot return its original certificate of authority, they must complete and attach an Affidavit of Lost Certificate of Authority (Form 15).

Item 2. Filing Fee
- Review check submitted in payment of fees for correct amount. In some instances the check may be held by another section of the insurance department. In that case, review the description of the check received.
- Forward check for deposit or provide information for proper processing of check.

Item 3. Statement of Withdrawal and Attachments
- The statement for withdrawal must include a thorough explanation for the surrender of its certificate of authority.
- The Applicant Company must provide sufficient explanations for outstanding claims, contingent liabilities, or laws suits currently existing.
- The Applicant Company must also state whether any business will be transferred to another insurer and attach any reinsurance agreements.

Item 4. State-Specific Information
- Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can cancel a Certificate of Authority. Before completing a UCAA Corporate Amendment Application, the Applicant Company should review the listing of State-Specific Requirements for the application state.
**NAIC Company Licensing Best Practices Handbook**

Appendix A – The Uniform Certificate of Authority Application (UCAA)

**THE UCAA**

In conjunction with the NAIC, the various states have worked toward the goal of streamlining and achieving uniformity in the insurer licensing process. The insurer licensing process encompasses the initial licensing of an insurer, as well as licensing in additional states and filings that modify or expand an existing certificate of authority. It was the intent of the former Accelerated Licensing Evaluation Review Technique (ALERT) Subgroup that each of the adopted application packages contains a complete listing of the requirements for licensing in a state. The Uniform Certificate of Authority Application (UCAA) website that provides a consistent frame of reference for all participants in the licensing process. There are three types of applications: primary, expansion and corporate amendments. Those application types and their component items are described below.

**Primary Application**

The UCAA primary application is for use in the formation of a new insurer, or for an existing insurer to use in making application to redomesticate to another state. It contains the following items:

1. Application Form and Attachments
2. Filing Fee
3. Minimum Capital and Surplus Requirements
4. Statutory Deposit Requirements
5. Name Approval
6. Plan of Operation
7. Holding Company Act Filings
8. Statutory Membership(s)
9. SEC Filings or Consolidated GAAP Financial Statement
10. Debt-to-Equity Ratio Statement
11. Custody Agreements
12. Public Records Package
13. NAIC Biographical Affidavits
14. State-Specific Information

**Primary Application – Redomestications Only**

The requirements of this section are only for those insurers seeking to redomesticate from one state to another and are in addition to the requirements of Section I, Item #1 through Item #14 of the primary checklist. A redomestication is the process where any insurer organized under the laws of any state may become a domestic insurer that transfers its domicile to another state by merger or consolidation or any other lawful method.
NAIC Company Licensing Best Practices Handbook
Appendix A – The Uniform Certificate of Authority Application (UCAA)

The Applicant Company files the primary application with the insurer’s new state of domicile when used for a redomestication. In addition to the items included with the primary application, the redomestication application will include the following items:

15. Annual Statements with Attachments
16. Quarterly Financial Statements
17. Risk-Based Capital Report
18. Independent CPA Audit Report
19. Reports of Examination
20. Certificate of Compliance
NAIC Company Licensing Best Practices Handbook
Appendix A – The Uniform Certificate of Authority Application (UCAA)

**Uniform Certificate of Authority Application (UCAA)**
**Primary Application Review Checklist**
**(Regulator Use Only)**

1. **Company and Structure**
   a. Identify if the Applicant Company is a stock, mutual, etc.
      i. Identify the type of business the Applicant Company will be providing (life, property & casualty, title, etc.).
   b. Articles (for compliance and/or approval in accordance with state law).
      i. Committee Structure
      ii. Par Value
      iii. Capitalization
      iv. Audit Committee – Were independence requirements met?
   c. Bylaws (for compliance and/or approval in accordance with state law) (if applicable).
      i. Committee Structure.
      ii. Audit Committee – Were independence requirements met?
   d. Board of Directors and Designated Committees.
      i. Minimum/maximum number of directors.
      ii. Number of directors.
      iii. Residency requirements.
      iv. Independence requirements.

2. **Review Quality and Expertise, including Biographical Affidavits**
   a. Review the biographical affidavits for fitness and propriety (the biographical affidavit should be completed on the most current revision date of the form and no more than six months (6 months)).
   b. Review third party verifications and fingerprint (where required).
   c. Review Form A database for other transactions and outcomes.
   d. Review SAD database for regulatory actions against the officer or director.
   e. Review biographical sketches (Form B).
   f. Review the quality and expertise of the ultimate controlling person, officers and directors and actuary.
   g. Review appointment letters for appointed actuary and appointed CPA.
   h. Verify Licenses.
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Appendix A – The Uniform Certificate of Authority Application (UCAA)

3. Holding Company (if applicable)

   a. Organizational Chart.
   b. Affiliated Organizations (affiliated agreements will be reviewed for licensing purposes, however, affiliated agreements are not being approved, a Form D filing is required for approval).
      i. Identify the type’s organizations (affiliated and unaffiliated).
      ii. List of services provided by affiliates.
      iii. Reimbursement terms fair & reasonable to the Applicant Company.
      iv. Financial condition.
   c. Review Holding Company Registration Statement (Form B), including amendments (if applicable); and Holding Company Filings.
   d. Review Ultimate Controlling Party (UCP) Financials - Verify if UCP is capable of providing support and experience level in operating the type of company proposed.
   e. Review Debt-to-Equity statement.
   f. Review lead state holding company system analysis and reports.
   g. Review Applicant Company contemplated and/or existing agreements with affiliates.
   h. Review and identify any concerns:
      i. five years of audited financial statements;
      ii. current financial statements (as of date within 90 days of filing); and
      iii. SEC reports, if applicable.
   i. Determine if financial projections are needed for the immediate parent or UCP. If obtained, are the financial projections for the Applicant Company and/or UCP consistent with business plan.

4. Business Plan and Operations

   a. Review the Applicant Company’s business plan.
   b. Review the Applicant Company’s business narrative including the types of products to be sold and how they will be distributed.
   c. Review Form 8 Questionnaire for the Applicant Company.
   d. Consider Officers/Directors compensation information as reported in annual statement.
   e. Identify if any Managing General Agents (MGA) and Third Party Administrator (TPA) will be used. If so, are they properly licensed or registered in the state?
   f. Determine if the Applicant Company will use any Professional Employer Organizations (PEO). If so, are they properly licensed or registered?
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Appendix A – The Uniform Certificate of Authority Application (UCAA)

5. Reasonableness of Projections

a. Identify if the projections appear to be reasonable, in relation to the business plan as provided.
b. What assumptions did the Applicant Company use in their projections, include feasibility study of projections if available.
c. Review the financial statement and exhibits and consider reasonableness of projections provided.
d. Does the Applicant Company appear to be aggressive or realistic in their growth projections?
e. Determine if the GWP and NWP ratios are within industry standards.
f. Review the projected RBC. Is it within the norms and does it make sense based on projections.
g. Review the capitalization of the Applicant Company.
   i. Where is it coming from?
NAIC Company Licensing Best Practices Handbook
Appendix A – The Uniform Certificate of Authority Application (UCAA)

   ii. Will there be any Parental Guarantees, etc.?
   iii. Are there any short or long-term financing arrangements contemplated?
   iv. Consider quality of capitalization.
   h. Did the Applicant Company project any growth? If so:
      i. What will be the source and type (cash, surplus notes) of any such contributions?
      ii. Are there any capital contributions that are being contemplated?
   i. For HMO’s, determine the minimum capital, surplus and deposit requirements based on the Applicant Company’s projections.

6. Company Financials (if redomicating)

   b. Request and review a copy of the Applicant Company’s Insurer Profile Summary from the domestic state.
   c. Request and review a copy of the latest holding company system analysis from the lead state.
   d. Review the Applicant Company’s FAST and Financial Profile
   e. Review AM Best and other rating agency ratings.
   f. Identify if the company was redomicating, was the company formed by the Secretary of State or under the business laws or insurance laws of the state.
   g. Verify the date the last financial examination was completed and determine if it met all state requirements.

7. Other

   a. Determine if Network Adequacy requirements are met, if HMO.
   b. Determine if a pre-licensing examination needs to occur.
   c. Designation of Registered Agent.
   d. Review applications filed in other states in the prior 12 months.
   e. Review the terms of any agreements with a broker-dealer.
   f. Review the market share impact.
NAIC Company Licensing Best Practices Handbook
Appendix A – The Uniform Certificate of Authority Application (UCAA)

Expansion Application

The UCAA expansion application is for use by an insurer that wishes to expand into one or more states. An insurer may file expansion applications simultaneously in as many states as desired. The expansion application is an abbreviated version of the UCAA designed to allow solidly performing companies that are in good standing in all admitted states to gain admission into new states quickly and easily. It is the goal to complete the review of expansion applications within 60 calendar days of receipt. The 60-day review process includes two weeks to determine if the application is complete and acceptable. During the remaining 45–60 day time span, the application will receive a financial and operational review. Based on the circumstances of a particular application, it may be necessary for the reviewing state to request additional information.

The UCAA expansion application has the following items:

1. Expansion Application Form
2. Filing Fee
3. Minimum Capital and Surplus Requirements
4. Statutory Deposit Requirements
5. Name Approval
6. Plan of Operation
7. Holding Company Act Filings
8. Certificate of Compliance
9. Report of Examination
10. Statutory Memberships
11. Public Records Package
12. NAIC Biographical Affidavits
13. Consent to Service of Process
14. State-Specific Information
NAIC Company Licensing Best Practices Handbook
Appendix A – The Uniform Certificate of Authority Application (UCAA)

Corporate Amendments Application

An existing insurer uses the UCAA corporate amendments application for requesting amendments to its certificate of authority. The Applicant Company can use the corporate amendments application to file more than one change in the same submission. The Applicant Company should mark all changes it files on the application form and submit all items required for those changes. This UCAA corporate amendments application has the following items:

1. Application Form and Attachments
2. Filing Fee
3. Articles of Incorporation
4. Bylaws
5. Minimum Capital and Surplus Requirements
6. Statutory Deposit Requirements
7. Plan of Operation
8. Statutory Membership(s)
9. Certificate of Compliance
10. State-Specific Information
11. Deleting Lines of Business

There are slightly different filing requirements for corporate amendments applications involving name changes, redomestication of foreign insurers, change of city within the state of domicile, change of mailing address/contact information and mergers of two or more foreign insurers.

UCAA Forms

In order to facilitate the uniform submission of information pertinent to each of the items of the various applications, a variety of forms were promulgated by the ALERT Subgroup. There is a matrix of the forms and the items to which they apply on the UCAA website.
NAIC Company Licensing Best Practices Handbook
Appendix A – The Uniform Certificate of Authority Application (UCAA)

REVIEW OF THE UCAA

The “Best Practices: Application Review” chapter of the Best Practices Handbook describes the recommended best practices for the review of the items and forms associated with the various types of UCAA applications.

Review of UCAA State Charts

In order to maintain accurate and current state requirements, the UCAA state charts should be reviewed by the insurance department at least on an annual basis. In addition, whenever the state is aware of a change, notify the company licensing coordinator as soon as practicable. Each chart listed should be reviewed for:

- State requirements
- Statutory references
- Department website links
- Contact information, including email, telephone number and extension.

All updates should be sent to the company licensing coordinator listed on the NAIC website.
NAIC Company Licensing Best Practices Handbook
Appendix B – Use of Electronic Documents

Many of the documents filed in the UCAA process are currently housed in electronic format at the NAIC or lend themselves easily to electronic storage and viewing.

The items included in the public records package that are already stored in either data tables or PDF file format, or both, at the NAIC are:

- Annual Financial Statements (in data tables and PDF files) with Attachments, Including the Actuarial Opinion and Management’s Discussion and Analysis (in PDF file format)
- Quarterly Financial Statements (in data tables and PDF files)
- Risk-Based Capital Reports (in data tables and PDF files)
- CPA Audit Reports (in PDF files)
- Examination Reports (in PDF files and in I-SITE in the Financial Exam Electronic Tracking System on a voluntary basis)
- SEC Filings (can be found at www.sec.gov/edgar.shtml)

The following documents are not currently stored in an explicit location in an NAIC database, but should at least be stored and made available in electronic format:

- Form B Registration Statement
- Consolidated GAAP Financial Statements
- Articles of Incorporation
- Bylaws

A concerted effort should be made to reduce the amount of paperwork created and stored with respect to the review of UCAA applications.
NAIC Company Licensing Best Practices Handbook
Appendix C – Review of Electronic Application Coordination and Processing (REACAP)

Companies may file an NAIC Uniform Certificate of Authority Application (UCAA) under the REACAP program upon application to and acceptance by the National Treatment and Coordination (E) Working Group (Working Group). Applications that are accepted into the REACAP program will have the timing, technology and substantive processing monitored, issues encountered will be reported to the Working Group and the applicant will provide feedback to the Working Group about the process. UCAA electronic applications are encouraged, and acceptance into the REACAP program is an option, not a requirement, when submitting an electronic application.

To apply for REACAP, companies should send to the co-chairs of the Working Group and the NAIC coordinator (www.naic.org/industry_ucaa.htm) an explanatory letter setting forth the basis for their application that meets the criteria for acceptance into the REACAP program. Companies should be aware that other factors, such as regulatory workload, may impact acceptance into the REACAP program.

For an expansion application, the explanatory letter must include all of the following for consideration for acceptance into the REACAP program:

1. A commitment to file application electronically and to work with the Working Group.
2. A commitment letter (attached) from the domestic regulator indicating their willingness to work with the Working Group should the REACAP application be accepted.
3. Whether the application will serve a national or regional market need and quantification of that need.
4. The number and name of states to which the expansion application will be submitted.
5. A description of the current affiliations with insurers licensed in one or more states.
6. The basic financial condition of the applicant (e.g., capital, surplus, RBC) and the “as-of” date of the most recent financial exam.
7. Whether the company is a start-up company.
8. The nature and extent of any parental guarantees.
9. Experience of the management team with the lines of business being applied for.
10. A brief description of all regulatory compliance enforcement actions by state for the past five years.
NAIC Company Licensing Best Practices Handbook
Appendix C – Review of Electronic Application Coordination and Processing (REACAP)

For a corporate amendment application, the explanatory letter must include all of the following for consideration for acceptance into the REACAP program:

1. A commitment to file application electronically and to work with the Working Group.
2. A commitment letter (attached) from the domestic regulator indicating their willingness to work with the Working Group should the REACAP application be accepted.
3. The number and name of states to which the corporate amendment application will be submitted.
4. If adding line(s) of business or merger:
   a. Whether the application will serve a national or regional market need and quantification of that need.
   b. A description of the current affiliations with insurers licensed in one or more states.
   c. The basic financial condition of the applicant (e.g., capital, surplus, RBC) and the “as-of” date of the most recent financial exam.
   d. Experience of the management team with the lines of business being applied for.
   e. Indicate if the transaction is date-specific.
5. If a name change, merger, redomestication, etc.:
   a. Indicate national or regional impact, including marketing and quantification of that impact.
   b. Provide a description of the affiliations with already licensed insurers involved in the transaction.
   c. Indicate if the transaction is date-specific.
6. Provide a brief description of all regulatory compliance enforcement actions by state for the past five years.

REACAP Expedited Review Guidelines

Some companies may request expedited review of a REACAP application. If so, the Applicant Company will need to clearly state, in writing, that request and the basis for it. The National Treatment and Coordination (E) Working Group will consider the request for expedited review with the request for acceptance into the REACAP program, including substantiation of market need, urgent circumstances, as well as the regulators’ other workload. Requests for expedited treatment may result in a REACAP request being denied. Further, applicants should be aware that state regulators cannot be compelled by the Working Group to complete an expedited review.
NAIC Company Licensing Best Practices Handbook
Appendix D – Form A Review Best Practices

Every Form A review should be tailored to the risks associated with the proposed acquisition, including the target company, acquiring entity, and the complexity of the transaction. The following best practices are presented as a guide for regulatory review and analysis of Form A acquisitions, recognizing that this list may not be comprehensive and not all items will apply to every acquisition. This list is intended to be a regulatory tool. The NAIC Form A database should be updated as applicable throughout the Form A review process.

1. Initial Review
   a) Determine if the filing is complete, note the missing items and promptly send a deficiency letter to the Applicant
   b) Identify attorneys, party contacts, and the other insurance regulator reviewing the Form A, including the lead regulator.
   c) The lead regulator should obtain key contact information from each state reviewing the Form A and consider organizing a regulator to regulator call to discuss concerns with the filing
   d) Assign appropriate analyst, legal and other professional staff to conduct regulatory review
   e) Carefully consider whether regulatory review can be completed by Applicant’s target close date, including any interim deadlines and obtain deemer extension or waiver if appropriate, and
   f) Schedule and notice hearing/consolidated hearing, if applicable, within statutory timeframes

2. Background, Identity and Risk Profile of Acquiring Persons
   a) Identify and review all relevant parties to the proposed acquisition
   b) Assess the feasibility of the acquiring persons holding company structure including location and control (direct/indirect) of the target company post acquisition
   c) Review the lead state’s assessment of the acquiring persons most recent ORSA Summary Report and Form F ERM, if applicable, to better understand the related risks
   d) Determine Ultimate Controlling Person and/or Parent (UCP), cross check with source of funds and consider debt funding sources
   e) Review NAIC and other external sources to gain a better understanding of the acquiring persons, its affiliates, and the UCP.
   f) Carefully scrutinize and understand complex organization and ownership structures
   g) Review Audited Financial Statements (or CPA reviewed financial statements for individuals) of the acquiring persons, its holding company, and the UCP, 10K and 10Qs, and other current financial information for enterprise condition, potential debt service by the UCP and its ability to service such debt. Understand the level of reliance on cash flow/dividends from the target company to service debt and other obligations of the holding company and UCP.
   h) Based upon nature of acquiring party, review detailed audited financial statement of all individuals who are source of funds.
NAIC Company Licensing Best Practices Handbook
Appendix D – Form A Review Best Practices

a. If not available, consider acceptability of unaudited financial statements, compiled personal financial or net worth statements and/or tax returns.
   i) Consider suitability of UCP through background review and regulatory review of the prospective new owners, using UCAA biographical affidavits and third-party background reviews by NAIC listed independent third-party reviewing companies or fingerprinting criminal checks if applicable, and
   j) Consider acceptability of SEC disclosures by board members of publicly traded UCPs in suitability review.

3. Communication and Record Maintenance
   a) Communicate response to any confidentiality requests in writing as soon as possible
   b) Create a contact list of relevant persons and representatives
   c) Separate confidential and public documents, information, and communications and maintain as appropriate
   d) Contact and collaborate with other reviewing regulators involved in the review process, as appropriate, including the lead state regulator regarding ORSA and ERM reviews
   e) As applicable, contact other regulators of noninsurance entities of the acquiring party or target
   f) Respond as appropriate to questions from third parties and interested regulators
   g) Keep the acquiring party representatives informed as to status of review
   h) Receive and consider any information provided by external sources, including possible financial or other incentives or motivation of those commenting on a particular transaction
   i) Summarize review, findings, conclusions and action taken on Form A review in final action document, including stipulations, and conditions subsequent, and
   j) File and maintain documents under state procedures.

4. Transaction Review
   a) Determine how acquisition will be achieved by carefully reviewing transactional documents, e.g. merger, stock purchase, stock exchange
   b) Consider disposition of all classes of target shares, including addressment of any beneficial owners
   c) Ascertain propriety of disposition of minority interests and concerns, if applicable
   d) Consider any affiliate or employee benefit as appropriate
   e) Determine how any ancillary regulatory reviews or other interim procedural steps will be completed, including Form E-Pre-Acquisition Notification Form, for other licensed states
   f) Obtain copies of shareholder communications or sole shareholder consent
   g) Consider obtaining copies of fairness and other contractually required opinions if available
   h) Review relevant portions of board resolutions, power points and related board minutes pertinent to the Form A transaction, use care to keep documents confidential, and
   i) Determine whether additional professional transaction review is warranted.
5. **Purchase Consideration**
   a) Determine fairness (equivalency) of total amount to be paid to total value to be received, including derivation of price and value of target under standard valuation methodologies or to book value
   b) Consider quality of consideration, giving careful scrutiny to payments other than cash or cash equivalents which are disfavored particularly when any funds are being transferred to the target.
   c) Consider fairness opinions and actuarial appraisals, if provided
   d) Consider source, type and valuation basis of funds to be used for consideration
      i. If funds are from a regulated entity, confirm the existence and valuation of such assets with that entity’s regulator
   e) If applicable, consider implications of any debt financing including
      i. The mechanics of any debt financing to be used to fund the transaction, whether funds are being borrowed in the ordinary course of business or on terms that are less favorable than generally commercial loans.
      ii. The percentage of debt versus non-debt funds to be used
      iii. The source of funds or stream of income to be used by parent for repayment and the ability of the acquiring party to repay the debt from sources other than the target
      iv. Identity of the creditor(s) and creditors’ financial condition.
      v. How will debt be secured; consider prohibiting securing of debt on shares of target or target’s assets if not already prohibited by state statute,
      vi. Compare time period of loan commitment with parent’s income stream over the same time period, including the ability of the acquiring party to repay the debt from sources other than the target until loan is repaid/retired, and
      vii. Consider the long term impact of parent’s debt service on operations of the target company and group.
      viii. Follow-up on Parent’s financial commitment to underlying insurer.

6. **Target License Qualification /Insurer Operations**
   a) Determine whether target insurer meets license qualifications upon change of control
   b) Consider operational changes post-acquisition, including business plans and projections
   c) Review required statutory deposits and authorized lines of business
   d) Consider changes to target management and key employees
   e) Consider suitability of changes to target management and key employees through background review and regulatory review of new owners, using UCAA biographical affidavits and third-party background reviews or fingerprinting criminal checks, if applicable
   f) Consider plans for technological interfacing with new affiliates and any potential adverse impact on operations including claims
NAIC Company Licensing Best Practices Handbook
Appendix D – Form A Review Best Practices

  g) Consider suitability of any new affiliated and non-affiliated material agreements, including managing general agents, third party administrators, any professional organizations and reinsurance arrangements

  h) Review any ERM analysis of the transaction performed by the acquiring entity, including impacts on risk assessment, risk appetite and tolerances, and prospective solvency (capital and liquidity)

  i) Require Form D filings for any affiliated material transactions, post-acquisition; consider including language in the approval order

  j) Determine target’s estimated financial condition and stability, post-acquisition, and

  k) Consider with disfavor any plans to liquidate the target or sell its assets, consolidate or merge, that may be unfair, unreasonable, or hazardous to policyholders

  l) Consider impact of U.S. insurer merging into an international insurer and/or alerting the legal entity structure and regulatory oversight performed by domestic state(s).

7. Market Impact
   a) Consider anticompetitive impact of acquisition on lines or products, including whether transaction will create a monopoly or lessen competition in insurance in the state; Disapprove transaction if completion will create a monopoly

   b) Consider Form E information and market concentration for combined lines and other appropriate information to assess market impact if warranted by nature of transaction, including coordination with other states where the target is admitted, and

   c) Consider imposing tailored conditions subsequent or undertakings as necessary to address competitive market concerns

8. Post-Approval Considerations, if applicable
   a) Receive notification of changes to effective closing date

   b) Confirm compliance with conditions precedent

   c) Receive waivers for market conduct or financial examination, and

   d) Receive notification if transaction does not close and consider withdrawal of approval.

9. Post-Acquisition Considerations
   a) Receive confirmation of the transaction following the closing, per your state’s statutory requirement timeframe

   b) Request written details of the final purchase price after all adjustments are complete on the transaction

   c) Request confirmation of any capital contribution contemplated in the transaction.

   d) Request the names and titles of those individuals whom will be responsible for the filing of the amended Insurance Holding Company System Annual Registration Statement

   e) Request an amended Insurance Holding Company System Registration statement per your state’s statutory timeframe within each applicable state’s statutory required timeframe after the close of the proposed transaction.

   f) Consider requesting for a period of two years, commencing six months from closing, a semiannual report under oath of its business operations in your state, including but not
limited to, integration process; any changes to the business of the Domestic Insurers; changes to employment levels; changes in offices of the Domestic Insurers; any changes in location of its operations in your state; and notice of any statutory compliance or regulatory actions taken by other state regulatory authorities against the acquiring parties or the Domestic Insurers

g) Consider prior approval of all dividends for a two-year period from the close date
h) Consider undergoing a target financial and/or market conduct examination following the closing or
i) In lieu of an examination a meeting, conference call or receipt of certain information can be requested
j) Confirm compliance or satisfaction with any other conditions subsequent or undertakings, and
k) Monitor target’s market performance to projections two years after transaction close date
l) Consider proactive communication with state(s) where the insurer conducts business if changes to the insurer’s corporate structure occurs post-acquisition.
NAIC Company Licensing Best Practices Handbook

Appendix E – Speed to Market

**Speed to Market** – Insurance company working in conjunction with state of domicile (lead state), where seeking expansion (target) states and facilitated by the National Treatment and Coordination (E) Working Group (NTCWG) to expand operations into multiple States.

1. **Applicant Company** must work in concert with lead state to ensure baseline compliance:
   - Applicant Company is in good standing with its lead State. It is not presently under or pending any regulatory actions, unless regulators have agreed upon a strategic plan to address such regulatory actions and a speed to market approach is needed.
   - Applicant company meets the minimum cap, surplus or net worth requirements of the target States.
   - Applicant Company meets or has approval to waive seasoning requirements of the target States.
   - Applicant Company has the appropriate or like kind licensing authority in its state of domicile as to what it is seeking in the target States.
   - Applicant Company has identified all state specific issues related to the target states and is willing to meet them.

2. **Applicant Company and Lead State** will request from NTCWG the speed to market process:
   - Applicant Company must have ownership commitment, managerial competence and financial wherewithal to ensure it can successfully operate in all target states.
   - Applicant Company will ensure compliance and management commitment to the UCAA electronic expansion application process.
   - Lead State will assist target states by sharing of information (IPS, etc.) and regulatory thought processes (addressing any RBC, funding, reinsurance issues and how the Applicant company addressed the issues raised by lead state)
   - Outline timelines and expectations.
   - Establish both universal points of contact for the Applicant Company, lead state, and target states.
   - Note any regulatory issues that might arise.

If NTCWG approves and 2 weeks after the Applicant Company has filed an expansion application:

- NTCWG will initiate a “kick off meeting” with Applicant Company, lead state, target states, NTCWG co-chairs and NAIC staff noting the following:
  - General background of the Applicant Company.
  - Address timelines/expectations.
  - Note any potential regulatory concerns.

**Lead State** will work in concert with NTCWG (via staff support) to set up Regulator to Regulator only call (Lead State, target States, NTCWG co-chairs):

- Discuss lead state IPS.
- Get initial consideration as to status of application and proposed timeline for licensing:
  - target states still have deficiencies and concerns.
  - What target states are ready to recommend approval.
  - If needed, schedule call to include Applicant Company.
NAIC Company Licensing Best Practices Handbook
Appendix E – Speed to Market

• Schedule date and time for next conference call to continue discussion.

As needed, all stakeholders follow up calls to address deficiencies and status of application.
National Treatment and Coordination (E) Working Group
Company Licensing Proposal Form

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

[ x ] UCAA Forms  [ ] UCAA Instructions  [ ] Enhancement to the Electronic Application Process  
[ ] Company Licensing Best Practices HB

Forms:
[ x ] Form 1 – Checklist  [ ] Form 2 - Application  [ ] Form 3 – Lines of Business
[ ] Form 6- Certificate of Compliance  [ ] Form 7 – Certificate of Deposit  [ ] Form 8 - Questionnaire
[ ] Form 8C - Corporate Amendment Questionnaire  [ x ] Form 11-Biographical Affidavit  [ ] Form 12-Uniform
Consent to Service of Process  [ ] Form 13- ProForma  [ ] Form 14- Change of Address/Contact Notification
[ ] Form 15 – Affidavit of Lost C of A  [ ] Form 16 – Voluntary Dissolution  [ ] Form 17 – Statement of Withdrawal

DESCRIPTION OF CHANGE(S)
Add a Purpose for Completion Section and added new lines for company name, address and phone number as well as a table for govt. id numbers.

REASON OR JUSTIFICATION FOR CHANGE **
The purpose of completion section will allow users to clearly define the purpose of why the biographical affidavit is being completed.

The company name, address and phone number were required previously, but by clearly defining them it will allow for greater ease of complete and clarity that each bio should be completed for only the Applicant Company.

The table for government id’s was added because some countries have more than one government id or the affiant may have more than one government id. The table allows for the affiant to list multiple id’s and to identify the country in which that id is associated.

Additional Staff Comments:
9-12-19 cgb – exposed proposal for 30-day comment period
11-6-19 cgb – no comments received and the Working Group adopted with an effective date of 1/1/20 with a friendly amendment to include the addendum pages, modify the “Purpose for Completion” reference from “Annual Update” to “Other,” and draft an FAQ for when the “Other” option should be selected.
11-19-19 jdb – email sent to regulators regarding the following clarifications: add “Specify” and move “Specify Purpose for Completion” as the heading above and centered over the following:
Form A: ____________  UCAA Type: ____________  Other: ____________
And include in the FAQs that the three options include one or more of the options listed and not a check mark.

Form A: Acquisition, Change of Control, Merger

UCAA: Primary, Expansion or Corporate Amendment

Other: New or Change Officer, Director, Annual Update, etc.

The Working Group Members agreed that this should be an editorial change to the original adoption.

** This section must be completed on all forms.  

Revised 01-2019
Applicant Company Name: ___________________________ NAIC No. ___________________________
FEIN: ___________________________

Uniform Certificate of Authority Application (UCAA)

BIOPHAGICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Specify Purpose for Completion (Print or Type)
Form A: ___________ UCAA Type: ___________ Other: ___________

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Applicant Company Name: ___________________________

Address: ___________________________  City: ___________________________

State/Province: ___________________________  Postal Code: ___________________________  Phone: ___________________________

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS “NO” OR “NONE,” SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS OR RESULT IN REJECTION OF THE APPLICATION.

1. Affiant’s Full Name (Initials Not Acceptable): First: ___________ Middle: ___________ Last: ___________

2. a. Are you a citizen of the United States? 
Yes [ ]  No [ ]

b. Are you a citizen of any other country? 
Yes [ ]  No [ ]

If yes, what country? ___________________________

3. Affiant’s occupation or profession: ___________________________

4. Affiant’s business address: ___________________________

Business telephone: ___________________________  Business Email: ___________________________

5. Education and training:

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Note:  If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
BIographiesH personal Affidavit
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Specify Purpose for Completion

<table>
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<th>Form A:</th>
<th>UCAA Type:</th>
<th>Other:</th>
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Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Applicant Company Name:

Address:  
City:  
State/Province:  
Postal Code:  
Phone:  

1. Affiant’s Full Name (Initials Not Acceptable): First:          Middle:          Last:  
If ANSWER IS “NO” OR “NONE,” SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS OR RESULT IN REJECTION OF THE APPLICATION.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?  

   Yes [ ]   No [ ]

If yes, give the reason if any, if NONE indicate such, and provide the full name(s) and date(s) used.

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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number:  

4. Government Identification Number if not a U.S. Citizen:  

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5. Foreign Student ID# (if applicable):  

6. Date of Birth: (MM/DD/YY):  

   Place of Birth, City:  

   State/Province:  

   Country:  

7. Name of Affiant’s Spouse (if applicable):
Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.
# National Treatment and Coordination (E) Working Group

## Company Licensing Proposal Form

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

[ ] UCAA Forms  [X] UCAA Instructions  [ ] Enhancement to the Electronic Application Process

[ ] Company Licensing Best Practices HB

**DESCRIPTION OF CHANGE(S)**

To clarify that all lines of business the Applicant Company is currently transacting must be included on Form 3, and for the lines requested the Applicant Company must currently be authorized in their domiciliary state.

**REASON OR JUSTIFICATION FOR CHANGE **

The current wording was confusing, whereas the Applicant Company thought they only need to provide the authorized lines for their domiciliary state.

**Additional Staff Comments:**

9-12-19 cgb – The Working Group exposed the proposal for a 30-day comment period.
10-11-19 cgb – One comment received.
11-6-19 cgb – The Working Group adopted the proposal with the amendment to include the reference “to transact” in the corporate amendment instructions.

**This section must be completed on all forms.** Revised 01-2019
Corporate Amendments Application Section I

Filing Requirements (Adding and/or Deleting Lines of Business)

This section provides a guide to understanding the focus of each document of the Corporate Amendment Application. However, there typically are multiple purposes for documents. Therefore, it is important that applications be complete.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents. Please review the state specific requirements in the state charts and state-specific requirements prior to contacting the states individually if there are questions about a specific document.

All forms required for the Corporate Amendment Application are located under the Corporate Amendment Application tab in the UCAA Forms Section. For electronic application submissions, required forms are provided for the application change type selected, therefore it is important to read the instructions prior to starting an electronic filing to ensure the necessary corporate amendment change type is selected and the appropriate forms are provided.

Table of Contents/ Application Requirements

1. Application Form and Attachments
2. Filing Fee
3. Articles of Incorporation
4. Bylaws
5. Minimum Capital and Surplus Requirements
6. Statutory Deposit Requirements
7. Plan of Operation
8. Statutory Membership(s)
9. Certificate of Compliance
10. State-Specific Information
11. Deleting Lines of Business

1. Application Form and Attachments - Item 1 of the application

The application must identify all lines of insurance that the Applicant Company is currently authorized to transact and specify the requesting lines of authority to add or delete from an existing Certificate of Authority, as identified by the Applicant Company’s in the plan of operation. The Applicant Company must be authorized in their domiciliary state for the lines of business requested to add in the application. The Applicant Company should review the Seasoning Requirements chart for each submission state. For hard-copy filings submit a completed Checklist (Form 1C), and an original executed Application Form (Form 2C), completed Lines of Business (Form 3) and a copy of the Applicant Company’s original Certificate of Authority or an affidavit of lost Certificate of Authority (Form 15) as Item 1 of the application. A cover letter may be included. The Checklist is automatically created in the electronic application and cannot be edited.
Expansion Application Section II
Filing Requirements

This section provides a guide to understanding the focus of each document of the Expansion Application. However, there typically are multiple purposes for the documents. Therefore, it is important that applications be complete.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents, although generally no more than five (5) years old. Please contact the states individually if there are questions about a specific document.

All forms required for the Expansion Application are located under the Expansion Application tab in the UCAA Forms Section.

Table of Contents

1. Expansion Application Form
2. Filing Fee
3. Minimum Capital and Surplus Requirements
4. Statutory Deposit Requirements
5. Name Approval
6. Plan of Operation
7. Holding Company Act Filings
8. Certificate of Compliance
9. Reports of Examination
10. Statutory Memberships
11. Public Records Package
12. NAIC Biographical Affidavits
13. Uniform Consent to Service of Process
14. State-Specific Information

1. Application Form and Attachments

The application must identify all lines of insurance (Form 3) the Applicant Company is currently licensed to transact in its state of domicile and all lines of insurance the Applicant Company is requesting authority to transact, as identified by the Applicant Company’s plan of operation. The Applicant Company must be authorized in their domiciliary state for the lines of business requested in the application. Submit a completed checklist (Form 1E) and original executed application form (Form 2E) as Item 1 of the application. A cover letter may be included as a component of Item 1 of the application. The Applicant Company should review the Seasoning Requirements chart for each state where the company plans to expand.
Restructuring Mechanisms (E) Working Group  
Austin, Texas  
December 8, 2019

The Restructuring Mechanisms (E) Working Group of the Financial Condition (E) Committee met in Austin, TX, Dec. 8, 2019. The following Working Group members participated: Elizabeth Kelleher Dwyer, Co-Chair, Matt Gendron and Jack Broccoli (RI); Buddy Combs, Co-Chair (OK); Mel Anderson (AR); Rolf Kaumann (CO); Kathy Belfi and Jared Kosky (CT); Kevin Fry (IL); Judy Weaver (MI); Fred Andersen (MN); John Rehagen (MO); Matt Holman (NE); John Sirovetz (NJ); Marshal Bozzo (NY); Joe DiMemmo (PA); Joe Cregan (SC); Jamie Walker and Amy Garcia (TX); Doug Stolte and David Smith (VA); David Provost (VT); Melanie Anderson (WA); and Amy Malm (WI). Also participating was: Bob Wake (ME).

1. **Adopted its Oct. 1 and Summer National Meeting Minutes**

The Working Group met Oct. 1 and Aug. 4. During its Oct. 1 meeting, the Working Group asked follow-up questions and heard answers from Enstar Group and Aon Service Corporation on their respective views on different restructuring mechanisms.

Ms. Malm made a motion, seconded by Mr. Kaumann, to adopt the Working Group’s Oct. 1 (Attachment Six-A) and Aug. 4 (see NAIC Proceedings – Summer 2019, Financial Condition (E) Committee, Attachment Five) minutes. The motion passed unanimously.

2. **Discussed Plans for Drafting a White Paper**

Superintendent Dwyer reminded the Working Group that its key charge is drafting a white paper that will consist largely of the information gathered to date by the Working Group. She stated that most of the information-gathering process should now be completed, but as the Working Group starts drafting the white paper, the co-chairs would like to hear views from Working Group members on the general organization for such a white paper. She stated that the 1997 *Liability-Based Restructuring White Paper* seems to provide an excellent jumping off point.

Mr. Rehagen asked if the Working Group could get a copy of all the issues that have been presented and discussed, emphasizing that Missouri is concerned about any conflict with its assumption reinsurance law, for which the transactions requires certain approvals. He stated another example is the guaranty fund issue.

Superintendent Dwyer discussed how the minutes would reflect discussions on each of these items, and suggested the Working Group could ask NAIC staff to review prior minutes, including discussion of the United Kingdom’s Part VII Control of Business (UK Part VII) requirements, and pull together a list of the issues discussed and circulate something to the Working Group.

Mr. Kaumann agreed, noting that that list, in combination with a copy of the 1997 *Liability-Based Restructuring White Paper*, might be a good start.

Mr. Gendron suggested more specifically that the table of contents from that 1997 *Liability-Based Restructuring White Paper* be used as a starting point for such a list, then with additions into that document where the minutes reflect other specific areas of discussion.

Superintendent Dwyer agreed, and suggested that listing also consider the table of contents from the 2009 *Alternative Mechanisms for Troubled Insurance Companies*. It was further recommended that the white paper focus on non-troubled companies, or at least note that at the outset of the paper; however, that was rejected on the basis that ignoring such seemed to be problematic. Therefore, it was agreed that some initial scoping in the paper should discuss both, but have an emphasis on the non-troubled company situations.
3. **Heard an Update from the ACLI on its Restructuring Transaction Principles**

Wayne Mehlman (American Council of Life Insurers—ACLI) and Rich Bowman (New York Life) discussed the finalized principles developed by the ACLI on restructuring techniques. Mr. Mehlman noted that, as presented to the Working Group during its July 8 conference call, the ACLI’s board of directors approved insurance business transfer (IBT) and corporate division principles and guidelines in June after many months of member deliberation.

Mr. Mehlman stated that the five main principles addressed are the following: 1) policyholders and other impacted stakeholders must have access to the process; 2) the regulatory review process must be robust; 3) independent experts must be utilized as part of the process; 4) court approval is required for IBT transactions but not necessarily for corporate division transactions; and 5) policyholders and state-based guaranty associations should be protected. He stated that the ACLI will not oppose legislation that substantially contains those principles; however, the ACLI will oppose legislation that does not substantially contain those principles. He stated that the ACLI will support corrective legislation that makes existing state legislation substantially adhere toward the ACLI principles, so long as the ACLI steering committee concurs.

Mr. Mehlman stated that the National Council of Insurance Legislators (NCOIL) is currently drafting a model act on this issue, noting that the ACLI is working with state legislators to incorporate the ACLI principles into that model. He stated that the ACLI will be glad to continue aiding this Working Group as it addresses its charges, including involvement in the white paper and related discussions, as well as those related to guaranty fund protection and protected cell companies and potential changes to NAIC models.

Mr. Bowman discussed the ACLI’s views on the National Conference of Insurance Guaranty Funds (NCIGF) position paper. He noted that the NCIGF will be discussing its views on restructuring and stated that while the ACLI appreciate the work the NCIGF is completing, the ACLI will talk about the significant differences in property/casualty (P/C) products and life insurance, annuity, disability and long-term care (LTC) products, which make it imperative that ACLI’s broader principles and guidelines also be considered.

Mr. Bowman discussed that IBT and corporate division transactions involving life, annuity, LTC or disability policies typically represent long-term obligations and a longer commitment by an insurer to its policyholders. In other words, consumers who buy life insurance and annuity contracts are relying on the insurer that they chose to be there for them for decades—in many cases, for the balance of their lives. Additionally, P/C insurance is generally yearly renewable and does not rely on an individual’s physical health for underwriting purposes. He stated that with the passage of time, it becomes increasingly difficult for a life, annuity, LTC or disability policyholder to obtain replacement coverage on comparable terms to be provided by insurance company. As such, it is difficult to have the flexibility to replace coverage. Given these considerations, is important from a consumer standpoint that, for IBT and corporate division transactions involving life annuity business, the successor company be licensed and regulated in a similar fashion to that of the original insurer.

Mr. Bowman said the *Life and Health Insurance Guaranty Association Model Act (#520)* requires an insurer to be licensed or formerly licensed in a state and be considered a member of that state’s guaranty fund association. He stated that the ACLI understands that the *Property and Casualty Insurance Guaranty Association Act (#540)* may not have the same strict licensing and requirements for companies to have eligible coverage, unlike the life industry. This difference in approach might be attributed to the fact that P/C funds have different coverage obligations than life and health guaranty associations. For example, P/C guaranty funds are obligated to retrospectively cover outstanding claims that were in existence at the time of liquidation. On the other hand, life and health guaranty associations are typically principally responsible for prospectively continuing coverage from long-term obligations under life and annuity LTC disability contracts. So, in order to mitigate the financial risk, the life and health guaranty association must cover those long-term obligations, and it is critical that insurers be subject to the relevant state licensing regulatory requirements to be eligible for guaranty association coverage. Mr. Bowman stated that the ACLI believes the ACLI principles and guidelines will help ensure the liability of those long-term obligations in the context of IBT or corporate division transactions.

Ms. Belfi asked Mr. Mehlman to clarify the ACLI’s position on independent experts, which, as he stated, the ACLI would oppose any legislation without this provision. Mr. Mehlman responded the ACLI would oppose legislation that does not substantially include the ACLI principles and guidelines.
Ms. Belfi asked if there had been any discussion about putting those principles somewhere else, such as in the Financial Analysis Handbook or Financial Condition Examiners Handbook, or something to that nature. Mr. Mehlman responded that the ACLI members prefer that the principles and guidelines be included in legislation to the extent possible.

Ms. Belfi stated that while she appreciates the need to utilize an independent expert in some cases, she could think of several examples where the regulator would want to utilize in-house personnel. She stated specifically that when a state has a potential transaction where a state insurance regulator is familiar with both companies, using in-house actuaries that understand the companies and the plans, there is no need for an independent expert to perform additional analysis. Ms. Belfi stated that for that reason, Connecticut’s corporate division bill uses the word “may.” She noted that she believes it is appropriate that there be regulator discretion when analyzing these transactions.

Mr. Mehlman thanked Ms. Belfi for her question and clarified the ACLI’s position, noting that the Connecticut position is certainly understandable. He stated that the ACLI members discussed this thoroughly for many months and noted that they were able to reach consensus on almost all of the elements that are imbedded in the principles and guidelines, and one of those relates to having not just an expert but an independent expert that is outside of the department. He noted that no one is an expert at everything, so it is the idea that if there should be an external party that is objective to look at these types of transactions. He stated it provides two things: 1) coverage protection for policyholders that an objective outside party has looked at this; and 2) protection for regulators from lawsuits.

Ms. Belfi stated that she respectfully disagrees. She said Connecticut believes it should be the regulator’s discretion as to whether it is appropriate to hire an outside expert. She noted that the applicant will be paying for the transaction and it is costly to hire outside experts. If it is a case where the department has actuaries who fully understand the transaction, then the department should be given discretion over whether to hire an outside expert.

Mr. Mehlman responded that he completely understands Ms. Belfi’s position, but said the ACLI members, after a long iteration, concluded that an expert outside the department—no matter how qualified experts may be within the department—should be required, not optional.

Mr. Bowman responded to a question dealing with whether existing state laws conform to the ACLI principles by stating the ACLI has not reviewed each one of those laws and performed that type of analysis. He stated that the ACLI has looked at Oklahoma’s statute and a proposed NCOIL model law that was drafted based on Oklahoma’s law. He stated that those laws lack many of the ACLI principles and guidelines, noting that the ACLI is currently trying to get changes incorporated into the NCOIL model.

Mr. Bowman stated that the ACLI prepared its principles by looking at all the state laws that are on the books, noting particular concern with corporate division laws that seem to have low regulation or little guidelines on how the process should occur. He stated that the IBT laws of many of the states try to cover at least some of the requirements included in the UK Part VII requirements, but not all the protections. He stated that the concern of the ACLI is that if there is an insurance company failure, the member companies end up paying for that failure.

Superintendent Dwyer asked if the ACLI principles could be included in regulation, because those have the same enforcement as law in most states. Mr. Mehlman responded that the ACLI certainly prefers the principles to be included in legislation and, to the extent they are not, the ACLI would be willing to have them included in regulation. The only problem is there is no guarantee that a particular state is going to follow up with regulations. He noted that the ACLI has heard presentations already through this Working Group where the states have indicated that they plan to proceed without any regulation, and the ACLI has concerns that if the principles are not embedded in statute, the ACLI will lose the opportunity for change upfront.

Superintendent Dwyer agreed with Ms. Belfi, noting that the Rhode Island statute provides an independent expert that reports to the department. She stated that she finds it troubling to completely skip the opinion of state, as a third-party does not have any requirements of a government official to look out for the consumer interest, and it is assumed this person has the consumer interest at heart because he or she has not worked for an insurance company in a couple of years. She stated that it makes no sense, as the department has a requirement to do an analysis for the consumer’s best interest and the state can use a disinterested consultant, but she does not believe that the requirement to use a disinterested consultant is getting any better results; it depends on the case.
Mr. Fry stated that Illinois has a division law, but it has not yet developed a regulation yet. He said the department is interested in developing a regulation someday, but he would like the flexibility to look at some of these deals before developing any kind of regulation. He echoed the comments from Ms. Belfi, noting that Illinois has been looking at these deals and they already consider similar issues in proposed Form As. He stated that while the bias of Illinois is going to be using outside experts, the reality is if you have seen one division transaction, then you have seen one division transaction. So, in talking about division transactions, he questioned whether an expert would be needed. Mr. Fry noted that Illinois has the same views as most of what has already been mentioned, and noted specifically that Illinois does know their companies better than anyone.

Mr. Bowman noted that some of the ACLI’s positions are because ACLI members have transactions that affect policyholders across the country, not just in the state where the transaction is occurring.

Ms. Weaver stated that she would agree with the ACLI principle from the standpoint that while she may have expertise in-house, she may choose to use an outside expert when dealing with states that do not always exercise the discretion other regulators would like. She stated that a state might think it has expertise or it might get political pressure to do something, and noted that having an outside expert opinion could add some value to the process. She stated that where she thinks a regulator needs to have discretion is once the regulator has the outside expert opinion. At that point, the commissioner or superintendent needs discretion on whether they agree with that opinion or whether they want to factor in other consumer concerns that need to be considered.

Mr. Combs said he completely agrees, noting that the way the Oklahoma process works is the independent expert works for the commissioner. He stated that he likes that idea, at least in terms for an IBT but not so much for a division, which is a different type of transaction. Mr. Combs stated that for an IBT, there needs to be a requirement for an independent expert who answers to the commissioner. He stated Oklahoma really sees it as a three-part transaction: 1) independent expert; 2) commissioner; and 3) the court. He discussed, however, that the way Oklahoma’s first transaction worked, department staff would have regular conference calls with the independent expert and then they would provide the department with information, which in turn would lead to back-and-forth on requests for deeper work in particular areas. At the completion of the work, the department was provided with a report and then the department did its own analysis of the transaction and a review of the report before moving to the next stage. Mr. Combs said Oklahoma sees it as a highly cooperative process.

Mr. Wake stated that he believes leaving corporate divisions out of the need for court approval and treating that as somehow fundamentally different is probably one of those points that was debated and stated that he is skeptical that divisions really deserve any less thorough or independent process. He stated there are many situations where specialized expertise is needed, noting that the department is going to try to find the best outside expert they can to at least assist the in-house staff. He stated he accepts the point that some departments will handle in-house review better than others, but said the departments that do a less than perfect job with deciding when they can do it themselves are also the ones that are going to do a less than perfect job in hiring an outside expert. He stated he does not think the fact that outside experts are in business for themselves makes them a better decision-maker or a more reliable decision-maker than a public servant.

4. Heard from the NCIGF Regarding its Adopted Position on Restructuring.

Barbara Cox (Barbara F. Cox LLC), representing the National Conference of Insurance Guaranty Funds (NCIGF), provided a summary of the NCIGF’s adopted position on restructuring (Attachment Six-B).

Ms. Cox described that the NCIGF recently adopted the statement and noted that essentially what it requires is guaranty fund coverage before the transaction. Conversely, if there was no guaranty fund coverage before the transaction, there should not be coverage after the transaction. She stated that the NCIGF is working on template language, but it likely will not be completed for about 30 days. She stated that because most of the states’ P/C guaranty fund laws would not provide for that result, it will take nationwide amendments.

Ms. Cox noted how the ACLI spoke about the licensing issue and said the NCIGF grappled with that issue for a long time in its Legal Committee and its Public Policy Committee. She stated that ultimately what NCIGF developed was just the broad carve-out in the guaranty fund that—notwithstanding the plain definition of “insolvent insurer” which does have licensing requirements—these transactions would be covered. She stated that not all NCIGF members will agree, but she believes most will. She stated that it has been vetted with the industry members and the guaranty fund members on the NCIGF’s Public Policy Committee and its board of directors, so it is widely supported.
Ms. Cox noted that on the topic of protected cells, some of the top guaranty fund lawyers in the country could not wrap their heads around protected cells and the impact the guaranty funds covered line of business placed into one of those cells by virtue of a transaction. She stated they had not yet solved that problem, noting that she is eager to hear from NAIC staff on that issue. She reiterated her request for support from the state insurance commissioners.

Mr. Wake noted that language in Model #540 might be helpful on this topic. Ms. Cox noted there is assumed business language in that model, but only eight or nine states have enacted that language. She noted, therefore, a wide solution is necessary because there are variances among the states.

Mr. Combs agreed with the point by Ms. Cox regarding policyholders retaining guaranty fund protection, noting that Oklahoma fully agrees with this position. He noted, however, Oklahoma had not spent much time considering a policyholder gaining guaranty fund protection and asked Ms. Cox how the mechanics could be completed on that. She noted that things such as surplus lines are clearly excluded, and discussed how the history of why coverages exist or do not exist should be retained.

5. Discussed Segregated Accounts, Protected Cells and Guaranty Fund Protection

Dan Schelp (NAIC) stated that his remarks would focus on the use of segregated accounts and protected cells, noting that it is from the perspective of the Financial Regulation Standards and Accreditation (F) Committee, for which he provides staff support related to the Part A standards. He stated that while he has not followed the Working Group closely, the use of segregated accounts and protected cells is being used in a different way from that which is contemplated in the Part A standards. Specifically, what is generally considered in NAIC standards is the use for securitizations. He stated he was not going to address specific state laws or specific situations, and that with respect to Part A standards, they do not directly address the use of segregated asset plans because they do not specifically protect or prohibit the use of these.

Mr. Schelp stated that, in the context of guaranty funds, there is some concern that if the segregated asset plan was to become insolvent, guaranty fund coverage may not be triggered unless the parent insurer was itself insolvent. He noted that he had several conversations with members of National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), who have expressed concerns this might be the case. He stated this was not just a Part A Accreditation issue, but rather a concern of all states impacted.

Mr. Schelp stated that he does not have a legal opinion on this issue but did want to report on this concern. He stated that without a change to Model #520, we may not know the answer to this question, and even then, it is possible some of the guaranty funds would take one view while other guaranty funds may take the opposite view. He stated that several questions arise, including how the assets are considered, either with the general account and segregated assets together or separate, and whether each is required to meet risk-based capital (RBC) requirements or both combined. He stated similar questions exist with respect to annual financial statement reporting or use of the Accounting Practices and Procedures Manual. He stated there are potentially several other issues but that this identifies some of them.

Mr. Wake discussed the use of separate account for variable annuities and how that issue was easier because in that case the amount retained in the separate account provides that the policyholder is at risk. He noted that the Protected Cell Company Model Act (#290) is opaquely worded but is to be used for securitizations and, therefore, it does not address the underlying issues being considered. He discussed how, in those cases, Model #290 is related to the investor who is funding the transaction and, therefore, would not be provided guaranty fund coverage. He stated that policyholder liabilities should always be liabilities of the insurance company, and the NAIC should treat them as subsidiaries and they should be subject to all the same NAIC requirements as the insurance company. However, if a state does not conform, it is possible they have broader powers, so some modification may be necessary, but, at the end of the day, prevention of issues ought to be the focus.

Superintendent Dwyer discussed how what was contemplated was modifying the protected cell model to address these situations and at the same time make sure the policyholder has guaranty fund coverage.

Mr. Wake noted that the most logical solution is that these things ought to be treated as subsidiary insurance companies and be subject to the same accounting and RBC requirements of an insurance company.
Ms. Malm discussed a situation that occurred in Wisconsin through rehabilitation years ago and how in that situation they realized quickly that the segregated account needed to be merged with the general account to make sure everyone had guaranty fund coverage.

6. Received the Report of the Restructuring Mechanisms (E) Subgroup

Mr. Smith reminded the Working Group of the Subgroup’s three primary charges, highlighting that their current focus will be on developing best practices. He stated that while the Subgroup has not met since the Summer National Meeting, he noted that in the past the Subgroup had previously distributed the Liability-Based Restructuring White Paper, which was drafted by the Liability-Based Restructuring Working Group of the Financial Condition (EX4) Subcommittee and was adopted in June 1997. He noted how this white paper noted key legal concerns, policyholder protections needed, guaranty fund concerns and the need for more stringent ongoing oversight.

Mr. Smith provided a summary of the activity that occurred prior to the Summer National Meeting, when the Subgroup heard from 12 commenters who provided letters. He stated that Subgroup members have also participated on Working Group calls to understand the core issues and noted how some of the comment letters referred to some of this specific information.

Mr. Smith noted that the Subgroup directed NAIC staff to develop a survey to send to the states to gain more insight into these transactions and what the states have been doing or plan to do to review, approve and monitor IBT and other restructuring transactions, including companies in run-off. He stated that the survey information has been compiled and most of the state-specific identifying information was removed to allow for public discussion on an upcoming call, which is planned for early January 2020.

Mr. Smith also discussed that there had been some discussions at the Statutory Accounting Principles (E) Working Group but that no guidance has been developed by that group. The Subgroup will continue to focus on the initial charge of developing best practices by utilizing: 1) best practices from the Liability-Based Restructuring White Paper; 2) best practices from the states; and 3) aspects of the United Kingdom (UK) Prudential Regulatory Authority (PRA) used in the UK Part VII requirements.

7. Discussed the Prudential and Rothesay Life Decision and Various Viewpoints

Casey McGraw (NAIC) discussed how the NAIC made this case available on the Working Group’s web page and described how it would be helpful to have a discussion on the topic.

Carey Child (Norton Rose Fulbright US LLP) presented a summary of the decision and related issues by providing a presentation (Attachment Six-C) based on his consultation with his firm’s London office, as they are involved in a number of these types of transactions. He emphasized certain aspects of the presentation, including a timeline of the key events for which he noted in particular how the transaction by Prudential was driven by their desire to separate the high growth Asian business from the slower growth business in other parts of the world. He also discussed how there have since been two UK Part VII decisions since the Rothesay decision, but neither of which were annuities. He also highlighted the standards that must be met under any proposed transaction, including both security and service. He noted the requirement of meeting reasonable expectations of policyholders.

Mr. Child also highlighted an important aspect of the requirements includes a communication plan, noting the PRA standards in the area. He emphasized how during the court approval stage, they court had received 7,300 responses to the notices and of those, 1,300, or 15% were characterized as objections. He stated that the court determined that was a significant level of objections for a Part VII transfer. Mr. Child noted how the reason for the rejection of the transaction was not one of capitalization or financial strength, as it was considered equal or better under the new party. He stated it was also not a service standard issue, nor was it an issue of independence or one related to the underlying business being annuities where the judge believed those type of annuities could be transferred.

Mr. Child stated that the primary issue was more related to how pensions operate in the UK, where all citizens are required to purchase pensions. He stated the court emphasized the nature of these liabilities and how these were marketed upon a well-known brand. He stated the court recognized created a reasonable expectation on the policyholders for the policyholders and
how the real difference came down to a different opinion on support. He stated the independent expert noted this more as a remote risk.

Mr. Child stated that, in closing, reading through the ruling, the judge seemed to have a concern that seemed to be related to private contracted rights being changed and how the judge noted that policyholders were getting nothing out of the transaction. Mr. Child described how the legal press had written on the topic after the ruling and one press outlet questioned if populism had come to Part VII transfers. Mr. Child stated that he believes the U.S. will have a different setup, because the U.S. constitution does have explicit provisions on state powers on contract rights including the contract clause and the due process clause, both of which have been litigated in the GTE Reinsurance Company Limited case.

Superintendent Dwyer asked about the two UK Part VII transactions approved since the decision and asked if he knew the specific types of each. Mr. Child indicated that one of the two was life protection, but he did not recall the other and would have to get back to the Working Group.

Superintendent Dwyer asked if the court in those situations referred to the Prudential Rothesay decision. Mr. Child stated his understanding is that it was referred to in one of the two cases.

Mr. Cregan asked if those objecting to the transaction had counsel and whether perhaps their lack of counsel may have led to the decision. Mr. Child responded that while he did not know if they had counsel, it did not appear part of the basis for the decision and noted several individuals appeared directly before the court. Mr. Child stated he would find out more from his colleagues.

Birny Birnbaum (Center for Economic Justice—CEJ) stated that he believes the independent expert in the case discussed was not an appropriate representative for policyholders. He also described how while the UK Part VII transfer process does allow objections to be made by policyholders, those policyholders are not privy to the same confidential information that is provided to the independent expert. He stated that the CEJ’s view is that the independent expert does not do justice, noting that there should be a policyholder advocate who not only represents the policyholders but also has access to confidential information that can be used to represent the policyholders’ interest.

Mr. Birnbaum summarized that, with respect to this case, the summary of the expert (Attachment Six-D) describes how the conclusion reached in terms of service was based on the policies and procedures of the two companies. He stated that this was inadequate in his view, noting that his proposed use of a policyholder advocate is needed to look at the actual outcome on the policyholders.

Mr. Combs emphasized that Oklahoma’s view is that the specific purpose of the independent expert is to look out for the protection of policyholders. He stated that, on this point, he disagrees that there is not an advocate of the policyholders with access to confidential information.

Mr. Birnbaum noted that presumably that is also the standard in the UK, but what he noticed was that the expert is focused on the financial condition of the companies and not the service to the policyholders. He described that there are certain skills that are needed to look at financial condition, noting that those differ from the skills needed to look at customer treatment. He described how this is like the difference between a financial regulator and a market conduct regulator.

Superintendent Dwyer said this discussion will continue in the future.

8. Discussed the APCIA’s Principles Regarding Restructuring Mechanism Transactions

Steven Broadie (American Property Casualty Insurance Association—APCIA) summarized the APCIA principles as it relates to restructuring mechanism transactions (Attachment Six-E) and stated the APCIA’s support for the NCIGF principles.

Mr. Broadie stated that the APCIA’s principles focus on: 1) robust due process to all stakeholders; 2) no impacted policyholders should lose or gain coverage as the result of a transaction; 3) robust regulatory review process; 4) an independent expert who is an advocate for policyholders and advise the department of insurance; and 5) court approval required for IBTs but not for corporate divisions.
Dennis Burke (Reinsurance Association of America—RAA) stated that the RAA does not believe there is a difference between IBTs and corporate divisions and should be treated as such, including court approval should be required on all such transactions.

With respect to this issue, Mr. Broadie noted that he was not part of the conversation when the APCIA made a distinction between IBTs and corporate divisions.

Mr. Combs asked about the position of a public hearing and the stage it should be conducted. Mr. Broadie noted that the APCIA had not addressed that point thus far.

9. Heard an Announcement from Oklahoma Regarding Approval of its First IBT

Mr. Combs noted that on Nov. 26, Commissioner Glen Mulready (OK) approved the first IBT between Providence Washington Insurance Company, a Rhode Island-based company, and Yosemite Insurance Company, an Oklahoma-based insurance company, both of which are Enstar companies. He noted that it involves all P/C liabilities, including asbestos and environment, workers’ compensation, other liability and a small amount of personal lines. He noted that the same day it was approved by the commissioner, the company filed it with the court and noted that the communication plan will begin later in December after the judge determines his position on that communication. He stated that the Oklahoma Insurance Department has spent a considerable amount of time on the transaction, including the greatest amount on the communication plan to policyholders. He noted that it is posted on the Oklahoma Insurance Department website.

Having no further business, the Restructuring Mechanisms (E) Working Group adjourned.
Restructuring Mechanisms (E) Working Group
Conference Call
October 1, 2019

The Restructuring Mechanisms (E) Working Group of the Financial Condition (E) Committee met via conference call Oct. 1, 2019. The following Working Group members participated: Elizabeth Kelleher Dwyer, Co-Chair, Matt Gendron and Jack Broccoli (RI); Buddy Combs, Co-Chair (OK); Jon Arsenault (CT); Shannon Whalen (IL); Steve Mayhew (MI); Barb Carey (MN); John Rehagen (MO); Matt Holman and Justin Schrader (NE); John Sirovetz and Diane Sherman (NJ); Joe DiMemmo (PA); Daniel Morris and Lee Hill (SC); Amy Garcia (TX); David Smith (VA); and Amy Malm and Richard Wicka (WI).

1. Heard Opening Comments from Co-Chair

Superintendent Dwyer reminded members of the Working Group that at the Summer National Meeting, the Working Group did not have enough time during its meeting to ask the speakers all the questions that they may have had. She said the purpose of today’s conference call is to give members an opportunity to ask questions of Paul Brockman (Enstar), whose presentation focused on the industry need for restructuring mechanisms, and Kelly Superczynski (Aon), whose presentation focused on the benefits of restructuring mechanisms.

2. Asked Enstar Questions

Superintendent Dwyer asked Mr. Brockman if he was aware that there are guaranty fund issues that arise with restructuring arrangements for personal lines, and whether Enstar had completed such a transaction with personal lines. Mr. Brockman responded Enstar had with a personal lines transaction in the United Kingdom (UK). Superintendent Dwyer asked if there was a difference in the guaranty funds in the U.S. and the UK. Robert Redpath (Enstar) responded that there really is nothing equivalent to the concept of guaranty funds in the UK. Superintendent Dwyer asked what would occur when a company is restructured and in a state where it was not domiciled at the time the business was written, how would the guaranty funds respond in the event of an insolvency. Mr. Brockman said there would be several areas where the laws would be affected, including guaranty funds, and that each transaction must be analyzed for the blocks of business being transferred and the existing licenses possessed by the company. He added that it was difficult to provide a general answer and noted that the state insurance regulator, the independent expert and the guaranty fund of the affected states would have to look at the transaction closely. Mr. Redpath stated Enstar intended to have licenses in each of the states in which the issuing company had conducted business. Superintendent Dwyer asked if Enstar had completed one of these transactions where these guaranty funds have been at issue. Mr. Brockman stated that they had not yet completed such a transaction and the issue would be more relevant to a U.S. transaction. Mr. Combs asked if a company should aim to have licenses in each of the states for which they are going to assume business. He asked if there are other ways to deal with a situation where they do not have such licenses, such as an agreement where the transfer for the policies does not take place until licenses are obtained in that state. Mr. Redpath agreed, noting the business transfer should wait until a license is obtained. There is an issue with getting a license when an entity is not actively writing business, and this might be something the states could investigate.

Birny Birnbaum (Center for Economic Justice—CEJ) asked if the Enstar representatives were familiar with the Prudential Rosebay transaction that the UK high court rejected in August. Mr. Redpath responded “yes.” Mr. Birnbaum asked if they could describe the reasons for the rejection. Mr. Redpath responded that it is his understanding the Court had some concerns with a transfer from of an old established insurance company compared to the assuming insurer, which was a new company. He stated he believes these were factors and noted that the various levels of review show that the process works, with a different view by the court than the prudential insurance regulator and the independent expert. Mr. Birnbaum asked if it was a capitalization issue. Mr. Redpath said he is not sure, noting that these were annuities and that the history of the companies may have been a larger factor. Mr. Birnbaum asked if there was a public hearing, if the policyholders had an advocate and if the expert recommended approval of the transaction. Mr. Brockman stated that it might be better if the company came back to the discussion later with a write-up of the facts. Mr. Birnbaum asked if the high court opinion could be distributed. Casey McGraw (NAIC) stated he would work to have the opinion distributed. Superintendent Dwyer asked that the issue be discussed at the Fall National Meeting. Mr. Birnbaum shared information from a news article noting that the judge rejected the transaction. He referenced comments from consumers in the article that each highlighted the policyholder concerns. He noted more specifically that there appears to be a need for different consumer rights for personal versus commercial business. Those transactions that do not require policyholder approval and that are confidential are concerning. He referenced the expert report in the UK.
transaction, which was brief in terms of consumer considerations. He stated he is concerned about the presentations at the Summer National Meeting where the ceding companies may be a weaker capitalized companies and were ceding from strongly capitalized companies. He noted that while that might be the case for commercial run-off business, that would not be the case with personal lines business. He noted that the expert report described policyholder benefits in terms of the capital base of the acquiring company. He stated for personal lines consumers, there should be more consumer considerations. He noted that at that the Summer National Meeting, the idea of freeing up capital for innovation was also noted, which was concerning given companies that provide such will certainly have access to capital due to demand. He noted concerns about consultants’ profiting off such transactions. He emphasized concerns with transfers of these business for personal lines, and if that does take place, there needs to be a consumer advocate for the transactions just as there is an independent expert. There were some questions about the specific independent report Mr. Birnbaum was referring to where the discussion was not completed given all the parties were not privy to the information. However, that does not change Mr. Birnbaum’s views. This also does not change Mr. Brockman’s view that the process works as Enstar has seen transactions stopped at different stages.

Mr. Rehagen asked how this issue would correspond with the assumption reinsurance law that exists in their state, and more specifically how that state requirement would be complied with such a transaction. Mr. Brockman stated that in Oklahoma, the independent expert acts on behalf of the department of insurance (DOI) and would reach a recommendation and would consider the notice requirements of Oklahoma. Mr. Rehagen responded the answer sounded to be “no.” Mr. Brockman stated they have a right to show up at the hearing, but that it is correct there is no standard to essentially veto the decision. Mr. Rehagen asked if his director and Missouri policyholders would need to travel and appeal to the Oklahoma court. Mr. Redpath responded “yes.” Superintendent Dwyer asked if any of the assumption reinsurance laws have any impact on the insurance business transfer laws. Mr. Redpath responded he is not aware. Albert Miller (ProTucket Insurance) stated that with respect to assumption reinsurance law, in Missouri, like many states, there is an exception for reinsurance transactions where the ceding company remains liable to the original policyholders. Therefore, in the case of an insurance business transfer for a reinsurance transaction, the assumption reinsurance law will not apply. Superintendent Dwyer asked if any court had addressed whether the assumption reinsurance law applies in an insurance business transfer and did not receive an affirmative response.

3. Asked Aon Questions

Superintendent Dwyer asked Ms. Superczynski if she is aware of any completed transactions that contained the guaranty fund issue that was asked of Mr. Brockman. Ms. Superczynski responded she is not aware of any completed transactions that had personal lines. She said she recognizes the guaranty fund issue is one the industry will need to overcome. However, assuming that the subject is a runoff book of business, the companies had already paid into the guaranty fund, and the scenario was that they had already contributed their fair share, then in theory coverage should be provided. She stated there were issues in terms of moving the policyholders and the logistics of payment, but funding had taken place from an economics basis. Therefore, the issues were more about how to address in a fair and equitable manner. Ken Selzer (Aon) stated he agrees and Aon sees the market first developing on commercial lines, excess workers compensation and assumed reinsurance transactions. Therefore, there may be time for the identified issues to be addressed that will require some focused attention. Superintendent Dwyer stated that she agrees that economically, consumers should receive guaranty fund coverage if they would have received it with the original company and the Working Group is most concerned about consumers losing that protection. Peter Gallanis (National Organization of Life and Health Insurance Guaranty Associations—NOLHGA) noted that different people use different definitions for closed blocks of business. It would encompass businesses that were no longer premium pay, such as structured settlements. However, he stated he would consider closed blocks, but they would be premium paying and very important, such as long-term disability and long-term care insurance (LTCI). He stated his comment was not germane to the presentations made but rather things that would need to be understood by the Working Group members. Superintendent Dwyer stated Rhode Island’s law is limited to property/casualty (P/C) commercial business. Superintendent Dwyer asked Ms. Superczynski if Aon had any views on the assumption reinsurance issue previously discussed. Ms. Superczynski asked Mr. Selzer to respond, who indicated Aon would give the issue more thought.

Having no further business, the Restructuring Mechanisms (E) Working Group adjourned.

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NCIGF Position Statement on Restructuring
Adopted by NCIGF Board October 1, 2019

**Background.** Efforts in states to enact restructuring statutes are progressing quickly. To date, eight states have enacted a restructuring statute in some form. These statutes permit an ongoing insurance company to divest itself of certain liabilities, along with a calculated amount of corresponding assets, **and relinquish any ongoing responsibility for the divested business.** This can be accomplished by a division, in which the dividing entity may or may not survive, and in which resulting companies are created, or an IBT, described in Oklahoma as a transaction that would “transfer insurance obligations or risks, or both, of existing or in-force contracts of insurance or reinsurance from a transferring insurer to an assuming insurer.”

IBT’s (like Oklahoma) and division statutes (like Illinois) are very different types of transactions. An IBT is intended to accomplish an assumption transaction by a “statutory” novation effectuated by operation of law (e.g., by court order), rather than by a novation that requires individual policyholder consent. (We believe that a number of guaranty fund laws already have language that may cover certain assumptions, but a complete analysis of guaranty fund laws as they will be applied to an IBT is still needed.)

In either case, the business divested would be put into a different insurance company or companies. In some states the business could be put into a protected cell. The statutes proposed typically call for a divestment plan to be filed with and approved by the state’s commissioner of insurance. Sometimes review and approval by the court is also required. Requirements for notice to policyholders and public hearings on the proposals vary from state to state. The most recent proposals do not limit the lines of business that can be subject to divisions. Hence, all types of insurance such as personal lines, workers compensation and long-term care insurance could be involved.

The NCIGF supports member guaranty funds in meeting immediate and future obligations to policyholders. The NCIGF does not take a position on any current or contemplated industry business practice.

NCIGF public policy is focused on preserving guaranty fund (GF) coverage for policies and claimants where there has been a division or an IBT:

- Where there was guaranty fund coverage before the division or IBT, state regulators should ensure that there is coverage after the division or IBT. A division or IBT should not reduce, eliminate or in any way impact GF coverage.
Where there was no coverage before the division or IBT, there should be no coverage after the transactions are completed. A division or IBT should not create, expand, or in any way impact GF coverage.

Guaranty fund representatives are a good resource for any guaranty fund coverage issues that arise in evaluating these transactions.

**NCIGF observes that insurance company divisions and IBTs that are reviewed and approved by state regulators may impact potential guaranty fund coverage for policyholders.** Existing P & C guaranty fund laws were generally not drafted with the division or IBT concepts in mind. Because of how some of the definitions in the guaranty fund laws were drafted, and because of how the division and IBT legislation operates, it is quite possible that some policyholders that now have guaranty fund coverage might no longer have that coverage if their policies are moved as a result of a division or IBT.

Possible technical gaps may be created if a state has adopted the NAIC P&C Guaranty Association Model Law. These gaps could include the definitions of Covered Claim, Member Insurer, Insolvent Insurer, and the Assumed Claims Transaction found in Section 5 of the P&C Guaranty Association Model Law.

Again, where the original company was a member of one or more guaranty funds and potential claimants and policyholders had been covered by a guaranty fund prior to the transaction, care should be taken to make sure that those same claimants and policyholders are covered by a guaranty fund after the transaction. This may require guaranty fund laws and/or other insurance laws to be amended in each of the states where the original company was a member of a guaranty fund before the transaction becomes final.

Although this is a developing issue, restructuring statutes as described above are part of the existing insurance landscape. Currently, the best course of action is for the guaranty fund system to work with industry, state and national trades, and regulators to resolve the guaranty fund coverage issues in a tailored fashion, taking account of variances in state laws and restructuring statutes that may come in to play.

In order to facilitate the needed amendments of the guaranty fund laws and or other insurance laws across the country that will be required to implement this policy, the NCIGF Board directs the Public Policy Committee to appoint a subcommittee to work with NCIGF members, industry, trade associations (national and local) regulators and other interested stakeholders to oversee a coordinated, national effort to enact the necessary changes in each state. This subcommittee will also assist in developing the requisite language needed in each state to accomplish this goal as it is recognized that
each state’s law may vary in terms of what amendments may be necessary. It is also recognized that the changes needed to be made to guaranty fund laws to address divisions may be different from those changes that are needed to address IBTs. The Public Policy Committee Chair will provide updates on the progress of this effort to the Board at each NCIGF Board meeting. NCIGF staff is instructed to provide the necessary support to the subcommittee.
Assessment of UK Part VII Decision: Prudential and Rothesay

Cary S. Child

Key Events

Regulatory Review Stage
Independent Experts Consider Policyholder Welfare

Selection

Approved (or nominated) by the Prudential Regulatory Authority ("PRA") after consulting with Financial Conduct Authority ("FCA")

The regulators expect the independent expert making the scheme report to be a neutral person, who:

1. is independent, that is any direct or indirect interest or connection he, or his employer, has or has had in either the transferor or transferee should not be such as to prejudice his status in the eyes of the court;

2. has relevant knowledge, both practical and theoretical, and experience of the types of insurance business transacted by the transferor and transferee.

Standards

(PRA's Policy Statement)

Regulators Consider Policyholder Welfare

The assessment is a continuing process, starting when the scheme promoters first approach the regulators about a proposed scheme. Among the considerations that the regulators may consider when reviewing the scheme are:

... (3) how the security of policyholders’ (who include persons with certain rights and contingent rights under the policies) contractual rights appears to be affected;

... (5) how policyholders’ rights and reasonable expectations appear to be affected;

... (6) the compensation offered to policyholders for any loss of rights or expectations;

... (9) the opportunity given to policyholders and other persons affected by the scheme to consider the scheme, that is whether they have been properly notified, whether they have had adequate information and whether they have had adequate time to consider that information.

(Draft for decision at 2.18)

Regulators Consider Policyholder Welfare

"Our approach to assessing Part VII Transfers is based on the application of our statutory objectives, which are to:

• secure an appropriate degree of protection for consumers
• protect and enhance the integrity of the UK financial system
• promote effective competition in the interests of consumers" (4.2)

"Applicants should clearly explain the reasons why they are proposing a transfer. We want to ensure that the transfer is not motivated by a desire to benefit either Applicant to the material detriment of Policyholders, or to unfairly bring benefit to one class of Policyholder to the detriment of another class." (Guidance at 4.5)
Regulators Consider Policyholder Welfare

“Both the PRA and the FCA are entitled to be heard in the proceedings. Both the PRA and the FCA may provide the court with written representations setting out their views on the proposed transfer scheme, for example, by way of a report to the court. The PRA will decide in relation to each insurance business transfer whether it is necessary or appropriate to prepare a report, bearing in mind its objectives and other relevant matters.” [PRA Policy Note at 2.8]

In the Prudential and Rothesay case, the FCA made two submissions to the court, and the PRA made three submissions to the court. [Decision at 81]

Policyholders Opportunity To Be Heard

Development of an agreed communications plan is a key step in the process.

Absent court approval, “notice of the application must be sent to all policyholders of the parties,” among others. [Policy Note at 2.9]

The PRA must “approve in advance the notices sent to policyholders and published in the press.” [id. at 2.51]

“ideally every recipient should understand in broad terms from the summary how the scheme is likely to affect them. This objective will be most nearly achieved if the summary is clear and concise while containing sufficient detail for the purpose.” [id. at 2.51]

Court found: requirement is “that policyholders were given sufficient time to consider and respond to the Finalised Scheme proposal and to participate fully at the hearings before me if they chose to do so. The FCA was satisfied that sufficient time was given to policyholders in that regard, and I am also satisfied that this was the case.” [Decision at 88]
Policyholders Opportunity To Be Heard

Mr. Justice Snowden confirmed that policyholder welfare was the focus of his inquiry, which was not a "rubber stamp." The court's inquiry will focus on the questions of whether policyholders' security of benefits and reasonable expectations of service standards will be adversely affected by the proposed scheme. As the authorities also indicate, the court will regard the first of those issues as 'primarily a matter of actuarial judgment, and in that respect will give close attention to the views of the independent expert and the regulators. (Decision at 85.)

But, the "court has a discretion of very real importance, which is not in any way intended simply as a 'rubber-stamp', for the opinion of the independent expert or the views of the regulators." (Decision at 85.)

Not a Capitalization or Size Issue

Mr. Justice Snowden took as undisputed that:

1. As measured by coverage ratios, "the relative financial strengths of PAC and Rothsay are currently comparable, or indeed that Rothsay could be considered to be slightly stronger than PAC."
2. Because the material consideration is capital relative to liabilities, "the fact that PAC is larger than Rothsay does not, of itself, mean that policyholders would have less security of benefits at Rothsay;" and
3. Although "Rothsay is less resilient than PAC due to having less diversification of risk,... this should be taken into account through Rothsay having a proportionately higher SCR." (Decision at 122 to 123.)
Not a Service Standards Issue

Both Prudential and Rothszen are subject to regulation by the PRA and FCA, and the IE concluded that “the administration, management and governance of the Transferring Policies will continue to be of the same standard following” the transfer. (Decision at 71.)

The court found no basis on the evidence for concluding that Rothszen would be unable to manage that expansion of its business. PAC has already outsourced the administration of the Transferring Policies to Diligent, and given the arrangements for that or a similar arrangement to continue if the policies are transferred to Rothszen, I see no reason to conclude that policyholders will be adversely affected by the Scheme in relation to the standards of service that they are likely to experience.”

(Decision at 175 to 176.)

Not An Issue of the Compensation Paid to the IE

That the independent expert was paid by Prudential and Rothszen is an issue that is frequently raised at scheme hearings, but there is nothing in it. Mr Dumbreck’s appointment was, as it had to be, approved by the PRA after consultation with the FCA, and there is no realistic alternative to him being paid by the applicants. Mr Dumbreck is suitably qualified and experienced, having been the independent expert in a number of other scheme cases, including Scottish Equitable. I have no reason to doubt that Mr Dumbreck understood the importance of his role and the need for independence, and he expressly acknowledged that he was aware of and had complied with his overriding duty to the Court.” (Decision at 84.)

Not A Per Se Rule About Personal Lines, or Annuities

Mr. Justice Snowden accepted that:

1. “A significant number of decisions show that the transfer of annuity policies is within the scope of Part VII” and that it was important for regulatory policy that the capability of transfer exist;

2. the court had the power to approve a “transfer of liabilities that would not otherwise be capable of being transferred without a person’s consent or concurrence; and

3. it is “not for the court to insist on an opt out” right for policyholders. (Decision at 102, 104 and 105.)

Instead, Turned On The Nature of Annuities Generally, Combined With The Manner In Which These Particular Annuities Were Marketed

Given the nature of annuities, it "was entirely reasonable for policyholders reading statements" made by Prudential in marketing its annuities to make the assumption that "it would be PAC and no other company that would be providing them with the resultant annuity for the rest of their life." (Decision at 127–128.)
Even That Expectation Was Not Itself Sufficient

The policyholder’s reasonable expectation regarding Prudential “does not mean that as a matter of law PAC could not seek to transfer the annuity policies under Part VIII…” (Decision at 131.)

I nevertheless consider that it is a matter that can and should be taken into account in the exercise of my discretion…” (Jay)

Specifically, Court Reassessed Parental Support

“In an adverse scenario that threatened PAC’s solvency, the financial resources of Prudential plc available to support PAC may be similarly constrained…”

[It is currently planned that Prudential plc will demerge its UK and European operations from its operations elsewhere, and if the demerger goes ahead as planned, it is likely that PAC will no longer benefit from parental support to the same degree as is currently the case…]

Additionally, Rothesay and its parent are able to undertake capital-raising activities… and have done so in the past.

…I am satisfied that both firms have an adequate range of actions at their disposal to mitigate a scenario in which their solvency position starts to deteriorate, and therefore there is no material adverse impact…” (Decision at 8.27-8.31)

Specifically, Court Reassessed Parental Support

“…any comfort that may be drawn from the potential for capital support from Prudential plc must be considered in the context of the likelihood of it being called upon, which is remote. Therefore it should not be considered material in comparison to the comfort that can be drawn from the capital resources of, and the strength of the regulatory capital requirements and capital management policies applicable to, PAC and Rothesay.” (Decision 8.6.2)

Specifically, Court Reassessed Parental Support

“But the fact that the PRA (or an actuary) cannot quantify a firm’s vulnerability or reputation in capital terms, does not mean that it also has to be disregarded by the court. I have already made the point that the court’s role under section 111(3) is not simply intended to replicate, or to be limited by, the risk-based approach of the regulators to the assessment of the scheme, or the actuarial approach of the independent expert…” (Decision 110.)
Specifically, Court Reassessed Parental Support

“...consider that the opposing policyholders were justified in their submission that such matters do not provide equivalent comfort to the existing availability of capital in the Prudential group and the commercial imperative that would motivate the other Prudential group companies to stand behind PAC. The provision of capital to enable the initial development and expansion of Rothsay’s business by acquisition of annuities from other insurers is not the same as the provision of restorative capital to make good an unexpected deterioration in the financial position of the company or to avoid its insolvency. Moreover, the business operations, names and reputations of Blackstone, GIC and MassMutual (or any investors that might replace them) are not integrated with, or inherently tied to the business of Rothsay in the same way as the business operations, name and reputation of other parts of the Prudential group are tied to the business of PAC.” (Decision at 144.)

Specifically, Court Reassessed Parental Support

“...prima facie, I consider that this disparity between the external support potentially available for PAC and Rothsay is a material factor affecting the interests of policyholders to be taken into account in the exercise of my discretion.” (Decision at 143.)

A concern about bare private commercial interest?

“The Scheme has been motivated by PAC’s desire to reduce its regulatory capital requirements in connection with a planned demerger of the group headed by Prudential plc... of which PAC is a significant member. The Scheme... offers no benefits to the transferring policyholders in connection with the enforced change of their annuity provider from PAC to Rothsay.” (Decision at 2, emphasis added.)

The “question of whether a particular policy was selected by PAC to be... transferred to Rothsay under the Scheme, depended entirely on whether or not it suited the commercial requirements of PAC and Rothsay. In particular, the selection of the affected policyholders was designed to provide PAC with its target level of regulatory capital release in order to facilitate the Demerger.” (at 66, emphasis added.)
**U.S. Constitution**

- **Contracts Clause**
  - No state shall ... pass any ... law impairing the obligation of contracts. U.S. Constitution, Art. I, § 10, Issue 1

- **Due-Process Clause**
  - No state shall ... deprive any person of life, liberty, or property without due process of law.
  - 14th Amendment to U.S. Constitution,

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**Framework for similar arguments in the U.S.**

As a general rule, parties do not have a right to expect performance from a particular party.

An obligor can generally delegate performance of duties capable of being performed by a number of different persons (looking to whether individual traits, skill, or judgment required).
Summary of the report of the Independent Expert

Background

I have been instructed by The Prudential Assurance Company Limited (“PAC”)1 and Rothesay Life Plc (“Rothesay”) to report to the High Court of Justice of England and Wales (the “Court”) on the terms of the proposed transfer of certain non-profit annuity insurance business of PAC (“the transferring policies”) to Rothesay. The transfer will be effected by means of a scheme of transfer (the “Scheme”) in accordance Part VII of the Financial Services and Markets Act 2000. Subject to Court approval, the date on which the transfer takes place (“the transfer date”) is expected to be 26 June 2019.

On 14 March 2018, Rothesay entered into an agreement to acquire the transferring policies from PAC. While the formal transfer of the transferring policies to Rothesay requires the sanction of the Court, PAC and Rothesay agreed that PAC’s economic interest in the material risks and rewards of the transferring policies should be transferred to Rothesay in the meantime2. This was achieved by putting in place a reinsurance agreement between PAC and Rothesay (“the Reinsurance Agreement”). Under the Reinsurance Agreement, Rothesay must reimburse PAC for all benefit payments made to holders of the transferring policies3 unless and until the transferring policies are formally transferred to Rothesay under the Scheme, after which Rothesay will make the payments directly. There are a number of policies that are covered by the Reinsurance Agreement which are not transferring policies. These policies will instead remain reinsured to Rothesay after the transfer date.

I am a Fellow of the Institute and Faculty of Actuaries in the UK and a partner of Milliman LLP. I have fulfilled the role of Independent Expert for over 20 insurance business transfers that have been approved by the Court. I confirm that I do not have any direct or indirect interest in PAC, Rothesay or any other related firms that could compromise my independence.

My assessment of the effect of the transfer has been informed by the financial positions of PAC and Rothesay at 30 June 2018, the most recent date at which both sets of financial results are available at the time of writing.

This is a summary of my full report dated 21 January 2019. Please refer to my full report (which is available from the PAC and Rothesay websites) for the scope of my work and my conclusions, and the reliances, limitations and standards applying to my work. The full report and this summary do not provide financial or other advice to individual policyholders.

Before the final Court Hearing I will prepare a further report (the “Supplementary Report”) to provide an update on my conclusions regarding the effect of the proposed transfer on the different groups of policyholders in light of any significant events arising after my full report has been finalised. The Supplementary Report will include information on the financial position of the companies at 31 December 2018.

The effect of the transfer on transferring policies of PAC

Benefit security

Transferring PAC policyholders will be transferred from a very large, long established company with a familiar brand name to a smaller, less well-known company founded only twelve years ago. However, the security of policyholders’ benefits depends primarily on factors other than the size and age of the company, and in reviewing the transfer I have considered, among other things:

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1 PAC is a UK insurance company and is the primary European insurance entity of the Prudential plc group.
2 With effect from 1 April 2018 for deferred annuities and 1 July 2018 for annuities in payment.
3 With the exception of differences in payments to policyholders that arise through differences between PAC’s and Rothesay's commutation factors.
Solvency cover: If the proposed transfer had taken place on 30 June 2018, the level of cover for regulatory solvency requirements\(^5\) would have been lower in Rothesay post-transfer than that in PAC pre-transfer. However, PAC’s solvency cover decreased from 14 December 2018 due to the transfer of the legal ownership of PAC’s Hong Kong subsidiaries to Prudential Corporation Asia, reversing the relative positions of the two companies.

Capital policies: PAC and Rothesay have capital policies aimed at maintaining solvency cover\(^5\) within an appropriate range. I have reviewed the capital policies of both companies and have concluded that they are of broadly comparable strength. At 30 June 2018 the solvency cover of each company exceeded the upper end of the target range set by its respective Board, and this would also have been the case after the transfer if it had taken place on that date. Each company is free to distribute to its shareholders any surplus capital which is not ring-fenced or expected to be needed by the business, and this means that additional security provided by solvency cover in excess of the target range may be temporary.

Risk exposures: Differences in the risks to which each fund is exposed may lead to differences in the variability of solvency cover as financial and other conditions change, and it is also necessary to take account of any such differences.

Based on my review of all the relevant factors, I am satisfied that the transfer will not have a material adverse impact on the security of benefits of the transferring policies.

Reasonable expectations of transferring policyholders

The transferring policies are all non-profit annuities\(^6\) and therefore, in my view, policyholders’ reasonable expectations in respect of their policies are principally that:

- They receive their income as guaranteed under the policy, on the dates specified, from the point of purchase;
- The administration, management, and governance of the policies are in line with the contractual terms of the policies; and
- The standards of service received after the transfer are at least as good as those they currently receive.

No changes are proposed to the terms and conditions of the transferring policies, and so the contractual benefits will be unchanged by the Scheme.

Holders of some of the transferring policies are able to elect to commute some or all of the contractual benefits of their policy in certain limited circumstances\(^7\); that is, the policyholder or contingent beneficiary may choose to forgo some or all of their annuity income in return for a lump sum payment. The amount of lump sum received is, in almost all cases, at the discretion of the insurer (subject to the overriding requirement to treat customers fairly), and is determined by a commutation factor\(^8\) that depends on the insurer’s estimate of the life expectancy of the customer, as well as prevailing market conditions (in particular the level of long-term interest rates). PAC is in the process of implementing a change to its commutation factors which will, by and large, result in the factors reducing. I have received analysis from PAC and Rothesay showing that, while PAC’s commutation factors (after the planned change) may be higher or lower than those of Rothesay depending on the features of the policy, the two sets of

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\(^4\) The UK insurance regulations specify minimum levels of capital that an insurer must hold based upon the risks that the insurer has written.

\(^5\) The capital that an insurer holds expressed as a percentage of the minimum level permitted by regulations.

\(^6\) All transferring policies are in-payment annuities with the exception of a very small number of deferred annuity policies.

\(^7\) For in-payment annuities, these circumstances comprise:
- a situation in which a pension sharing order has been issued; or
- a situation where the benefits of a contingent beneficiary are small enough to qualify for trivial commutation following the death of the main policyholder.

\(^8\) A commutation factor is the lump sum received by the policyholder for each £1 p.a. of pension income forgone. For example, a commutation factor of 20 means that the policyholder would receive a £20 lump sum for each £1 p.a. of pension forgone.
factors will not differ materially. I have provided more details on this aspect in my full report and I will provide an update in my Supplementary Report.

Since October 2018, the administration and servicing of all of PAC’s annuity business (including the transferring policies) has been carried out by Tata Consultancy Services ("TCS") and Diligenta, its UK subsidiary. Subject to putting in place a suitable transitional services agreement, PAC will continue to provide administration and servicing (undertaken by TCS on its behalf) to Rothesay for 12 to 24 months after the transfer date, which means that no changes to administration or service standards are expected as a result of the transfer during this period. While this transitional services agreement is in place, there is no reason to expect that administration and service standards will differ from those that the transferring business would have received if the Scheme had not been implemented. After the expiry of the transitional services agreement, Rothesay would choose either to put in place a direct relationship with TCS/Diligenta or the administration would migrate to a service provider of Rothesay’s choice. Rothesay already manages approximately 380,000 non-profit annuities and administers these via outsourcing agreements. I have reviewed the target service standards for these policies and I consider the service standards to be reasonable. I have no reason to believe that the future outsourcing arrangements for the transferring policies organised by Rothesay will result in materially different service standards from those applicable to Rothesay’s existing non-profit annuities. I will comment on the outcome of the discussions surrounding the Transitional Services Agreement in my Supplementary Report. However, assuming that a suitable Transitional Services Agreement is put in place, I am satisfied that the implementation of the Scheme will not result in a material adverse impact on service standards applicable to the Transferring Policies.

Following the transfer, the transferring policies will be managed by Rothesay and subject to the governance of the Rothesay Board of Directors. As noted above, Rothesay currently manages large volumes of non-profit annuity business, and is therefore experienced in the management and governance of such business.

After the transfer date it will be necessary to use Rothesay’s Pay As You Earn ("PAYE") reference for transferring policies. For some holders of transferring policies, this may trigger a change in their PAYE tax code, either at or directly after the transfer date. Rothesay and PAC are liaising with HMRC to establish the best approach to minimise any inconvenience for affected policyholders. I will comment further on this aspect in my Supplementary Report.

In October 2016, the Financial Conduct Authority (the “FCA”) announced the findings of its Thematic Review of Annuity Sales Practices ("TRASP") which assessed whether firms had provided new annuity customers with sufficient information about the availability of enhanced annuities at the point of sale. As a result of TRASP a number of firms, including PAC, were asked by the FCA to review all non-advised annuity sales since July 2008 and provide compensation where appropriate. PAC is currently conducting this review.

Depending on the outcome of the TRASP review, PAC may need to make lump sum compensation payments and/or augment the level of annuity payments for certain policies, including some of the transferring policies. The planned processes for reviewing and, where appropriate, providing TRASP compensation after the transfer have been designed with the aim that a transferring policyholder’s experience would be the same as that of a non-transferring policyholder of PAC. Therefore, transferring policyholders should not experience a delay in receiving any compensation due as a result of the implementation of the Scheme, nor will the amount of compensation they receive be affected.

Conclusions for transferring policies

I am satisfied that the implementation of the Scheme will not have a material adverse effect on:

- The security of benefits under the transferring policies;
- The reasonable expectations of the transferring policyholders; or

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8 An annuity sold to an individual in poorer than average health, which pays out a higher annuity amount to reflect their lower life expectancy relative to a healthy individual.

9 When a customer does not receive financial advice when purchasing an annuity, it is called a ‘non-advised annuity sale’.
The service standards and governance applicable to the transferring policies.

The effect of the transfer on non-transferring policies of PAC

Benefit security

If the proposed transfer had taken place on 30 June 2018, there would have been an improvement to PAC’s financial strength as a result of the transfer. However, this improvement would be relatively small as PAC has already transferred the risks and rewards associated with the transferring policies to Rothesay through the Reinsurance Agreement, and so has already realised most of the financial benefits of the transfer.

The proposed transfer will not lead to any material change in the risk appetite\textsuperscript{11} or capital policy in accordance with which PAC is managed, and PAC’s ability to comply with its capital policy will not be materially affected by the transfer.

Reasonable expectations of non-transferring PAC policyholders

No changes will be made to the terms and conditions of non-transferring policies in PAC as a result of the transfer. Furthermore, there will be no change to the operation of PAC and the governance of non-transferring PAC policies will continue to be the responsibility of the PAC Board of Directors and, in the case of with-profits policyholders (none of which will transfer to Rothesay), the role of the PAC With-Profits Committee will be unchanged.

The non-transferring policies in PAC will continue to be administered under the same arrangements and will therefore not experience any change to service standards as a result of the transfer.

The Scheme will have no effect on the benefits payable under policies remaining in PAC.

Conclusions for non-transferring policies

I am satisfied that the implementation of the Scheme will not have a material effect on:

- The security of benefits under non-transferring policies in PAC;
- The reasonable benefit expectations of non-transferring policyholders of PAC; or
- The service standards and governance applicable to non-transferring policies of PAC.

The effect of the transfer on Rothesay policies

Benefit security

Based on the financial information I have received as at 30 June 2018, there will be no material change to the financial strength of Rothesay as a result of the transfer as PAC has already transferred the risks and rewards associated with the transferring policies to Rothesay through the Reinsurance Agreement.

Rothesay’s existing business consists solely of annuities in payment and deferred annuities, and while the Reinsurance Agreement significantly increased the volume of business in Rothesay, it did not materially change the nature of the risks to which its policies are exposed (principally longevity risk\textsuperscript{12} and credit risk\textsuperscript{13}). As the risks on the transferring policies have already been passed to Rothesay through the Reinsurance Agreement, the transfer itself will not add to these risks.

\textsuperscript{11} Risk appetite is the amount and type of risk that an organisation is willing to take in order to meet its strategic objectives.

\textsuperscript{12} Longevity risk is the risk of an adverse financial impact arising from annuity policyholders living longer than expected.

\textsuperscript{13} Credit risk is the risk of losses arising from a loan made to a third party. A loss may arise from failure of the counterparty to make payments when due. A loss may also arise because the market considers the likelihood of the counterparty defaulting has increased, and so the value at which the loan may be traded falls.
The proposed transfer will not lead to any material change in the risk appetite or capital policy in accordance with which Rothesay is managed, and Rothesay’s ability to comply with its capital policy will not be materially affected by the transfer.

Reasonable expectations of existing Rothesay policyholders

The transfer will not alter the terms and conditions of existing policies in Rothesay. The transfer will not lead to any changes to the servicing and administration arrangements for existing Rothesay policies, and no change is expected to service standards for these policies as a result of the Scheme. The governance of the existing policies will continue to be the responsibility of the Rothesay Board of Directors.

Conclusions for existing Rothesay policies

I am satisfied that the implementation of the Scheme will not have a material effect on:

- The security of benefits of the policyholders of Rothesay;
- The reasonable expectations of the policyholders of Rothesay; or
- The service standards and governance applicable to the policyholders of Rothesay.

Overall Conclusions

I am satisfied that the implementation of the Scheme will not have a material adverse effect on:

- The security of benefits of the policyholders of PAC and Rothesay;
- The reasonable benefit expectations of the policyholders of PAC and Rothesay; or
- The service standards and governance applicable to the PAC and Rothesay policies.

I am also satisfied that the Scheme is equitable to all classes and generations of PAC and Rothesay policyholders.

The Independent Expert’s full report is available online at pru.co.uk/annuitytransfer. It shows in much more detail how the Independent Expert has reached his conclusions. You can also request a copy by post, by calling PAC’s helpline on 0800 640 9164 or +44 203 755 9194 if calling from outside the UK, or by writing to PAC at Rothesay Life Transfer, Prudential, PO Box 3122, Lancing BN15 8GB.
APCIA Principles for Insurance Business Transfers (IBT) and Division Statutes

Due Process

- Robust due process must be afforded to stakeholders impacted by a transaction (policyholders, reinsurers, guaranty associations). This should include:
  - Notice to stakeholders as determined by the regulator
  - Public hearing
  - Opportunity to submit written comments

Guaranty Fund Coverage

- No impacted policyholder should lose or gain guaranty fund protection as a result of a transaction.

Robust Regulatory Review Process

- The regulatory review must be robust and should, at a minimum, include the following findings:
  - The assets to be allocated to insurers involved in the transaction are adequate to cover the insurer’s liabilities.
  - The impact and terms of the transaction do not have a material adverse impact on policyholders, reinsurers, or guaranty associations.
  - The review should consider the plans of any insurer involved in the transaction to liquidate another involved insurer, sell its assets, consolidate, merge, or make other changes, and the resulting impact on policyholders, reinsurers, and guaranty associations.

Independent Expert

- The regulatory review process for insurance business transfers will utilize an independent expert to advise and assist the regulator in reviewing proposed transactions (including advising on any material adverse impact on policyholders, reinsurers, or guaranty associations) and to provide any other assistance or advice the regulator may require.

Court Approval

- Court approval must be required for insurance business transfer transactions but not for divisions.
The Group Solvency Issues (E) Working Group of the Financial Condition (E) Committee met in Austin, TX, Dec. 7, 2019. The following Working Group members participated: Justin Schrader, Chair (NE); Doug Slape, Vice Chair (TX); Kathy Belfi and Michael Shanahan (CT); Virginia Christy and Carolyn Morgan (FL); Kim Cross and Mike Yanacheak (IA); Cindy Andersen and Eric Moser (IL); Roy Eft (IN); John Turchi (MA); Judy Weaver (MI); Shannon Schmoeger (MO); Marlene Caride (NJ); Stephen Doody (NY); Tim Biler and Dale Bruggeman (OH); Joe DiMemmo and Kimberly Rankin (PA); Doug Stolte (VA); and Amy Malm (WI).

1. Received an Update from the ORSA Implementation (E) Subgroup

Ms. Belfi provided an update of recent activities of the ORSA Implementation (E) Subgroup, which has not met since the Summer National Meeting but has been engaged in ongoing projects. She said the NAIC held its first Own Risk and Solvency Assessment (ORSA) Peer Review session in August, which was led by the Risk-Focused Surveillance (E) Working Group but supported by the Subgroup. She stated that she was able to attend the session as an observer. During the session, several sound practices and opportunities for improvement were identified for use in reviewing and incorporating ORSA work into ongoing analysis and examination processes. Ms. Belfi stated that Subgroup leadership has worked with NAIC staff to develop a state insurance regulator only ORSA Review Sound Practices document to share these takeaways with other states. In addition, as the session was very well received, the NAIC intends to conduct another ORSA Peer Review session in 2020 to allow other states to participate.

Ms. Belfi stated that in addition to its support for ORSA Peer Review work, the Subgroup has also been engaged in the development of guidance for use in reviewing and evaluating an insurer’s use of internal capital models. She said this guidance is not intended as a standard set of procedures to be performed at all ORSA filers, but it will instead be optional supporting guidance for those states that want to dig deeper into their insurers’ use of internal capital models. As such, the guidance is intended for use as a state insurance regulator-only tool, and it is being discussed and developed during regulator-to-regulator calls of the Subgroup. At this point, a first draft of guidance was developed and exposed for state insurance regulator comment. Comments were received from several states, and the proposed guidance is currently being revised to address comments received. Ms. Belfi stated that once a revised draft is developed, it will be reviewed by the Subgroup and approved for use as an optional state insurance regulator-only tool.

2. Heard a Report on IAIS Activities

Mr. Schrader provided a report on recent group-related activities of the International Association of Insurance Supervisors (IAIS), including the status of ongoing projects of the Insurance Groups Working Group. He said that now that the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) has been adopted, several supporting activities are underway at the IAIS to assist in implementation. A supervisory college workshop is in development to assist supervisors in learning best practices for use in conducting college sessions. Other related projects include the ongoing development of an aide memoire to assist in post-implementation review, as well as a frequently asked questions (FAQ) document for supervisors.

3. Discussed State Insurance Regulator Approach to ComFrame Implementation

Mr. Schrader stated that the Working Group will be receiving a significant new charge for 2020 related to ComFrame implementation. The IAIS adopted ComFrame on Nov. 14, which establishes supervisory standards and guidance focusing on the effective group-wide supervision of Internationally Active Insurance Groups (IAIGs). ComFrame is a comprehensive and outcome-focused framework aimed at facilitating effective group-wide supervision of IAIGs by providing qualitative and (in a future phase) quantitative supervisory minimum requirements tailored to the international activity and size of IAIGs. The intent of ComFrame is to help supervisors address group-wide risks and avoid supervisory gaps by supporting coordination across jurisdictions.
Mr. Schrader stated that ComFrame builds on, and expands upon, the high-level standards and guidance currently set out in the Insurance Core Principles (ICPs) of the IAIS, which generally apply on both an insurance legal entity and group-wide level. Consistent with the application of the ICPs, the minimum requirements established by ComFrame are expected to be implemented and applied in a proportionate manner. However, supervisors have the flexibility to tailor implementation of supervisory requirements and application of insurance supervision to achieve the outcomes described in ComFrame Standards.

Mr. Schrader stated that certain elements of ComFrame were incorporated into the 2014 revisions to the Insurance Holding Company System Regulatory Act (#440), which were developed by the Working Group. However, there have been a number of additions and enhancements to ComFrame since that time, which is why the Working Group is intended to receive the following charge for 2020: “Assess the IAIS Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) and make recommendations on its implementation in a manner appropriate for the U.S.”

Mr. Schrader stated that ComFrame requirements are quite broad and extensive, with elements included in 10 of the 25 ICPs, as well as the ICP Introduction and Assessment Methodology. He said that many of the key elements of ComFrame may already be incorporated into the U.S. system of state insurance regulation, at least partially; but it will be the Working Group’s assignment to identify other elements that may not yet be incorporated and discuss how to address them. He stated that the Working Group asked for comments on how to proceed with addressing this charge in 2020, and it received requests to speak on this topic from several interested parties.

Tom Finnell (America’s Health Insurance Plans—AHIP) stated his agreement that many of the ComFrame elements are already at least partially incorporated into the U.S. system of state-based regulation. In addition, while the ComFrame language and wording tends to emphasize or encourage a centralized approach to group management and oversight, he encouraged state insurance regulators to consider the introductory guidance and assessment methodology that allows for additional flexibility in applying oversight to different types of insurance groups. He stated that the guidance related to who is considered the head of an insurance group is very important, and it should be carefully considered in applying ComFrame concepts in the U.S.

Stephen Broadie (American Property Casualty Insurance Association—APCIA) stated that the language in the charge stating that ComFrame should be implemented “in a manner appropriate for the U.S.” is very important as new requirements should not be adopted or implemented if they do not make sense within the U.S. system of state-based insurance regulation. He also stated that ComFrame is designed to produce equivalent outcomes, but such outcomes can be achieved in different ways. As such, he encouraged state insurance regulators to not adopt ComFrame elements that would promote a prescriptive approach to company management and oversight.

Mariana Gomez-Vock (American Council of Life Insurers—ACLI) stated her support for an approach that identifies existing practices in the U.S. system that address ComFrame elements before identifying and addressing any gaps that may need to be considered.

Bill Schwegler (Transamerica) stated that he was speaking on behalf of several U.S. insurance groups, including Jackson National Life Insurance and Protective Live Insurance, that are subsidiaries of foreign-based groups that will be subject to ComFrame requirements imposed by their group-wide supervisors. Therefore, to ensure that these groups are not put at a disadvantage in U.S. ComFrame implementation, he recommended that state insurance regulators consider three important points. First, state insurance regulators should create an appropriate legal architecture to coordinate and share information across jurisdictions. Second, state insurance regulators should avoid placing additional requirements on IAIGs that are not specifically associated with their international activities. Third, as the distinction between IAIGs and other large insurers is not very significant in the U.S. market, state insurance regulators should avoid setting an inappropriate scope in implementing ComFrame requirements.

Mr. Shrader thanked interested parties for their comments, and he committed to hold implementation discussions in an open manner while keeping the interested party comments in mind. Ms. Belfi asked if the ComFrame guidance could be separated out from the ICPs and distributed to Working Group members for review. Mr. Schrader asked NAIC staff to extract the ComFrame elements from the ICPs and distribute the guidance to the Working Group. Mr. Schrader also asked NAIC staff to begin work on a document comparing ComFrame elements to existing practices in the U.S. system of state-based regulation for Working Group review.
4. **Discussed Other Matters**

Mr. Schrader said the Group Capital Calculation (E) Working Group has been discussing the need to revise the holding company models to allow for the collection of data associated with the calculation, and he has submitted a Request for NAIC Model Law Development to the Executive (EX) Committee for approval. He said that the Group Solvency Issues (E) Working Group will be involved in the project due to its role in overseeing Model #440.

Mr. Bruggeman stated that the Statutory Accounting Principles (E) Working Group exposed agenda item 2019-34 for public comment and would be asking the Working Group to review and provide comment on the proposed changes that are intended to clarify accounting and reporting requirements for related parties. As related parties are more difficult to appropriately identify and disclose in large insurance groups, the proposed revisions should be relevant to the Group Solvency Issues (E) Working Group.

Having no further business, the Group Solvency Issues (E) Working Group adjourned.
MEMORANDUM

TO: Financial Condition (E) Committee

FROM: NAIC Staff

DATE: November 15, 2019

RE: Examiners’ Suggested Salary

For its work in 2020, the Risk-Focused Surveillance (E) Working Group received the following charges from the Financial Condition (E) Committee:

Continually maintain and update standardized job descriptions/requirements and salary range recommendations for common solvency monitoring positions to assist insurance departments in attracting and maintaining suitable staff.

In 2019, the Working Group developed and referred Handbook revisions that would provide clearer compensation suggestions to both the Financial Analysis Solvency Tools (E) Working Group and the Financial Examiners Handbook (E) Technical Group. Both groups adopted their revisions earlier this year and will therefore include related guidance in 2020 editions of their respective Handbooks. The Working Group has also sent a referral to the Financial Regulation Standards and Accreditation (F) Committee to enhance consideration of Department compensation during the Accreditation review process. Those revisions were also adopted in 2019.

To avoid negatively impacting states that base compensation on the current Salary and Per Diem Guidelines, NAIC staff have continued to maintain the existing Handbook guidance on compensation which is being updated via this memorandum. NAIC staff also recommend that the Risk-Focused Surveillance (E) Working Group assume the responsibility to oversee development of updates to all compensation related guidance pursuant to the charge outlined above.

The Consumer Price Index (CPI), as defined by the U.S. Bureau of Labor Statistics (BLS), is a measure of the average change in prices of goods and services purchased by households over time. The CPI is based on prices of food, clothing, shelter, fuels, transportation fares, charges for doctors’ and dentists’ services, drugs, and other goods and services purchased for day-to-day living. In 2008, it was decided that because the CPI takes into consideration most costs incurred by the average household, it is reasonable that an increase in salary should be within the same parameters as the increase in the cost of living. It was therefore proposed, and that proposal accepted, that the CPI be used as a basis for examiner salary increases. In years in which the CPI does not accurately reflect market conditions, additional work—including surveys and salary studies—may be completed to ensure proper salary suggestions. Consistent with past years, inflation has continued to show modest increases in prices and appears appropriate as a metric on which to base a suggested compensation increase.

The following data table shows the average annual salary increases adopted in the previous five years as compared to the CPI, as well as the proposed increase for the following year. The information “as published by BLS” compares the CPI as of July of each year, consistent with the analysis performed in past years.
As shown above, in recent years, the rates suggested by the NAIC were consistently comparable to those published by the BLS, regardless of the method used.

Based upon the current CPI data available (July 2018–July 2019), the estimated annual change in CPI is approximately 1.81%. As such, if the Committee intends to base salary increases on changes in the CPI, we would recommend a 2% increase in all classification categories as shown below.

<table>
<thead>
<tr>
<th>Classification</th>
<th>2018 Daily Rates</th>
<th>Suggested Increase</th>
<th>2019 Daily Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Company Examiner, AFE*</td>
<td>329</td>
<td>2%</td>
<td>$ 336</td>
</tr>
<tr>
<td>Automated Examination Specialist, AFE (no AES**)</td>
<td>403</td>
<td>2%</td>
<td>$ 411</td>
</tr>
<tr>
<td>Senior Insurance Examiner, CFE***</td>
<td>403</td>
<td>2%</td>
<td>$ 411</td>
</tr>
<tr>
<td>Automated Examination Specialist, AES</td>
<td>453</td>
<td>2%</td>
<td>$ 462</td>
</tr>
<tr>
<td>Automated Examination Specialist, CFE (no AES)</td>
<td>453</td>
<td>2%</td>
<td>$ 462</td>
</tr>
<tr>
<td>Insurance Examiner In-Charge, CFE</td>
<td>485</td>
<td>2%</td>
<td>$ 495</td>
</tr>
<tr>
<td>Supervising or Administrative Examiner</td>
<td>515</td>
<td>2%</td>
<td>$ 525</td>
</tr>
</tbody>
</table>

* Accredited Financial Examiner  
** Automated Examination Specialist  
*** Certified Financial Examiner
Process for **Developing and Maintaining** the **NAIC List of Evaluating Qualified and Reciprocal** Jurisdictions
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I. Preamble

Purpose

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

Background

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

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

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

**Reciprocal Jurisdictions**

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

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

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

1. The NAIC model revisions applicable to certified reinsurers are intended to facilitate cross-border reinsurance transactions and enhance competition within the U.S. market, while ensuring that U.S. insurers and policyholders are adequately protected against the risk of insolvency. To be eligible for certification, a reinsurer must be domiciled and licensed in a Qualified Jurisdiction as determined by the domestic regulator of the ceding insurer. A Qualified Jurisdiction not subject to an in-force Covered Agreement under the Dodd-Frank Act may also be determined to be a Reciprocal Jurisdiction, and reinsurers that have their head office or are domiciled in any such Reciprocal Jurisdiction will not be required to post reinsurance collateral, provided they meet the minimum capital and financial strength requirements and comply with the other requirements of the Credit for Reinsurance Models.

2. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions and Reciprocal Jurisdictions will be conducted in accordance with the provisions of the Credit for Reinsurance Models and any other relevant guidance developed by the NAIC.

3. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Financial Regulation Standards and Accreditation Program (Accreditation Program), adherence to international supervisory standards, and relevant international guidance for recognition of reinsurance supervision. It is not intended as a prescriptive comparison to the NAIC Accreditation Program. In order for a Qualified Jurisdiction that is not subject to an in-force Covered Agreement to be evaluated as a Reciprocal Jurisdiction, that Qualified Jurisdiction must agree to recognize the states’ approach to group supervision, including group capital, and other such requirements as provided under the Credit for Reinsurance Models.

4. The states shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the Qualified Jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of Qualified Jurisdiction status is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

5. Each state may evaluate a non-U.S. jurisdiction to determine if it is a Qualified Jurisdiction. A list of Qualified Jurisdictions will be published through the NAIC committee process. A state must consider this list in its determination of Qualified Jurisdictions, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Qualified Jurisdictions contained in the Credit for Reinsurance Models. The creation of this list does not constitute a delegation of regulatory authority to the NAIC. The regulatory authority to recognize a Qualified Jurisdiction resides solely in each state and the NAIC List of Qualified Jurisdictions is not binding on the states.

6. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models.
7. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination that a jurisdiction is a Qualified or Reciprocal Jurisdiction. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings. The NAIC Lists of Qualified and Reciprocal Jurisdictions are intended to facilitate the passporting process.

6-8. Both Qualified Jurisdictions and Reciprocal Jurisdictions must agree to share information and cooperate with the state with respect to all certified applicable reinsurers domiciled within that jurisdiction. Critical factors in the evaluation process include but are not limited to the history of performance by assuming insurers in the applicant jurisdiction and any documented evidence of substantial problems with the enforcement of final U.S. judgments in the applicant jurisdiction. A jurisdiction will not be a Qualified Jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

7.9. The determination of Qualified Jurisdiction status can only be made with respect to the reinsurance supervisory system in existence and applied by a non-U.S. jurisdiction at the time of the evaluation.

8-10. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.
III. Procedure for Evaluation of Non-U.S. Jurisdictions


   a. The NAIC will initially evaluate and expedite the review of those jurisdictions that were approved by the states of Florida and New York prior to the adoption of the revised Credit for Reinsurance Models (i.e., Bermuda, Germany, Switzerland and the United Kingdom). The NAIC may also consider expediting the review of additional jurisdictions, as outlined in paragraph 1(d) below. While the same evaluation procedure and methodology will be applicable to any jurisdiction under review, U.S. state insurance regulators’ familiarity with these particular jurisdictions may lead to a more expeditious review. Subsequent priority will be on the basis of objective factors including but not limited to ceded premium volume and reinsurance capacity issues raised by the states. Priority will also be given to requests from the states and from those jurisdictions specifically requesting an evaluation by the NAIC.

   b. Formal notification of the NAIC’s intent to initiate the evaluation process will be sent by the NAIC to the reinsurance supervisory authority in the jurisdiction selected, with copies to the FIO and other relevant federal authorities as appropriate. The NAIC will issue public notice on the NAIC website upon confirmation that the jurisdiction is willing to participate in the evaluation process. The NAIC will at this time request public comments with respect to consideration of the jurisdiction as a Qualified Jurisdiction. The process of evaluation and all related documentation are private and confidential matters between the NAIC and the applicant jurisdiction, unless otherwise provided in this document, subject to a preliminary confidentiality and information sharing agreement between the NAIC, relevant states and the applicant jurisdiction.

   c. Relevant U.S. state and federal authorities will be notified of the NAIC’s decision to evaluate a jurisdiction.

   d. Expedited Review Procedure. Based on the prior review and approval by Florida and New York of reinsurers domiciled in Bermuda, Germany, Switzerland and the United Kingdom, the NAIC will apply an expedited review procedure with respect to these jurisdictions. The NAIC may also consider extending this expedited review procedure to other jurisdictions approved by a state as a Qualified Jurisdiction, provided that:

      i. The state provides a report to the Qualified Jurisdiction Working Group confirming that it has completed a full review of the jurisdiction in accordance with that set forth in Part IV: Evaluation Methodology. If current information as outlined in paragraph 1(e)(i) (i.e., FSAP Report and ROSC) is not available to the state, it must demonstrate that it has obtained and reviewed information consistent with Appendix A and Appendix B.

      ii. The state completes the full review and lists the jurisdiction as a Qualified Jurisdiction within 60 days of the NAIC’s adoption of the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions.

This procedure is not intended to eliminate or reduce any element provided under Part IV: Evaluation Methodology, but is intended to allow for a designation of Conditional Qualified Jurisdiction of these jurisdictions in order to facilitate the certification of reinsurers domiciled therein. Final qualification of each jurisdiction will be contingent upon completion of the full, outcomes-based evaluation procedure.
Upon confirmation that a jurisdiction is willing to be considered for designation as a Conditional Qualified Jurisdiction, the following expedited review procedure will apply:

i. The Qualified Jurisdiction Working Group will perform an initial review of the jurisdiction’s most recent Detailed Assessment of Observance on Insurance Core Principles under the International Monetary Fund (IMF)/World Bank Financial Sector Assessment Program (FSAP Report), Report on Observance for Standards and Codes (ROSC), and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system in conjunction with the information provided under Section C through Section G of the Evaluation Methodology. The NAIC will invite each jurisdiction (or its designee) to provide information relative to Section C through Section G of the Evaluation Methodology in order to complete or supplement publicly available information. The NAIC may designate the jurisdiction as a Conditional Qualified Jurisdiction, to be effective immediately, upon: (1) receipt of all necessary initial information requested in this section; (2) opportunity for comment by interested parties; and (3) conclusion of any appropriate communication with the FIO, USTR and other relevant federal authorities.

ii. During this period as a Conditional Qualified Jurisdiction, the Qualified Jurisdiction Working Group will complete its full analysis of the information provided by the jurisdiction, in addition to any specific information that is subsequently requested by the NAIC, in order to evaluate the jurisdiction’s laws, regulations, practices and procedures from an outcomes-based perspective in accordance with the guidance provided under Appendix A and Appendix B of the Evaluation Methodology. Upon satisfactory completion of the outcomes-based review of this information, the NAIC may upgrade the jurisdiction’s designation to Qualified Jurisdiction. The NAIC may also address any issues identified within the review or revoke the designation of Conditional Qualified Jurisdiction.

iii. A jurisdiction may be permitted to maintain the designation of Conditional Qualified Jurisdiction for one year, unless: (1) an extension is granted by the Qualified Jurisdiction Working Group; or (2) a determination is made that the jurisdiction is not a Qualified Jurisdiction.

2. Evaluation of Jurisdiction

a. Evaluation Materials. The Qualified Jurisdiction Working Group will initiate evaluation of a jurisdiction’s regulatory system by using the information identified in Section A through Section G of the Evaluation Methodology (Evaluation Materials). The Qualified Jurisdiction Working Group will begin by undertaking a review of the most recent Financial Sector Assessment Program (FSAP) Report, prepared by the International Monetary Fund (IMF), including the Technical Note on Insurance Sector Supervision, ROSC and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Qualified Jurisdiction Working Group will also invite each jurisdiction or its designee to provide information relative to Section A through Section G of the Evaluation Methodology in order to update, complete or supplement publicly available information. The Qualified Jurisdiction Working Group may also request or accept relevant information from reinsurers domiciled in the jurisdiction under review.

b. The Qualified Jurisdiction Working Group will notify the jurisdiction of any information upon which the Working Group is relying—that was not otherwise provided by the jurisdiction. In that communication, the NAIC will invite the supervisory authority to compare the materials identified by the NAIC to the materials...
described in Appendix A and Appendix B, and provide information required to update the identified public information or supplement the public information, as required, to address the topics identified in Section G of the Evaluation Methodology. The use of publicly available information (e.g., the FSAP Report and/or the ROSECInsurance Sector Technical Note) is intended to lessen the burden on applicant jurisdictions by requiring the production of information that is readily available, while still addressing substantive areas of inquiry detailed in the Evaluation Methodology. The Qualified Jurisdiction Working Group’s review at this stage will be focused on how the jurisdiction’s laws, regulations, administrative practices and procedures, and regulatory authorities regulate the financial solvency of its domestic reinsurers in comparison to key principles underlying the U.S. financial solvency framework\(^{1}\) and other factors set forth in the Evaluation Methodology.

c. After reviewing the Evaluation Materials, the Qualified Jurisdiction Working Group may request that the applicant jurisdiction submit supplemental information as necessary to determine whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. The Working Group will address specific questions directly with the jurisdiction related to items detailed in the Evaluation Methodology that are not otherwise addressed in the Evaluation Materials.

d. The NAIC will request that all responses from the jurisdiction being evaluated be provided in English. Any responses submitted with respect to a jurisdiction’s laws and regulations should be provided by a person qualified in that jurisdiction to provide such analyses and, in the case of statutory analysis, qualified to provide such legal interpretations, to ensure that the jurisdiction is providing an accurate description.

e. The NAIC does not intend to review confidential company-specific information in this process, and has focused the procedure on reviewing publicly available information. No confidential company-specific information shall be disclosed or disseminated during the course of the jurisdiction’s evaluation unless specifically requested, subject to appropriate confidentiality safeguards addressed in a preliminary confidentiality and information-sharing agreement. If no such agreement is executed or the jurisdiction is unable to enter into such an agreement under its regulatory authority, the NAIC will not accept any confidential company-specific information.

### 3. NAIC Review of Evaluation Materials

a. NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise will review the jurisdiction’s Evaluation Materials.

b. Expenses with respect to the evaluations will be absorbed within the NAIC budget. This will be periodically reviewed.

c. Timeline for review. A project management approach will be developed with respect to the overall timeline applicable to each evaluation.

d. Upon completing its review of the Evaluation Materials, the internal reviewer(s) will report initial findings to the Qualified Jurisdiction Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to FIO and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.

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\(^{1}\) The U.S. financial solvency framework is understood to refer to the key elements provided in the NAIC Financial Regulation Standards and Accreditation Program. Appendix A and Appendix B are derived from this framework.
4. Discretionary On-site Review

a. The NAIC may request or ask the jurisdiction under consideration for the opportunity to perform an on-site review of the jurisdiction’s reinsurance supervisory system. Factors that the Qualified Jurisdiction Working Group will consider in determining whether an on-site review is appropriate include the completeness of the information provided by the jurisdiction under review, the general familiarity of the jurisdiction by the NAIC staff or other state regulators participating in the review based on prior conduct or dealings with the jurisdiction, and the results of other evaluations performed by other regulatory or supervisory organizations. If the review is performed, it will be coordinated through the NAIC, utilizing personnel with the appropriate knowledge, experience and expertise. Individual states may also request that representatives from their state be added to the review team.

b. The review team will communicate with the supervisory authority in advance of the on-site visit to clearly identify the objectives, expectations and procedures with respect to the review, as well as any significant issues or concerns identified within the review of the Evaluation Materials. Information to be considered during the on-site review includes, but is not limited to, the following:
   i. Interviews with supervisory authority personnel.
   ii. Review of organizational and personnel practices.
   iii. Any additional information beneficial to gaining an understanding of document and communication flows.

c. Upon completing the on-site review, the reviewer(s) will report initial findings to the Qualified Jurisdiction Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation.

5. Standard of Review

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

6. Additional Information to be Considered as Part of Evaluation

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

a. Documents, reports and information from appropriate international, U.S. federal and U.S. state authorities.

b. Public comments from interested parties.

c. Rating agency information.

d. Any other relevant information.
7. Preliminary Evaluation Report

a. NAIC staff and/or outside consultants will prepare a Preliminary Evaluation Report for review by the Qualified Jurisdiction Working Group. This preliminary report will be private and confidential (i.e., may only be reviewed by Working Group members, designated NAIC staff, consultants, the states, the FIO and other relevant federal authorities that specifically request to be kept apprised of this information, provided that such entities have entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction. Any outside consultants retained by the NAIC will be required to enter into a confidentiality and nondisclosure agreement.).

b. The report will be prepared in a consistent style and format to be developed by NAIC staff. It will contain detailed advisory information and recommendations with respect to the evaluation of the jurisdiction’s reinsurance supervisory system and the documented practices and procedures thereunder. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a Qualified Jurisdiction.

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


a. The Qualified Jurisdiction Working Group’s review of the Preliminary Evaluation Report will be held in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings.

b. The Qualified Jurisdiction Working Group will make a preliminary determination as to whether the jurisdiction under consideration satisfies the Standard of Review and is deemed acceptable to be included on the NAIC List of Qualified Jurisdictions. If the preliminary determination is that the jurisdiction should not be included on the NAIC List of Qualified Jurisdictions, the Qualified Jurisdiction Working Group will set forth its specific findings and identify those areas of concern with respect to this determination.

c. The results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review.


a. Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. This is not intended to be a formal appeals process that would initiate U.S. state administrative due process requirements.

b. The Qualified Jurisdiction Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Qualified Jurisdiction Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings. This report will be approved upon an affirmative vote of a majority of the members in attendance at this meeting.
c. Upon approval of the Final Evaluation Report, the Qualified Jurisdiction Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the summary for public comment. The detailed report will be a confidential, regulator-only document. The report may be shared with any state indicating that it is considering relying on the NAIC List of Qualified Jurisdictions and has entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction.

10. NAIC Determination regarding List of Qualified Jurisdictions

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

b. In the event that a jurisdiction is not approved as a Qualified Jurisdiction, the supervisory authority will be eligible for reapplication at the discretion of the NAIC.

c. Upon final adoption of the Qualified Jurisdiction Working Group’s determination with respect to a jurisdiction, the Final Evaluation Report will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential.

11. Memorandum of Understanding (MOU)

a. A Qualified Jurisdiction must agree to share information and cooperate on a confidential basis with the U.S. state insurance regulatory authority with respect to all certified reinsurers domiciled within that jurisdiction.

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

d. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.

12. Process for Periodic Evaluation after Initial Approval

a. The process for determining whether a non-U.S. jurisdiction is a Qualified Jurisdiction is ongoing and subject to periodic review. The Qualified Jurisdiction Working Group will perform a yearly review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. This yearly review shall follow such abbreviated process as may be determined by the Qualified Jurisdiction Working Group to be appropriate.

b. Qualified Jurisdictions must provide the Qualified Jurisdiction Working Group with notice of any material change in the applicable reinsurance supervisory system that may affect the status of the Qualified Jurisdiction. A U.S. jurisdiction should also notify the Qualified Jurisdiction Working Group if it receives notice of any material change in the applicable reinsurance supervisory system, or any adverse developments with respect to enforcement of final U.S. judgments, that may affect the status of the Qualified Jurisdiction. Upon receipt of any such notice, the Qualified Jurisdiction Working Group will consider whether it is necessary to re-evaluate the status of the Qualified Jurisdiction.

e. Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate.

d-e. If the Qualified Jurisdiction Working Group finds the jurisdiction to be out of compliance at any time with the requirements to be a Qualified Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review, and the status as a Qualified Jurisdiction may be placed on probation, suspended or revoked.

e-d. The Qualified Jurisdiction Working Group will monitor those jurisdictions that have been approved as Qualified Jurisdictions by individual states, but are not included on the NAIC List of Qualified Jurisdictions.

13. Review of Qualified Jurisdictions as Reciprocal Jurisdictions

a. In undertaking the evaluation of a Qualified Jurisdiction as a Reciprocal Jurisdiction, the Qualified Jurisdiction Working Group shall utilize such processes and procedures as outlined in the immediately-preceding paragraphs 1 – 12 of Section III. Procedure for Evaluation of Non-U.S. Jurisdictions such as the Qualified Jurisdiction Working Group deems is appropriate. Specifically, the Qualified Jurisdiction Working Group will use processes and procedures outlined in paragraph 1 (Initiation of Evaluation of the Reinsurance Supervisory System of an Individual Jurisdiction), paragraph 3 (NAIC Review of Evaluation Materials), paragraph 7 (Preliminary Evaluation Report), paragraph 8 (Review of Preliminary Evaluation Report), paragraph 9 (Opportunity to Respond to Preliminary Evaluation Report), paragraph 10 (NAIC Determination regarding List of Qualified Jurisdictions), paragraph 11 (Memorandum of Understanding) and paragraph 12 (Process for Evaluation after Initial Approval), as modified for use with Reciprocal Jurisdictions.
b. A Qualified Jurisdiction may not be reviewed for inclusion on the NAIC List of Reciprocal Jurisdictions, unless it has undergone the Evaluation Methodology outlined in Section IV, and remains in good standing with the NAIC as a Qualified Jurisdiction. The Qualified Jurisdiction Working Group may, if it determines an extended review period to be appropriate after its initial approval of a new Qualified Jurisdiction, defer consideration of that jurisdiction as a possible Reciprocal Jurisdiction until there has been sufficient United States experience with that jurisdiction and its Certified Reinsurers that the Working Group believes it is appropriate to progress from collateral reduction to collateral elimination. Nothing in this process requires a finding that a Qualified Jurisdiction meets the standards for recognition as a Reciprocal Jurisdiction, and the Qualified Jurisdiction Working Group may base such recommendation on factors not specifically included in this process.

c. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the NAIC List of Reciprocal Jurisdictions. In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the NAIC List of Reciprocal Jurisdictions, the Qualified Jurisdiction Working Group shall undertake the following analysis in making its evaluation:

   i. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in that jurisdiction is received by United States ceding insurers;

   ii. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

   iii. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the Qualified Jurisdiction;

   iv. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State,
which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

v. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in Section 9C(2) and (3) of Model #786; i.e., must maintain minimum capital and surplus of no less than $250,000,000, and maintains on an ongoing basis the required minimum solvency or capital ratio, as applicable.

d. In order to satisfy the requirements of subsection (c) above, the chief insurance supervisor of the Qualified Jurisdiction being evaluated as a Reciprocal Jurisdiction may provide the NAIC with a written letter confirming, as follows:

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

- An insurer which has its head office or is domiciled in [Jurisdiction] shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in [Jurisdiction] is received by United States ceding insurers. [Jurisdiction] does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by [Jurisdiction] or as a condition to allow the ceding insurer to recognize credit for such reinsurance.

- [Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that insurance groups that are domiciled or maintain their worldwide headquarters in jurisdictions accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the [Jurisdiction].

- [Jurisdiction] confirms that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the [Jurisdiction].

- [Jurisdiction] will annually provide to the states confirmation that applicable assuming insurers domiciled in [Jurisdiction] maintain minimum capital and surplus of no less than $250,000,000, and maintain on an ongoing basis the required minimum solvency or capital ratio, as applicable.
Finally, I confirm that [Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

e. The Qualified Jurisdiction Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate, and will prepare for the review by the Reinsurance Task Force a Summary of Findings and Determination recommending that the Qualified Jurisdiction be recognized as a Reciprocal Jurisdiction. Upon approval by the Task Force, the Summary of Findings and Determination must be adopted by a vote of the NAIC Executive (EX) Committee and Plenary for inclusion on the List of Reciprocal Jurisdictions.

f. The Qualified Jurisdiction Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable equivalency assessment conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

g. Except for Reciprocal Jurisdictions entitled to automatic recognition, a jurisdiction’s status as a Reciprocal Jurisdiction may be placed on probation, suspended or revoked for good cause in the same manner as provided for Qualified Jurisdictions under paragraph 12. If cause is found to question the fitness of a Reciprocal Jurisdiction that is subject to an in-force covered agreement, or its compliance with applicable requirements of the covered agreement, the Qualified Jurisdiction Working Group would report any concerns to its parent Task Force for further discussion and communication with appropriate federal and/or international authorities.
IV. Evaluation Methodology

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

The Evaluation Methodology consists of the following:

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

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

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

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

1. Confirmation of the jurisdiction’s most recent FSAP Report, including relevant updates with respect to descriptions or elements of the FSAP Report in which changes have occurred since the assessment or where information might otherwise be outdated.

2. Confirmation of the jurisdiction’s ROSC, including relevant updates with respect to descriptions or elements of the ROSC in which changes have occurred since the report was completed or where information might otherwise be outdated.

3. If materials responsive to the topics under review have been provided in response to information exchanges between the jurisdiction under review and the NAIC, such prior responses may be cross-referenced provided updates are submitted, if required to address changes in laws or procedures.

4. Any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC’s evaluation process in order to address, on an outcomes basis, the key elements described within Appendix A.

The NAIC will review the information provided by the applicant jurisdiction and determine whether it is adequate to reasonably conclude whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. After reviewing the initial submission, the NAIC may request that the applicant jurisdiction

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2 The basic considerations under this section are derived from Model #786, Section 8C(2), which include: (a) the framework under which the assuming reinsurer is regulated; (b) the structure and authority of the jurisdiction’s reinsurance supervisory authority with regard to solvency regulation requirements and financial surveillance; (c) the substance of financial and operating standards for reinsurers domiciled in the jurisdiction; and (d) the form and substance of financial reports required to be filed or made publicly available by reinsurers domiciled in the jurisdiction and the accounting principles used.
submit supplemental information as necessary in order to make this determination. An applicant jurisdiction is strongly encouraged to provide thorough, detailed and current information in its initial submission in order to minimize the number and extent of supplemental information requests from the NAIC with respect to Section A of this Evaluation Methodology. The NAIC will provide a complete description in the Final Evaluation Report of the information provided in the Evaluation Materials, and any updates or other information that have been provided by the applicant jurisdiction.

Section B: Regulatory Practices and Procedures

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

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

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

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

Section D: Regulatory Cooperation and Information-Sharing

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

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

a. Number of reinsurers domiciled in the jurisdiction, and a list of any reinsurers domiciled in the jurisdiction that have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, of no less than $250,000,000.

b. Up to a 10-year history of any regulatory actions taken against specific reinsurers.

c. Up to a 10-year history listing any reinsurers that have gone through insolvency proceedings, including the size of each insolvency and a description of the related outcomes (e.g., reinsurer rehabilitated or liquidated, payout percentage of claims to priority classes, payout percentage of claims to domestic and foreign claimants).

d. Up to a 10-year history of any significant industry-wide fluctuations in capital or profitability with respect to domestic reinsurers.

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

Section F: Enforcement of Final U.S. Judgments

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

Section G: Solvent Schemes of Arrangement

The jurisdiction is requested to provide a description of any legal framework that allows reinsurers domiciled in the jurisdiction to propose or participate in any solvent scheme of arrangement or similar procedure. In addition, the jurisdiction is requested to provide a description of any solvent scheme of arrangement or similar procedure that a domestic reinsurer has proposed or participated in and the outcome of such procedure.
V. Appendices: Specific Guidance with Respect to Section A and Section B

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

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

1. Examination Authority

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

a. Frequency and timing of examinations and reports.

b. Guidelines for examination.

c. Whether the jurisdiction has the authority to examine reinsurers whenever it is deemed necessary.

d. Whether the jurisdiction has the authority to have complete access to the reinsurer’s books and records and, if necessary, the records of any affiliated company.

e. Whether the jurisdiction has the authority to examine officers, employees and agents of the reinsurer when necessary with respect to transactions directly or indirectly related to the reinsurer under examination.

f. Whether the jurisdiction has the authority to share confidential information with U.S. state insurance regulatory authorities, provided that the recipients are required, under their law, to maintain its confidentiality.

2. Capital and Surplus Requirement

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

a. Whether the jurisdiction has the authority to require reinsurers to maintain minimum capital and surplus, including a description of such minimum amounts.

b. Whether the jurisdiction has the authority to require additional capital and surplus based on the type, volume and nature of reinsurance business transacted.

c. Capital requirements for reinsurers, including reports and a description of any specific levels of regulatory intervention.

3. Accounting Practices and Procedures

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

a. Description of the accounting and reporting practices and procedures.

b. Description of any standard financial statement blank/reporting template, including description of content/disclosure requirements and corresponding instructions.

4. Corrective Action

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

a. Identification of specific standards which may be considered to determine whether the continued operation of the reinsurer might be hazardous to the general public.

b. Whether the jurisdiction has the authority to issue an order requiring the reinsurer to take corrective action when it has been determined to be in hazardous financial condition.
5. Regulation and Valuation of Investments

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

a. Whether the jurisdiction has the authority to require a diversified investment portfolio for all domestic reinsurers as to type, issue and liquidity.

b. Whether the jurisdiction has the authority to establish acceptable practices and procedures under which investments owned by reinsurers must be valued, including standards under which reinsurers are required to value securities/investments.

6. Holding Company Systems

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

a. Whether the jurisdiction has access to information via the parent or other regulated group entities about activities or transactions within the group involving other regulated or non-regulated entities that could have a material impact on the operations of the reinsurer.

b. Whether the jurisdiction has access to consolidated financial information of a reinsurer’s ultimate controlling person.

c. Whether the jurisdiction has the authority to review integrity and competency of management.

d. Whether the jurisdiction has approval and intervention powers for material transactions and events involving reinsurers.

e. Whether the jurisdiction has authority to monitor, or has prior approval authority over:

   i. Change in control of domestic reinsurers.

   ii. Dividends and other distributions to shareholders of the reinsurer.

   iii. Material transactions with affiliates.

7. Risk Management

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

a. Whether the jurisdiction has Own Risk and Solvency Assessment (ORSA) requirements and reporting.

b. Any requirements regarding the maximum net amount of risk to be retained by a reinsurer for an individual risk based on the reinsurer’s capital and surplus.

c. Whether the jurisdiction has authority to monitor enterprise risk, including any activity, circumstance, event (or series of events) involving one or more affiliates of a reinsurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the reinsurer or its insurance holding company system as a whole.

d. Whether the jurisdiction has corporate governance requirements for reinsurers.
8. **Liabilities and Reserves**

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

a. Liabilities incurred under reinsurance contracts for policy reserves, unearned premium, claims and losses unpaid, and incurred but not reported (IBNR) claims (including whether discounting is allowed for reserve calculation/reporting).

b. Liabilities related to catastrophic occurrences.

c. Whether the jurisdiction requires an opinion on reserves and loss and loss adjustment expense reserves by a qualified actuary or specialist for all domestic reinsurers, and the frequency of such reports.

9. **Reinsurance Ceded**

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

a. Credit for reinsurance requirements applicable to reinsurance retroceded to domestic and non-domestic reinsurers.

b. Collateral requirements applicable to reinsurance contracts.

c. Whether the jurisdiction requires a reinsurance agreement to provide for insurance risk transfer (i.e., transfer of both underwriting and timing risk).

d. Requirements applicable to special purpose reinsurance vehicles and insurance securitizations.

e. Affiliated reinsurance transactions and concentration risk.

f. Disclosure requirements specific to reinsurance transactions, agreements and counterparties, if such information is not provided under another item.

10. **Independent Audits**

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

a. Requirements for the filing of audited financial statements prepared in conformity with accounting practices prescribed or permitted by the supervisory authority.

b. Contents of annual audited financial reports.

c. Requirements for selection of auditor.

d. Allowance of audited consolidated or combined financial statements.

e. Notification of material misstatements of financial condition.

f. Supervisor’s access to auditor’s workpapers.

g. Audit committee requirements.

h. Requirements for reporting of internal control-related matters.

11. **Receivership**

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

12. Filings with Supervisory Authority

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

a. The use of standardized financial reporting in the financial statements, and the frequency of relevant updates.

b. The use of supplemental data to address concerns with specific companies or issues.

c. Filing format (e.g., electronic data capture).

d. The extent to which financial reports and information are public records.

13. Reinsurance Intermediaries

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

14. Other Regulatory Requirements with respect to Reinsurers

Any other information necessary to adequately describe the effectiveness of the jurisdiction’s laws and regulations with respect to its reinsurance supervisory system.
Appendix B: Regulatory Practices and Procedures

1. Financial Analysis

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

a. Qualified Staff and Resources
   The resources employed to effectively review the financial condition of all domestic reinsurers, including a description of the educational and experience requirements for staff responsible for financial analysis.

b. Communication of Relevant Information to/from Financial Analysis Staff
   The process under which relevant information and data received by the supervisory authority are provided to the financial analysis staff and the process under which the findings of the financial analysis staff are communicated to the appropriate person(s).

c. Supervisory Review
   How the jurisdiction’s internal financial analysis process provides for supervisory review and comment.

d. Priority-Based Analysis
   How the jurisdiction’s financial analysis procedures are prioritized in order to ensure that potential problem reinsurers are reviewed promptly.

e. Depth of Review
   How the jurisdiction’s financial analysis procedures ensure that domestic reinsurers receive an appropriate level or depth of review commensurate with their financial strength and position.

f. Analysis Procedures
   How the jurisdiction has documented its financial analysis procedures and/or guidelines to provide for consistency and continuity in the process and to ensure that appropriate analysis procedures are being performed on each domestic reinsurer.

g. Reporting of Material Adverse Findings
   The process for reporting material adverse indications, including the determination and implementation of appropriate regulatory action.

h. Early Warning System/Stress Testing
   Whether the jurisdiction has an early warning system and/or stress testing methodology that is utilized with respect to its domestic reinsurers.
2. **Financial Examinations**

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

a. **Qualified Staff and Resources**
   The resources employed to effectively examine all domestic reinsurers. This should include whether the jurisdiction prioritizes examination scheduling and resource allocation commensurate with the financial strength and position of each reinsurer, and a description of the educational and experience requirements for staff responsible for financial examinations.

b. **Communication of Relevant Information to/from Examination Staff**
   The process under which relevant information and data received by the supervisory authority are provided to the examination staff and the process under which the findings of the examination staff are communicated to the appropriate person(s).

c. **Use of Specialists**
   Whether the supervisory authority’s examination staff includes specialists with appropriate training and/or experience or whether the supervisory authority otherwise has available qualified specialists that will permit the supervisory authority to effectively examine any reinsurer.

d. **Supervisory Review**
   Whether the supervisory authority’s procedures for examinations provide for supervisory review.

e. **Examination Guidelines and Procedures**
   Description of the policies and procedures the supervisory authority employs for the conduct of examinations, including whether variations in methods and scope are commensurate with the financial strength and position of the reinsurer.

f. **Risk-Focused Examinations**
   Does the supervisory authority perform and document risk-focused examinations and, if so, what guidance is utilized in conducting the examinations? Are variations in method and scope commensurate with the financial strength and position of the reinsurer?

g. **Scheduling of Examinations**
   Whether the supervisory authority’s procedures provide for the periodic examination of all domestic reinsurers, including how the system prioritizes reinsurers that exhibit adverse financial trends or otherwise demonstrate a need for examination.

h. **Examination Reports**
   Description of the format in which the supervisory authority’s reports of examinations are prepared, and how the reports are shared with other jurisdictions under information-sharing agreements.

i. **Action on Material Adverse Findings**
   What are the jurisdiction’s procedures regarding supervisory action in response to the reporting of any material adverse findings.
3. **Information Sharing**

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

4. **Procedures for Troubled Reinsurers**

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

5. **Organization, Licensing and Change of Control of Reinsurers**

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

   a. **Licensing Procedure**
      Whether the supervisory authority has documented licensing procedures that include a review and/or analysis of key pieces of information included in a primary licensure application.

   b. **Staff and Resources**
      The educational and experience requirements for staff responsible for evaluating company licensing.

   c. **Change in Control of a Domestic Reinsurer**
      Procedures for the review of key pieces of information included in filings with respect to a change in control of a domestic reinsurer.
ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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Blanks (E) Working Group Agenda Item Submission Form 2019-18BWG Modified;
Effective Annual 2020; Add NAIC Designation Modifier to NAIC Designation Column
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For Note 33, Modify the Illustration to Disclosure Individually Separate Account with
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Blanks (E) Working Group Agenda Item Submission Form 2019-22BWG; Effective Annual 2020;
Add a Question Regarding the Executive Summary of the PBR Actuarial Opinion to the
Supplemental Exhibits and Schedules Interrogatories (Attachment Two-D) ........................................................................................10-458
Blanks (E) Working Group Agenda Item Submission Form 2019-23BWG Modified; Effective
1st Quarter 2020; Modify the Instructions and Illustration for Note 8 – Derivatives for Disclosures
Adopted by SSAP No. 108—Derivative Hedging Variable Annuity Guarantees. Add Instruction
and a Blank Page for Schedule DB, Part E, to the Quarterly Statement (Attachment Two-E) .................................................................10-460
Blanks (E) Working Group Agenda Item Submission Form 2019-24BWG; Effective 1st Quarter 2020;
Add a Life Experience Data Contact to the Electronic Jurat Page for Life/Fraternl Companies
Only. Health, Property and Title are Included in the Proposal Due to the Jurat Instructions Being
Uniform for All Statement Types (Attachment Two-F) ................................................................................................................10-467
Blanks (E) Working Group Editorial Revisions to the Blanks and Instructions Presented at the Oct. 22, 2019, Meeting (Attachment Two-G) ........................................................................................................... 10-469
Blanks (E) Working Group Agenda Item Submission Form 2019-20BWG Modified; Effective Annual 2019; Add “Qualification Documentation” to Require the Appointed Actuary to Maintain Workpapers Explaining How the Actuary Meets the Definition of a “Qualified Actuary.” Add a New Objective Definition of “Qualified Actuary” and the Results of an Assessment of Actuarial Educational Syllabi in an “NAIC-Accepted Actuarial Designation” Section (Attachment Three-A) ........................................................................................................... 10-483
The Accounting Practices and Procedures (E) Task Force met in Austin, TX, Dec. 8, 2019. The following Task Force members participated: Kent Sullivan, Chair, represented by Jamie Walker (TX); Jeff Rude, Vice Chair, represented by Linda Johnson (WY); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridding represented by Sheila Travis (AL); Allen W. Kerr represented by Mel Anderson (AR); Andrew N. Mais represented by William Afantis and Kathy Belfi (CT); Stephen C. Taylor represented by N. Kevin Brown (DC); Trinidad Navarro represented by Ryllyn Brown (DE); David Altmaier represented by Virginia Christy (FL); Dafne M. Shimizu represented by Alice Sebastian-Cruz (GU); Colin M. Hayashida represented by Andrew Kurata (HI); Doug Ommen represented by Carrie Mears (IA); Dean L. Cameron represented by Nathan Faragher (ID); Stephen W. Robertson represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Nancy G. Atkins represented by Sandy Batts (KY); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by James A. McCarthy (MA); Eric A. Cioppa represented by Vanessa Sullivan (ME); Anita G. Fox represented by Judy Weaver (MI); Steve Kelley represented by Kathleen Orth (MN); Chloria Lindley-Myers represented by John Rehagen (MO); Mike Chaney represented by David Browning (MS); Mike Causey represented by Jackie Obusek (NC); Jon Godfred represented by Matt Fischer (ND); Bruce R. Ramge represented by Justin Shadrer and Lindsay Crawford (NE); Marlene Caride represented by Diana Sherman (NJ); John G. Franchini represented by Lea Geckler (NM); Jillian Froment represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowberger (OK); Jessica Altman represented by Kimberly Rankin (PA); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Larry Deiter represented by Johanna Nickelson (SD); Hodgen Mainda represented by Trey Hancock (TN); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Doug Stolte and Dave Smith (VA); Michael S. Piecik represented by Karen Ducharme (VT); Mike Kreidler represented by Patrick McNaughton (WA); Mark Afable represented by Amy Malm (WI); and James A. Dodrill represented by Justin Parr (WV).

1. Adopted its Minutes

Ms. Walker directed the Task Force to its Aug. 22 and Summer National Meeting minutes, which were previously distributed.

Mr. Phifer made a motion, seconded by Mr. Bruggeman, to adopt the Task Force’s Aug. 22 minutes (Attachment Three) and its Aug. 4 minutes (see NAIC Proceedings – Summer 2019, Accounting Practices and Procedures (E) Task Force). The motion passed unanimously.


Mr. Bruggeman provided the Dec. 7 report of the Statutory Accounting Principles (E) Working Group. Mr. Bruggeman stated that the Working Group adopted its Sept. 9 and Summer National Meeting minutes.

Mr. Bruggeman stated that the Working Group adopted the following nonsubstantive revisions to statutory accounting guidance:

a. Revisions to Statement of Statutory Accounting Principles (SSAP) No. 61R—Life, Deposit-Type and Accident and Health Reinsurance adopt: 1) SSAP No. 61R disclosures with an effective date of Dec. 31, 2020; 2) A-791 Question and Answer (Q&A) updates regarding contracts with medical loss ratios (MLRs); and 3) updates to the 2c. Q&A regarding risk transfer and group term life yearly renewable term (YRT) reinsurance with an effective date of Jan. 1, 2021. The proposed revisions to the A-791 Q&A regarding the scope of nonproportional contracts subject to Appendix A-791 were referred to the informal Life and Health Reinsurance Drafting Group to address application questions. The Working Group directed notification to the Life Actuarial (A) Task Force.

b. Revisions to SSAP No. 68—Business Combinations and Goodwill clarify that goodwill resulting from the acquisition of a subsidiary, controlled or affiliated (SCA) entity by an insurance reporting entity that is reported on the SCA financial statements (resulting from the application of pushdown) is subject to the 10% admittance limit based on the acquiring entity’s capital and surplus. The remainder of the agenda item was re-exposed to consider comments received on pushdown accounting and receive specific examples from interested parties.

c. Revisions clarify the recognition and measurement guidance for derivatives that do not qualify as hedging, income generation or replication transactions.
d. Revisions clarify that nonadmittance is required when there is an unalleviated substantial doubt about an SCA’s ability to continue as a going concern identified in any part of the audit report, accompanying financial statements or notes to the financial statements.

e. Revisions clarify that only wash sales that cross reporting period-end dates are subject to the wash sale disclosure.

f. Revisions clarify what should be captured in Supplemental Investment Risk Interrogatory Line 13: 10 Largest Equity Interests, noting that a look-through should only occur for non-diversified funds. The Working Group directed a Blanks (E) Working Group proposal for 2020 year-end application.

g. Revisions to Appendix A-785, Credit for Reinsurance adopted to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) related to the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement).

h. Revisions reject the following Accounting Standards Updates (ASUs):

1. ASU 2019-03, Updating the Definition of Collections
2. ASU 2019-31, Clarifying the Scope and Accounting Guidance for Contributions Received and Contributions Made
3. ASU 2019-05, Targeted Transition Relief.
4. ASU 2019-06, Extending the Private Company Accounting Alternatives on Goodwill and Certain Identifiable Intangible Assets to Not-for-Profit Entities

Mr. Bruggeman stated that the Working Group adopted the following editorial revisions to:

a. SSAP No. 62R—Property and Casualty Reinsurance: Revisions clarify wording in an existing disclosure.

b. SSAP No. 86—Derivatives: Revisions reference the definition of a structured note in SSAP No. 26R—Bonds.

c. SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities: Revisions add two new suffixes for Securities Valuation Office (SVO) filings that have been carried over from the prior year.

Mr. Bruggeman stated that the Working Group exposed a revised issue paper and a draft substantively revised SSAP No. 32—Preferred Stock as part of the Investment Classification Project to revise the definitions, measurement guidance and impairment guidance for preferred stock. He stated that SSAP No. 105—Working Capital Finance Investments was also to incorporate industry revisions to program requirements, as directed by the Working Group during the Summer National Meeting. The Working Group directed NAIC staff to draft an issue paper related to the SSAP No. 105 revisions.

Mr. Bruggeman stated that the Working Group exposed the following nonsubstantive revisions to statutory accounting guidance:

a. Revisions specify that cash pooling structures that meet specified criteria qualify as cash equivalents.

b. Revisions incorporate additional principle concepts in classifying investments as cash equivalents or short-term investments to prevent the “rolling” of certain investments. Revisions exclude qualifying cash pools from the short-term rolling provisions.


d. Revisions reject ASU 2017-11, Accounting for Certain Financial Instruments with Down Round Features; Replacement of the Indefinite Deferral for Mandatorily Redeemable Financial Instruments of Certain Noncontrolling Interests with a Scope Exception and incorporate guidance for when certain freestanding instruments shall be recognized as liabilities, not equity.
e. Revisions expand guidance regarding financial guarantees and the use of the equity method for when losses exceed the equity value. With the revisions, the equity value of an SCA would not go negative, and guarantee liabilities would be reported to the extent that there is a financial guarantee or commitment. The “Illustration of the Application of INT 00-24” will be inserted into SSAP No. 97 as Exhibit F.

f. Revisions data-capture existing related party and affiliate disclosures currently completed in a narrative format.

g. Revisions clarify the types of entities that are included as related parties, that a non-controlling ownership interest greater than 10% is a related party and subject to the related party disclosures, the guidance for disclaimers of affiliation and control for statutory accounting; reject seven ASUs for statutory accounting and directed notification to the Group Solvency Issues (E) Working Group. The exposure includes an intent to dispose agenda item 2011-16, a historical item, drafted to consider the definition in SSAP No. 25—Affiliates and Other Related Parties.

h. Revisions provide enhanced surplus notes disclosures to identify when an issued surplus note’s anticipated or typical cash flows have been partially or fully offset by a held asset.

i. Revisions eliminate the multi-step financial modeling designation guidance in determining final NAIC designations for residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS). The Working Group noted action would be coordinated with the Valuation of Securities (E) Task Force.

j. Revisions include footnote excerpts in the reporting exhibits to aggregate deposit-type contracts captured in Exhibit 5 – Life Contracts and an inquiry as to whether a similar footnote would be beneficial for Exhibit 6 – Accident and Health Contracts. Additionally, feedback regarding instruction clarifications for Exhibit 7 – Deposit-Type Contracts has been requested. With exposure, directed notification to the Financial Stability (EX) Task Force.

k. Revisions propose minor edits to the liquidity disclosures regarding withdrawal characteristics for life and deposit-type contracts to match noted reporting clarifications.

l. Revisions expand managing general agent and third-party administrator disclosures.

m. Revisions incorporate interested parties’ recommendations to separate the guidance by product type and emphasize guidance that loss and loss adjusting expense liabilities are established regardless of payments to third parties (except for capitated health claim payments). The revisions emphasize existing guidance that claims and related adjusting liabilities are not recognized as paid until the losses are paid to claimants or claims are adjusted.

n. Revisions incorporate disclosure updates for reinsurers from reciprocal jurisdictions.

o. Comments are requested on the preferred approaches for reporting retroactive contracts that meet the exception for prospective accounting and the disadvantages to approaches being used. Industry and state insurance regulator volunteers are requested to assist with developing this guidance. The Working Group directed notification to the Casualty Actuarial and Statistical (C) Task Force and the Property and Casualty Risk-Based Capital (E) Working Group will be notified of the exposure.

p. Revisions include additional NAIC staff modifications regarding persistency commission and levelized commission arrangements to address certain comments received to allow for further discussion. With exposure, directed a referral to the Life Actuarial (A) Task Force.

q. Revisions clarify the reporting of derivatives with financing premiums and requested comments as to whether guidance allowing offset should be considered derivatives and related financing provisions that would not meet the SSAP No. 64—Offsetting and Netting of Assets and Liabilities right of offset criteria.

r. Revisions clarify that the fair value of collateral received or held for derivative disclosure purposes shall be reported net of collateral paid/pledged if a counterparty has the legal right to offset.
s. Revisions clarify that the “assignment” of goodwill is a disclosure element. The Working Group also directed revisions to the Sub-1 Acquisition Overview filing template to capture this information for new SCA acquisitions.

t. Revisions clarify that a look-through of a more than one holding company structure is permitted if each of the holding companies within the structure complies with the requirements in SSAP No. 97.


v. Revisions reject ASU 2016-14, Presentation of Financial Statements of Not-for-Profit Entities.

w. Exposed the following editorial revisions to statutory accounting:

   1. Update references in Exhibit A – Implementation Questions and Answers, which provides a retroactive reinsurance illustration and update, and paragraph 85 to match the current format of property/casualty (P/C) annual statement Schedule F – Reinsurance.

   2. Revise references to the annual statement instructions for consistency and combine the life and fraternal references.

Mr. Bruggeman noted that the Working Group received an update on the following projects and referrals:

a. The Working Group has scheduled a conference call on Jan. 8, 2020, to discuss comments received on Ref #2019-21: SSAP No. 43R – Equity Interests.

b. NAIC staff are in the process of collecting information from a data call on “linked” surplus notes, with responses requested by Dec. 31, 2019.

c. Received an update that the Financial Accounting Standards Board (FASB) delayed implementation of ASU 2016-13: Credit Losses until 2023 for everyone except large U.S. Securities and Exchange Commission (SEC) filers, which are required to follow the ASU in 2020.


e. Received an update on current U.S. generally accepted accounting principles (GAAP) exposures, noting that no comments by the Working Group are planned.

f. Received information from the industry on recent FASB discussions. NAIC staff are closely monitoring the expected Reference Rate Reform FASB project and will review the update upon issuance.

Mr. Bruggeman stated that the comment deadline for new and exposed items is Jan. 31, 2020, except for the editorial agenda item (Ref #2019-44EP), which has a Dec. 20, 2019, comment deadline.

Mr. Bruggeman made a motion, seconded by Ms. Obusek, to adopt the report of the Statutory Accounting Principles (E) Working Group (Attachment One). The motion passed unanimously.


Mr. Garn provided the report of the Blanks (E) Working Group, which met via conference call Oct. 22 and took the following action:

a. Adopted its Sept. 5 and Aug. 22 minutes, which included:

   1. An e-vote for exposure of blanks proposal 2019-24BWG. The proposal adds a life experience data contact to the electronic Jurat page for life/fraternal company filers only to allow NAIC staff and state insurance regulators to locate a contact person more easily from each legal entity life insurance company to facilitate communication regarding data studies and submissions to the NAIC.
b. Adopted four blanks proposals:

1. 2019-21BWG – Modify the illustrations for Note 33 to disclose individually the separate account with guarantees products and separate account nonguaranteed products.

2. 2019-22BWG – Add a question regarding the Executive Summary of the principle-based reserving (PBR) actuarial opinion to the Supplemental Exhibits and Schedules Interrogatories.


c. Exposed its revised procedures.

d. Exposed three proposals for a public comment period ending Nov. 22.

e. Adopted the editorial listing.

f. Approved the State Filing Checklist templates.

g. Approved the posting of clarifying 2019 filing guidance for the Life Analysis of Operations by Lines of Business.

Mr. Garn made a motion, seconded by Mr. Eft, to adopt the report of the Blanks (E) Working Group (Attachment Two). The motion passed unanimously.

Having no further business, the Accounting Practices and Procedures (E) Task Force adjourned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met in Austin, TX, Dec. 7, 2019. The following Working Group members participated: Dale Bruggeman, Chair (OH); Jim Armstrong, Vice Chair, and Carrier Mears (IA); Sheila Travis (AL); Kathy Belfi and William Arfanis (CT); Ryllynn Brown (DE); Eric Moser and Cindy Andersen (IL); Stewart Guerin (LA); Judy A. Weaver (MI); Doug Bartlett (NH); Tom Dudek (NY); Joe DiMemmo and Kimberly Rankin (PA); Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. **Adopted its Sept. 9 and Summer National Meeting Minutes**

The Working Group met Sept. 9 to consider draft statutory accounting guidance for insurance and reinsurance operations reported within segregated accounts.

Ms. Walker made a motion, seconded by Ms. Malm, to adopt the Working Group’s Sept. 9 (Attachment One-A) and Aug. 3 (see NAIC Proceedings – Summer 2019, Accounting Practices and Procedures (E) Task Force, Attachment One) minutes. The motion passed unanimously.

2. **Adopted Non-Contested Statutory Accounting Revisions During its Public Hearing**

The Working Group held a public hearing to review comments (Attachment One-B) on previously exposed items.

Ms. Malm made a motion, seconded by Mr. Bartlett, to adopt the statutory accounting revisions detailed below as non-contested statutory accounting revisions. The motion passed unanimously.

a. **Agenda Item 2019-19**

Mr. Bruggeman directed the Working Group to agenda item 2019-19: SIRI – Equity Interests. Julie Gann (NAIC) stated that during the Summer National Meeting, the Working Group exposed revisions to clarify what should be captured in the Supplemental Investment Risk Interrogatory (SIRI) Line 13: Largest Equity Interests. With the exposed revisions, a look-through to the underlying investments shall occur for non-diversified funds. However, underlying investments in diversified funds would not need to be individually assessed and aggregated in determining the top 10 largest equity interests. Ms. Gann stated that if an individual equity fund (diversified or non-diversified) was one of the top 10 largest equity interests, the fund shall be reported in the top 10 listing. Ms. Gann stated no comments were received and no statutory accounting revisions would be required, but the Working Group will sponsor a blanks proposal to update Annual Statement Instructions for year-end 2020. (Attachment One-C)

b. **Agenda Item 2019-22**

Mr. Bruggeman directed the Working Group to agenda item 2019-22: Wash Sales Disclosures. Jake Stultz (NAIC) stated that this nonsubstantive agenda item clarified wash sale disclosures would only be required when applicable transactions took place over quarterly or year-end reporting periods. Wash sales occurring within a reporting period do not need to be reported. Mr. Stultz stated that interested parties were supportive of the proposal. (Attachment One-D)

c. **Agenda Item 2019-23**

Mr. Bruggeman directed the Working Group to agenda item 2019-23: Going Concern. Mr. Stultz stated this nonsubstantive agenda item expands language to clarify that if an unalleviated going concern is noted in any location within an audit opinion or in the financial statements, an investment in a subsidiary, controlled and affiliated (SCA) entity shall be nonadmitted. No comments were received. (Attachment One-E)
d. Agenda Item 2019-26

Mr. Bruggeman directed the Working Group to agenda item 2019-26: A-785 Covered Agreements. Mr. Stultz stated that this nonsubstantive agenda item adopts language to incorporate covered agreements into Appendix A-785. Interested parties noted one paragraph reference edit was required. Mr. Stultz recommended adoption with the editorial change as requested by interested parties. (Attachment One-F)

e. Agenda Item 2019-27EP

Mr. Bruggeman directed the Working Group to agenda item 2019-27EP: Editorial Updates. Mr. Stultz stated this nonsubstantive agenda item covered three editorial revisions exposed from the Summer National Meeting and that no comments were received. (Attachment One-G)

f. Agenda Item 2019-28

Mr. Bruggeman directed the Working Group to agenda item 2019-28: Accounting Standards Update (ASU) 2019-05, Targeted Transition Relief. Jim Pinegar (NAIC) stated this nonsubstantive agenda item provides an alternative accounting treatment for certain financial assets previously held at amortized cost. He advised the ASU was proposed for rejection as it allows alternative measurements methods, which are not permitted in the applicable investment Statements of Statutory Accounting Principles (SSAPs). Interested parties’ comments supported the proposed action. (Attachment One-H)

g. Agenda Item 2019-29

Mr. Bruggeman directed the Working Group to agenda item 2019-29: ASU 2019-06, Extending the Private Company Accounting Alternatives on Goodwill and Certain Identifiable Intangible Assets to Not-for-Profit Entities. Mr. Pinegar stated that this ASU extends goodwill alternatives currently allowed for private companies to not-for-profit entities, in that either an impairment only or amortization method is permitted. This nonsubstantive agenda item proposes to reject the ASU as it allows optionality in goodwill accounting. Interested parties’ comments supported the proposed revisions. (Attachment One-I)

3. Adopted Revisions to Reject U.S. GAAP as Not Applicable to Statutory Accounting

Ms. Walker made a motion, seconded by Mr. Dudek, to revise Appendix D—Nonapplicable GAAP Pronouncements to reject the following U.S. generally accepted accounting principles (GAAP) ASUs as not applicable. The motion passed unanimously.

- ASU 2019-03, Updating the Definitions of Collections (Agenda Item 2019-30 – Attachment One-J)
- ASU 2018-08, Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made. (Agenda Item 2019-31 – Attachment One-K)

4. Reviewed Comments and Considered Action on Exposed Items with Minimal Discussion

The Working Group held a public hearing to review comments (Attachment One-B) on previously exposed items.

a. Agenda Item 2018-26

Mr. Bruggeman directed the Working Group to agenda item 2018-26: SCA Loss Tracking – Accounting Guidance. Ms. Gann stated that during the Summer National Meeting, the Working Group exposed nonsubstantive revisions to update the existing financial reporting requirements when a reporting entity has a negative equity value in an SCA investment and the reporting entity has provided a financial guarantee or commitment. She stated that with the last exposure, the SCA investment would be reported at zero on the investment schedule, and the financial guarantee or commitment would be recognized as a liability pursuant to SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets. Ms. Gann stated that NAIC staff support the comments received and believe the Working Group could consider adoption of the guidance, as revised by the interested parties’ comments. However, she stated that since the change would result in a distinct change from current reporting guidance and it is close to year-end, NAIC staff were recommending exposure of the proposed guidance to ensure adequate time to review the revisions and incorporate system changes. Additionally, she noted that the intent was to incorporate a new exhibit into SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities to pull in guidance from an existing statutory accounting
Ms. Walker made a motion, seconded by Ms. Mears, to expose the nonsubstantive revisions to SSAP No. 5R and SSAP No. 97 to revise the reporting guidance for SCAs that have a negative equity value when there is a reporting entity financial guarantee or commitment, as modified from the interested parties’ comments, along with the proposed SSAP No. 97, Exhibit F, for a public comment period. The motion passed unanimously.

b. **Agenda Item 2019-04**

Mr. Bruggeman directed the Working Group to agenda item 2019-04: SSAP No. 32 – Investment Classification Project. Ms. Gann stated that during the Summer National Meeting, the Working Group exposed an issue paper to revise the definitions, measurement and impairment guidance for SSAP No. 32—Preferred Stock, pursuant to the investment classification project. She stated that most of the comments received had been reflected in a revised issue paper, with the key exception proposed modifications from the U.S. GAAP definitions for redeemable and perpetual preferred stock. Although NAIC staff agree that some aspects of the definitions primarily reflect the perspective of the issuer (e.g., whether redemption is within control of the issuer), these characteristics should be considered by the holder in properly classifying preferred stock as redeemable or perpetual. She stated that NAIC staff support retaining consistency between U.S. GAAP and statutory accounting principle (SAP) definitions.

Resh Reese (Teachers Insurance and Annuity Association of America—TIAA), representing interested parties, stated support for the consideration of submitted comments and will review the revised issue paper and draft SSAP during the exposure period.

Ms. Brown made a motion, seconded by Mr. Bartlett, to expose the revised issue paper and substantively revised SSAP No. 32 for a public comment period. The motion passed unanimously.

c. **Agenda Item 2019-08**

Mr. Bruggeman directed the Working Group to agenda item 2019-08: Reporting Deposit Type Contracts. Ms. Gann stated that this nonsubstantive agenda item originated to gather information on deposit-type contracts that were being reported in the annual statement exhibits as life (Exhibit 5) or accident and health (A&H) (Exhibit 6) contracts. She stated that the long-standing practice is to classify and report contracts at policy inception. As a significant redesign of classifying insurance contracts is not supported, a footnote excerpt is proposed to detail amounts reported as life contracts that no longer have an associated mortality or morbidity risk. The exposure proposes the footnote for exhibit 5 and requests feedback if a similar footnote is needed for Exhibit 6. Finally, state insurance regulator and industry feedback is requested regarding the Annual Statement Instructions for classifying deposit-type contracts in Exhibit 7.

Mr. Bruggeman stated NAIC staff conferred with the Financial Stability (EX) Task Force staff to ensure the proposal would address the current concerns on aggregating contracts without mortality or morbidity risks for liquidity analysis. He also stated that in response to interested party comments, the intent of collecting this information was to identify the amount based on risk type. This is different from the degree of risk as referenced in the interested parties’ comments. John Bauer (Prudential), representing interested parties, stated agreement with the suggested recommendation and noted that interested parties will provide additional information as requested with the proposed exposure.

Ms. Walker made a motion, seconded by Ms. Weaver, to expose the nonsubstantive agenda item with the proposed footnote to Exhibit 5 and the inquiries for additional information regarding Exhibit 6 and Exhibit 7 for a public comment period. The motion passed unanimously. The Working Group directed NAIC staff to notify the Financial Stability (EX) Task Force of the exposure.

d. **Agenda Item 2019-18**

Mr. Bruggeman directed the Working Group to agenda item 2019-18: Other Derivatives. Ms. Gann stated that this nonsubstantive agenda item was re-exposed at the Summer National meeting in response to interested parties’ comments requesting more time to evaluate investments to determine if there would be unintended consequences with the proposed
accounting guidance. She stated that the proposed revisions clarify the accounting guidance in SSAP No. 86 — Derivatives when a derivative is not part of a hedging, an income generation or an asset replication transaction. Ms. Gann stated that the exposed revisions clarify that other derivatives shall be reported at fair value and nonadmitted. Ms. Gann stated that the nonadmitted classification is consistent with the current guidance applicable pursuant to SSAP No. 4 — Assets and Nonadmitted Assets, as other derivatives are not currently identified as admitted assets. As the exposed language is a clarification of existing guidance, adoption for year-end 2019 was recommended.

Mr. Bruggeman stated statutory accounting guidance does not override state investment code and does not preclude a permitted or prescribed practice. Joshua Bean (Transamerica), representing the American Council of Life Insurers (ACLI), stated that in conjunction with the North American Securities Valuation Association (NASVA), the ACLI has submitted a comment letter to the Capital Adequacy (E) Task Force in response to the referral sent from the Working Group to the Task Force pertaining to this item. He advised that their comment letter requested that risk-based capital (RBC) charges not be imposed on structured notes reported as other derivatives and nonadmitted.

Ms. Brown made a motion, seconded by Ms. Mears, to adopt the exposed nonsubstantive revisions to SSAP No. 86 (Attachment One-L) for a public comment period. The motion passed unanimously.

5. Reviewed Comments and Considered Action on Exposed Items

The Working Group held a public hearing to review comments (Attachment One-B) on previously exposed items.

a. Agenda Item 2017-28

Mr. Bruggeman directed the Working Group to agenda item 2017-28: Reinsurance Credit – Informal Life and Health Reinsurance Drafting Group Recommendations. Robin Marcotte (NAIC) stated that during the Summer National Meeting, the Working Group exposed for comment four items that were recommended by the informal life and health reinsurance drafting group, including SSAP No. 61R — Life, Deposit-Type and Accident and Health Reinsurance disclosures and three A-791 Life and Health Insurance Question and Answers. Ms. Marcotte recommended that the Working Group adopt the nonsubstantive SSAP No. 61R disclosures with paragraph number updates with an initial effective date of Dec. 31, 2020. She noted that the disclosures were originally requested by the Financial Analysis (E) Working Group. Ms. Marcotte also recommended that the Working Group adopt the new A-791 question and answer (Q&A) item regarding contracts with medical loss ratios (MLRs).

Ms. Marcotte then recommended that the Working Group adopt the A-791 Q&A revisions regarding paragraph 2c with the addition of applying to contracts in effect Jan. 1, 2021. She stated that after discussion with industry representatives, their comments are supportive of the adoption of the exposed Q&A for A-791, question 2c. She noted that these revisions would prevent risk transfer for group term yearly renewable term (YRT) contracts, which have risk-limiting features when the reinsurance contract premium exceeds the underlying direct premium. She stated that the interested parties’ recommendation was that this Q&A have a Jan. 1, 2021, effective date. She stated that while some of the informal state insurance regulator comments received by NAIC staff note that they are not in full agreement with the industry provided comments on other non-group YRT contracts, there is agreement on the item exposed and that the exposed language is specific to the described contracts. She noted that NAIC staff also recommend that the Working Group send a notification to the Life Actuarial (A) Task Force as part of its YRT project.

Ms. Marcotte recommended that the Working Group refer to the informal life and health reinsurance drafting group the exposed revisions to the A-791 Q&A update to clarify the phrase “certain non-proportional contracts” to address informal questions received by NAIC staff regarding: 1) the application of the exposed language regarding measurement period and settlement period; and 2) the application of substantially less likely than not. She stated that based on informal input from various drafting group members, more discussion is needed regarding this Q&A item, and she believes that this is an issue that the drafting group can lend some useful expertise. She noted that a few of the technical members did not fully agree on the application of certain wording.

Mr. Bruggeman noted that the Life Actuarial (A) Task Force is continuing its work on the reinsurance credit that a YRT contract can generate under principle-based reserving (PBR) and that a notification would be beneficial.
Steve Clayburn (ACLI) stated support for a Jan. 1, 2021, effective date of the paragraph 2c A-791 QA.

Mr. Stolte made a motion, seconded by Ms. Travis, to: 1) adopt the SSAP No. 61R disclosures with a year-end 2020 effective date; 2) adopt the A-791 Q&A on products subject to MLRs; 3) adopt the A-791 Q&A on paragraph 2c regarding group term life YRT contracts with an effective date of Jan. 1, 2021; and 4) refer the initial A-791 Q&A on the phrases “certain non-proportional contracts” back to the informal drafting group (Attachment One-M). The motion passed unanimously.

b. Agenda Item 2018-38

Mr. Bruggeman directed the Working Group to agenda item 2018-38: Prepaid Providers. Ms. Marcotte stated that this nonsubstantive agenda item was exposed during the Summer National Meeting with revisions to emphasize existing guidance that unpaid loss and loss adjusting expense (LAE) liabilities are established regardless of payments to third parties. She stated industry comments suggested separating guidance by product type.

Tom Finnell (America’s Health Insurance Plans—AHIP) stated support for the Working Group’s continued work on this topic and said he looks forward to providing additional feedback as a result of this exposure.

Ms. Malm made a motion, seconded by Ms. Walker, to expose agenda item 2018-38 with revisions to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses incorporating a majority of interested parties’ comments for a public comment period. The motion passed unanimously.

c. Agenda Item 2019-12

Mr. Bruggeman directed the Working Group to agenda item 2019-12: ASU 2014-17, Business Combinations, Pushdown Accounting. Ms. Gann stated this nonsubstantive agenda item was exposed during the Summer National Meeting with three options presented for Working Group consideration: 1) full rejection of pushdown accounting; 2) allowing pushdown for non-insurance SCAs; or 3) allowing pushdown for non-insurance U.S. Securities and Exchange Commission (SEC) registrants. She stated that interested parties have requested additional time in order to provide specific examples for consideration. Ms. Gann stated that while re-exposure is recommended, a nonsubstantive revision for year-end 2019 was proposed to clarify in SSAP No. 68—Business Combinations and Goodwill that admitted goodwill is limited to 10% of the acquiring entity’s adjusted capital and surplus, regardless if pushdown was used. She stated that the proposed edit is specific to SCAs acquired directly by an insurance reporting entity. Ms. Gann stated that in order to prevent questions on whether the proposed edit will require amortization of goodwill pushed down to U.S. GAAP SCAs (instead of the U.S. GAAP impairment test), a proposal to separate the existing paragraph 9 into two separate paragraphs was suggested.

Ms. Brown stated support for the proposed edit to clarify the statutory admitted goodwill limitation. She asked whether additional disclosures will be presented to capture supplemental information on the use of pushdown in the statutory financial statements. Ms. Gann stated that a new agenda item is planned to capture additional goodwill disclosures and the use of pushdown as insurance reporting entities do not appear to currently be including this information in the statutory financial statements. Mr. Bruggeman asked whether the proposed edit to clarify the 10% admittance limitation should be effective immediately or for year-end 2020. Mr. Stolte and Mr. Smith responded for an immediate effective date.

Ms. Reese stated appreciation for the clarification of the history of goodwill and the assessment of nonsubstantive changes provided in the agenda and indicated that the TIAA would be involved in the continued pushdown discussion.

Keith Bell (The Travelers Companies) requested clarification of the Working Group direction regarding pushdown disclosures. He stated that there are concerns with pushdown disclosures as entities have pushed down goodwill on a U.S. GAAP basis, not a statutory accounting basis. Ms. Gann stated that the existing guidance in SSAP No. 68, paragraph 4 provides the calculation of goodwill and explicitly encompasses acquired SCAs reported on the basis of the audited U.S. GAAP equity of the investee (entities captured under paragraph 8.b.iii of SSAP No. 97.) Ms. Gann stated that the calculation of goodwill is different between U.S. GAAP and SAP, and if goodwill was pushed down on the basis of the U.S. GAAP calculation, it would seem that the existing guidance in SSAP No. 68 was not followed. Mr. Bell stated that in order to obtain a clean audit opinion for an SCA, pushdown may have been required on a U.S. GAAP basis and asked if the requested disclosures would only apply to U.S. GAAP SCAs. Mr. Bruggeman stated anticipated disclosures would detail the amount of goodwill pushed down if a reporting
entity directly purchased an SCA. He stated that the disclosures would likely include only SCAs reported on the basis of U.S. GAAP equity and requested feedback when the agenda item is exposed.

Ms. Brown made a motion, seconded by Mr. Stolte, to adopt the clarification edit indicating that goodwill from an insurance reporting entity’s acquisition of an SCA that is pushed down and reported on the SCA’s financial statements is subject to the 10% admittance limitation as a nonsubstantive change effective for year-end 2019, and to separate SSAP No. 68, paragraph 9 into two paragraphs. This motion also included re-exposure of agenda item 2019-12 with a request for comments on the three options for future consideration of pushdown and the request of explicit examples on the historical use of pushdown. The motion passed unanimously (Attachment One-N). The Working Group also directed NAIC staff to develop a new agenda item to capture statutory accounting disclosures on the use of pushdown and other goodwill/intangible asset items.

d. Agenda Item 2019-14

Mr. Bruggeman directed the Working Group to agenda item 2019-14: Attribution of Goodwill. Ms. Gann stated this nonsubstantive agenda item is a disclosure item when a reporting entity purchases a holding company, and the holding company owns multiple entities, goodwill shall be allocated/assigned to each entity at the time of purchase. She stated that comments received from interested parties on this item were combined with the comments received for agenda item 2019-12 and requested additional time for assessment. Ms. Gann stated that although this agenda item is strictly a disclosure item and is not planned for data-capture, it may be difficult to compile the disclosure information for year-end 2019 reporting. As such, re-exposure could occur to provide additional time for comments and still allow for disclosures to be adopted for year-end 2020. Ms. Gann suggested that the Working Group direct NAIC staff to revise the Sub-1 SCA filing template to capture this information beginning with Sub-1 submissions in 2020.

Ms. Walker made a motion, seconded by Mr. Dudek, to re-expose agenda item 2019-14 and directed NAIC staff to revise the Sub-1 filing template to capture this information for new SCA acquisitions. The motion passed unanimously.

e. Agenda Item 2019-20

Mr. Bruggeman directed the Working Group to agenda item 2019-20: Rolling Short-Term Investments. Ms. Gann stated that this nonsubstantive agenda item was originally exposed during the Summer National Meeting to address certain investments that were structured to mature at or around 364 days in order to be classified as short-term investments, with those investments being rolled or renewed. She stated that the definition of a cash equivalent is an investment, that when acquired, has a remaining maturity of three months or less, while a short-term investment, when acquired, has a remaining maturity of one year or less. Ms. Gann stated that while investments default to a long-term reporting schedule, if they meet the maturity date parameters at acquisition, they are reported as cash equivalents or short-term investments. She stated that examples have risen where entities purchase affiliated investments that are scheduled to mature within one year. However, the investments continuously roll or have the expectation of being renewed or rolled with recurring short-term maturity dates. Under existing statutory accounting guidance, these investments are continuously reported as short-term investments, and this reporting results with favorable RBC charges and avoids other requirements imposed on long-term investments, including the requirement to obtain an NAIC designation.

Ms. Gann stated this agenda item proposes that if a short-term investment is expected to renew, it shall be reported as a long-term investment. Further, if a short-term investment is renewed or rolled, upon subsequent renewal, it shall be reported as a long-term investment, in effect acting as a tainting rule to prevent continuous reporting as a short-term investment. Ms. Gann stated that comments from interested parties expressed concerns that cash pooling arrangements were not excluded from the exposed short-term rolling guidance. She stated cash pools were not originally excluded as they are not currently addressed in SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments. However, from information received, entities have been reporting pooling arrangements as cash equivalents. She stated NAIC staff recommend exposure of this agenda item with revisions to exclude qualifying cash pooling arrangements as defined in agenda item 2019-42 from the rolling short-term guidance and to request industry and state insurance regulator feedback on other investments that should be considered in scope of the short-term rolling guidance, or excluded from the guidance and permitted to be continuously reported as short-term. In response to comments received on other investments, Ms. Gann stated NAIC staff do not recommend expanding exemptions for affiliate loans or collateral loans and noted that collateral loans already receive favorable RBC charges under their designation reporting line on Schedule BA – Other Long-Term Invested Assets. She also indicated that using re-underwriting
provisions as a threshold for continuous short-term reporting may be difficult for state insurance regulators and auditors to assess.

Lyle Rudin (State Farm), representing interested parties, stated support for the cash pool exemption from the proposed short-term rolling guidance and stated that it will review the qualifying conditions for cash pools in that exposure.

Ms. Belfi made a motion, seconded by Ms. Weaver, to expose agenda item 2019-20 with the revisions to exclude qualifying cash pools from the short-term rolling restrictions and to request comments on other investments that should be considered within or excluded from the short-term rolling restrictions for a public comment period. The motion passed unanimously.

f. Agenda Item 2019-24

Mr. Bruggeman directed the Working Group to agenda item 2019-24: Levelized and Persistency Commission. Ms. Marcotte stated that during the Summer National Meeting, the Working Group exposed nonsubstantive revisions to SSAP No. 71—Policy Acquisition Costs and Commissions to clarify the existing levelized commissions guidance and provide additional guidance regarding commissions based on policy persistency. She stated that the exposed recommendations were intended to be consistent with the original intent of SSAP No. 71, as well as the Statutory Statement of Concept on Recognition, which states that liabilities require recognition as they are incurred and accounting treatments, which tend to defer expense recognition, do not generally represent acceptable SAP treatment. Ms. Marcotte noted that three comment letters were received from the original exposure. For the current Fall National Meeting, Ms. Marcotte recommended that the Working Group expose the agenda item with additional NAIC staff modifications regarding persistency and levelized commission guidance to allow for further discussion. She stated that the intent of the additional revisions was to focus on levelized commission arrangements, particularly those that are currently being miscategorized.

In response to comments received about the intent of the guidance, Ms. Marcotte stated that Issue Paper No. 71—Policy Acquisition Costs and Commissions, paragraph 10, identifies the pre-codification statutory accounting guidance, which is the basis for the existing SSAP No. 71 guidance. She stated that the pre-codification guidance quoted in the 1996 issue paper also notes the same concerns regarding reporting entities’ use of levelized commission arrangements, which operate as funding agreements. She stated that the referenced paragraph provides that, “The accounting treatment for certain transactions, characterized as levelized commissions, which results in enhancement of surplus, has been determined to be inappropriate for statutory reporting.” She stated that the intent of SSAP No. 71 for levelized commissions is that repayment of a funding advance, even if it has been labeled as a commission, requires the establishment of a liability for the full amount of unpaid principal and accrued interest.

Ms. Marcotte noted that additional edits proposed for exposure attempts to address some of the industry concerns on traditional persistency commissions. She stated that one of the challenges is trying to make a distinction between a true persistency commission and the use of a levelized commission arrangement that functions as a funding agreement as described in SSAP No. 71. She noted that it is more difficult because some of the identified funding agreements are calling the repayment a persistency commission. She stated that the intent of the exposed guidance was not to change the annual accrual of normal persistency commission, but rather to require accrual of levelized commission arrangements, which are being termed persistency. Some of the proposed edits remove previously exposed revisions and add clarifying phrases regarding persistency commission accrual, with the addition of clarifying phrases to assist with identifying levelized commission funding agreements and redrafting of the footnote to remove double negative wording.

Ms. Marcotte stated that the levelized commission arrangements described to NAIC staff had a third-party (“super-agent”) paying agents upfront, which represents a large commission similar to normal initial sales commission policy acquisition costs for business directly written on behalf of the reporting entity in the year of policy issuance. She stated that repayment to the third party by the reporting entity was expected, but not necessarily guaranteed, and was over a period of years. She stated that consistent with the guidance in SSAP No. 71, paragraph 4, the levelized commission arrangement was repaying the super-agent amounts “which are less than the normal first-year commissions but exceed the normal renewal commissions.”

Marty Carus (Marty Carus Consulting) noted that they looked forward to reviewing the updated revisions during the exposure. He stated that a significant segment of the industry views the change as substantive and that the revisions affect a wide range of products. He said the Working Group should take this into account when reviewing this item. He stated that the NAIC staff comments noted preliminary discussion with the Life Actuarial (A) Task Force staff regarding the industry comments about
PBR methodology, and he recommended additional dialogue with the Task Force on this aspect. Ms. Marcotte stated that the PBR methodology takes commission into account when projecting future cash flows. However, per discussion with the Task Force staff, the projected future cash flows would not be double-counted if there is an existing liability. She requested if there is specific Valuation Manual language in VM-20, Requirements for Principle-Based Reserves for Life Products, and VM 21, Requirements for Principle-Based Reserves for Variable Annuities, that needs to be addressed in the coordination process, to provide specific concerns. Mr. Bruggeman noted that his understanding is that PBR takes into account future commissions when determining the present value of future cash flows, but would not set up an additional liability if there is an existing liability. Mr. Bruggeman noted that it would be beneficial to notify the Life Actuarial (A) Task Force of the exposure.

Lynn Kelley (Delaware Life), representing interested parties, stated support for the consideration of their comments and the additional exposure to allow time for discussion to distinguish between levelized commission arrangements and other commission arrangements.

Ms. Walker made a motion, seconded by Ms. Travis, to expose nonsubstantive revisions to SSAP No. 71, modified from the prior exposure as discussed during the meeting, regarding levelized commissions for a public comment period and to notify the Life Actuarial (A) Task Force of the exposure. The motion passed unanimously.

6. Considered Maintenance Agenda—Pending Listing—Exposures

Mr. Dudek made a motion, seconded by Ms. Mears to move agenda items 2019-32 through 2019-49 to the active listing, and expose all items for a public comment period, with distinction of each item as either substantive or nonsubstantive, and with corresponding referrals as recommended by NAIC staff. The motion passed unanimously.

a. Agenda Item 2019-32

Mr. Bruggeman directed the Working Group to agenda item 2019-32: Look-Through with Multiple Holding Companies. Ms. Gann stated that this nonsubstantive agenda item was drafted from Working Group direction at the Summer National Meeting. Ms. Gann stated that it was agreed that multiple holding companies in a structure could be looked-through if each holding company qualifies with the look-through requirements in SSAP No. 97. With this conclusion from the Summer National Meeting, interested parties had requested that this be clarified within the SAP guidance.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

b. Agenda Item 2019-33

Mr. Bruggeman directed the Working Group to agenda item 2019-33: SSAP No. 25 – Disclosures. Ms. Gann stated that this nonsubstantive agenda item has been drafted to data-capture disclosures from SSAP No. 25—Affiliates and Other Related Parties. She noted that disclosures from SSAP No. 25 are currently completed in a narrative (portable document format [PDF]) format. With the proposal to data-capture disclosures, state insurance regulators can aggregate and query party relationships. She noted that there are items that are proposed to be data-captured that are not explicitly included in the narrative description but are presumed to be currently captured in the existing general references for “information considered necessary to obtaining an understanding of the effects of the transactions on the financial statements.” She stated that all of these instances are specifically noted in the agenda item. Ms. Gann stated that this item is separate from agenda item Ref #2019-34, which is considering revisions to clarify what is captured in SSAP No. 25, in order to follow a separate workstream to allow for year-end 2020 data-capturing. If the revisions being considered under the separate agenda item are adopted by June 2020, then those disclosures may modify or expand the data templates proposed in this agenda item.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

c. Agenda Item 2019-34

Mr. Bruggeman directed the Working Group to agenda item 2019-34: Related Parties, Disclaimer of Affiliation and Variable Interest Entities. Mr. Stultz stated that the intent of this nonsubstantive agenda item is to clarify identification of related parties and affiliates in SSAP No. 25 and to incorporate new disclosures to ensure state insurance regulators have a full picture of complicated business structures. He noted that this agenda item intends to have the related party and affiliate reporting more
closely match that of SEC filings, and this will be done by adding language from SEC guidance and by clarifying the disclaimer of affiliation or control from a statutory reporting standpoint. He noted that the proposed revisions intend to address the following key aspects: 1) clarify the identification of related parties and ensure that any related party identified under U.S. GAAP or SEC reporting requirements would be considered a related party under statutory accounting principles; 2) clarify that non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation; 3) clarify the impact of a disclaimer of control or disclaimer of affiliate under SAP. He stated that disclaimers of control or affiliation may affect holding company group allocation or reporting as an SCA under SSAP No. 97, but do not eliminate the classification as a “related party” and the disclosure of material transactions as required under SSAP No. 25; and 4) propose rejection of several Financial Accounting Standards Board (FASB) ASUs related to Variable Interest Entities (VIE) and Consolidation (FASB Codification Topic 810). Mr. Stultz stated the concept of consolidation has been rejected for statutory accounting. As such, the main concepts included in the FASB ASUs discussed in this agenda item are proposed to be rejected for statutory accounting. While this agenda item is not intended to change the concept of consolidation for statutory accounting, Mr. Stultz noted that there is a need and justification for enhanced disclosures to supplement the reporting process of related parties and affiliates within a company structure. Mr. Stultz noted that the requirements for the SEC filings do not allow for a disclaimer of affiliation, as is allowed in the Insurance Holding Company System Regulatory Act and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions and included in Appendix A-440.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

d. **Agenda Item 2019-35**

Mr. Bruggeman directed the Working Group to agenda item 2019-35: Update Withdrawal Disclosures. Ms. Marcotte stated that the Working Group updated the life, health and separate account liquidity disclosures to provide more granularity of the withdrawal characteristics by product type. These updates were developed by the Financial Stability (EX) Task Force and were adopted in agenda item 2018-28: Updates to Liquidity Disclosures, with an effective date of year-end 2019. Ms. Marcotte stated that this nonsubstantive agenda item proposes minor clarifying edits to the disclosures identified subsequent to the adoption of the related 2019 annual statement blanks proposal. She stated that revisions are proposed as follows: 1) add a consistency revision to SSAP No. 51R—Life Contracts to ensure separate account guaranteed products are referenced in all applicable paragraphs of the withdrawal characteristics disclosures; 2) correct an identified inconsistency in one of the new disclosures that was added regarding products that will move from the reporting line of having surrender charges at 5% or more to the reporting line of surrender charges at less than 5%. A clarification is being recommended to ensure consistency in annual statement reporting; and 3) add a cross reference from SSAP No. 56—Separate Accounts to the existing disclosures by withdrawal characteristics in SSAP No. 51R and SSAP No. 61R as the disclosures include separate account products.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

e. **Agenda Item 2019-36**

Mr. Bruggeman directed the Working Group to agenda item 2019-36: Expanded MGA and TPA Disclosures. Ms. Marcotte stated that this nonsubstantive agenda item was drafted pursuant to a request from two states that the existing annual statement disclosure regarding managing general agents or third-party administrators (TPAs) be expanded to include additional information. She stated that state insurance regulators and policyholders should be able to fully understand the level and extent that core services and binding authority are provided by managing general agents (MGA) and TPAs. The state sponsors have advocated that this understanding would also help in the assessment of the enterprise risk management (ERM) framework, Own Risk Solvency Assessment (ORSA) report, market analysis reviews, operational risks, group analysis, and recovery and resolution considerations. Ms. Marcotte noted that the enhanced disclosure would list any MGA and TPA and the respective core service(s) provided to the insurer or authority granted by the insurer. Additionally, the affiliated, related party or unaffiliated relationship would be disclosed, along with whether the entity is independently audited and/or bonded.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.
f. **Agenda Item 2019-37**  
Mr. Bruggeman directed the Working Group to agenda item 2019-37: Surplus Notes – Enhanced Disclosures. Mr. Pinegar stated this nonsubstantive agenda item was drafted from the Working Group’s request that additional disclosures be captured in SSAP No. 41R—Surplus Notes. He stated the disclosure reflects items detailed in the current surplus note data call. While numerous disclosures are proposed, key concepts relate to the cashflows (or lack thereof) between the surplus note issuer and holder, related party identification, descriptions of the types and fair value of the assets received, and information regarding the third-party financial guarantor, which is commonly referred to a source of liquidity for the surplus note issuer.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

g. **Agenda Item 2019-38**  
Mr. Bruggeman directed the Working Group to agenda item 2019-38: Financing Derivatives. Ms. Gann stated this topic was discussed a few years ago. However, after reviewing the year-end 2018 financial statements, the issue is being reintroduced as a nonsubstantive revision to clarify the reporting of derivatives with financing components on derivative schedules DB-A and DB-B. NAIC staff stated that financing derivatives represent situations where the premium due as a result of acquiring or writing a derivative is paid throughout the derivative term or at maturity. She stated that the agenda item proposes the elimination of the allowance of net reporting, with a requirement for gross reporting for derivatives purchased or sold. Ms. Gann said that the current process to net the derivative asset and premium due generally results in a net zero-value at inception, which does not present a clear picture on derivative activity in the statutory financial statements. Ms. Gann stated that the original discussion on this item focused on acquired financed derivatives. However, from the review of the 2018 financial statements, it was identified that reporting entities also use financing components in the writing of derivatives. She stated that the proposed revisions to SSAP No. 86 would require gross reporting of derivatives, without the effect of financing premiums due or payable and would present the true financial asset and liability position associated with the use of derivatives. She noted that proposed concepts included in the agenda item suggest revisions to the RBC calculations so that the premium due can be considered similar to derivative collateral. If the statutory accounting revisions are supported, a future referral would be considered to the Capital Adequacy (E) Task Force for consideration of these RBC changes.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

h. **Agenda Item 2019-39**  
Mr. Bruggeman directed the Working Group to agenda item 2019-39: Acceptable Collateral for Derivatives. Mr. Pinegar stated that a potential misinterpretation exists in the annual statement instructions regarding the reporting of collateral for derivatives. Currently, the instructions indicate reporting “net positive variation margin,” which by definition only reflects collateral flows due to daily changes in market values. He stated that an additional type of margin should be considered—i.e., initial margin, which reflects the original collateral given to initiate a position. SSAP No. 86 refers to disclosures of “net assets held,” which infers a totality of assets. Mr. Pinegar stated this nonsubstantive agenda item is to clarify that collateral held reflects both initial and variation margin.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

i. **Agenda Item 2019-40**  
Mr. Bruggeman directed the Working Group to agenda item 2019-40: Reporting of Installment Fees and Expenses. Ms. Marcotte noted that SSAP No. 53—Property Casualty Contracts—Premiums, paragraph 6, provides specific guidance that allows for installment fees that meet specified criteria to be excluded from premium and reported as other income. She stated that an installment fee is the amount policyholders pay if they make the choice to pay their premium on an installment basis and that the fee is allowed to be excluded from premium income if it is an avoidable amount by the policyholders and the policy would not be cancelled for nonpayment of the installment fee.

Ms. Marcotte stated that NAIC staff have received state insurance regulator-requested clarifications regarding potential diversity in the application of the SSAP No. 53 installment fee guidance. She stated that the recommendation in the nonsubstantive agenda item is to expose revisions to SSAP No. 53 and request comments. She stated that the revisions note
that the installment fee and services charges guidance should be applied narrowly to the specific situation described and not analogized to exclude other fees from written premium. Ms. Marcotte stated that in addition, notification of the exposure to the Casualty Actuarial and Statistical (C) Task Force and the Property and Casualty Risk Based Capital (E) Working Group was recommended. She stated that the questions for exposure are as follows:

- Should the Working Group develop guidance to allow reporting of installment fee expenses associated with fees that are reported in other income according to the criteria in SSAP No. 53, be categorized as an expense in “Other Income”?

- If included in “Other Income,” there is no line to report “other expenses” in the annual statement blank. Therefore, should the expense be classified as a contra revenue in or an “Aggregate Write-Ins for Miscellaneous Income”?

- Installment fees and expenses are often immaterial for property/casualty (P/C) except for nonstandard writers. Should diversity be allowed in reporting installment fee expenses (that is optional to report as other expense category of contra other revenue “Aggregate Write-Ins for Miscellaneous Income”), particularly for immaterial amounts?

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure with the request for comments on the noted questions and with notifying the Casualty Actuarial and Statistical (C) Task Force and the Property and Casualty Risk Based Capital (E) Working Group of the exposure.

j. Agenda Item 2019-41

Mr. Bruggeman directed the Working Group to agenda item 2019-41: SSAP No. 43R – Financial Modeling. Mr. Pinegar stated the current residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) multi-step modeling practice is the only remaining approach that uses breakpoints to determine final NAIC designations. During the Spring National Meeting, the Working Group adopted modifications to eliminate reference to multi-step modeling for modified filing exempt (MFE) securities. He stated this nonsubstantive agenda item was in conjunction with an expected proposal from the Valuation of Securities (E) Task Force, in which it is also proposing to eliminate multi-step modeling. Mr. Pinegar stated exposure is contingent upon the Task Force exposure and that final action will not occur on this agenda item until the Task Force adopts elimination of the multi-step modeling. Mr. Bruggeman stated that this agenda item was proposed to remain current with the Task Force and that the exposure of this agenda item will be removed from the exposure listing if the Task Force does not expose its corresponding agenda item.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

k. Agenda Item 2019-42

Mr. Bruggeman directed the Working Group to agenda item 2019-42: Cash Equivalent – Cash & Liquidity Pools. Mr. Pinegar stated this nonsubstantive agenda item arose as a result of the short-term rolling agenda item (Ref #2019-20), in which interested parties commented that cash pools were not appropriately scoped out of the proposed short-term restriction guidance. He stated cash pools are techniques in which affiliates combine excess cash in order to earn additional interest, access additional short-term investment markets and improve liquidity management. Mr. Pinegar stated that this agenda item proposes to allow cash pools that meet certain requirements to be reported as cash equivalents. He stated several safeguards were proposed, including restrictions related to investments, liquidity requirements and the disallowance of notional pooling where one participant can cover the expenses of another.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

l. Agenda Item 2019-43

Mr. Bruggeman directed the Working Group to agenda item 2019-43: ASU 2017-11, Earning Per Share, Distinguishing Liabilities from Equity, Derivatives & Hedging. Mr. Pinegar stated this ASU primarily details accounting guidance for financial instruments with “down round” features. A down round feature is a provision in certain financial instruments that allows for a reduction in an option’s strike price in certain situations. He stated that as a result of this ASU, down round features are allowed to be considered indexed to stock in which the value of the instrument is reclassified from a liability to equity. Mr. Pinegar stated that this specific guidance is proposed for rejection. However, the nonsubstantive agenda item proposes language for
SSAP No. 5R and SSAP No. 72—*Surplus and Quasi-Reorganizations* to reflect that freestanding financial instruments with characteristics of both liability and equity shall be reported as a liability to the extent the instrument embodies an unconditional obligation of the issuer. Mr. Pinegar stated that while this language is new for these particular SSAPs, the liability versus equity concept is not new to statutory accounting. He stated that the concepts are materially consistent with guidance that currently exists in Exhibit A in SSAP No. 104R—*Share-Based Payments*.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

m. *Agenda Item 2019-44EP*

Mr. Bruggeman directed the Working Group to agenda item 2019-44EP: Editorial Updates. Ms. Marcotte stated that this nonsubstantive agenda item proposes editorial revisions to update paragraph references for SSAP No. 62R—*Property and Casualty Reinsurance* and update references to the Annual Statement Instructions to reflect proper titles. In order to ensure revisions are in the 2020 *Accounting Practices and Procedures Manual* (AP&P Manual), a shortened exposure period was suggested ending Dec. 20.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

n. *Agenda Item 2019-45*

Mr. Bruggeman directed the Working Group to agenda item 2019-45: *ASU 2013-11, Income Taxes – Presentation of Unrecognized Tax Benefits*. Mr. Pinegar stated this ASU addressed the financial statement presentation of unrecognized tax benefits. An unrecognized tax benefit represents a tax position that does not meet the more-likely-than-not recognition threshold and in essence is a tax deduction that has a less than 50% likelihood of being used or upheld. He stated that this nonsubstantive agenda item proposes to reject the ASU as items having less than a 50% likelihood of being upheld require current year expense recognition per SSAP No. 101—*Income Taxes*.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

o. *Agenda Item 2019-46*

Mr. Bruggeman directed the Working Group to agenda item 2019-46: *ASU 2016-14, Presentation of Financial Statements for Not-for-Profit Entities*. Mr. Pinegar stated this ASU requires financial statement presentation of two classes of net assets for not-for-profit entities: 1) with donor restrictions; and 2) without donor restrictions. He stated this nonsubstantive agenda item proposes to reject the ASU as not being applicable for statutory accounting.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

p. *Agenda Item 2019-47*

Mr. Bruggeman directed the Working Group to agenda item 2019-47: VM-21 Grading. Ms. Marcotte stated that at the Summer National Meeting, the NAIC Executive (EX) Committee and Plenary adopted comprehensive revisions drafted by the Life Actuarial (A) Task Force to Section 21 VM-21 and also to *Actuarial Guideline XLIII—CARVM for Variable Annuities* (AG 43), which provide guidance on reserving for variable annuities. The revisions adopted to VM-21 and AG 43 represent a change in accounting principle that must be recognized as a change in valuation basis under SSAP No. 51R.

Ms. Marcotte stated that this nonsubstantive agenda item proposes revisions to SSAP No. 51R and reference to the additional grade-in disclosure requirements in SSAP No. 3—*Accounting Changes and Corrections of Errors* for reporting years beginning Jan. 1, 2020. She stated that the revisions are to remove the existing guidance, which prohibits grading-in changes in valuation basis unless provided for in the statement, to allow a grade-in for changes in valuation basis if permitted by the statement or the *Valuation Manual* in VM-21. She stated that in deferring to VM-21 on grade-in options, there will be less comparability in reporting because there is more optionality in reserve reporting.

Ms. Marcotte stated that to address the issue of lack of comparability, additional disclosure regarding grade-in has been proposed. She stated that the proposed revisions to SSAP No. 51R expand the disclosure for changes in valuation basis as a...
change in accounting principle under SSAP No. 3 to also include details regarding grade-ins of changes in valuation basis, including the grade-in period applied, the remaining amount to be graded-in, remaining time for the grade-in period, and the initial grade-in amount and any adjustments to the original amount. She noted that a reference in SSAP No. 3 regarding additional disclosures of grade-in features is also proposed.

Ms. Marcotte stated that a change in valuation basis under SSAP No. 51R is recognized through surplus. As the unrecognized graded-in reserve represents an unrecognized adjustment to surplus, the proposed revisions require the unrecognized grade-in amount from a change in valuation basis, if resulting with an increase in reserves (decrease from surplus), to be reported as an allocation from unassigned funds to special surplus until the amount has been fully graded into unassigned funds. She stated that the proposed reclassification from unassigned funds to special surplus does not reduce total surplus. She said this proposal is to provide transparency regarding the increased reserve amount that has not been reflected into surplus. As amounts are graded-in to reduce surplus, the amount in special surplus is reclassified to unassigned funds.

Mr. Bruggeman noted that statutory accounting does not typically allow optionality and that providing disclosure for comparability and having some accounting transparency seems to be useful. Ms. Marcotte noted that NAIC staff plan a future agenda item regarding exercise of commissioner discretion in the Valuation Manual.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

q. Agenda Item 2019-48

Mr. Bruggeman directed the Working Group to agenda item 2019-48: Disclosure Update for Reciprocal Jurisdiction Reinsurers. Mr. Stultz stated that on June 25, the Executive (EX) Committee and Plenary adopted revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) to incorporate relevant provisions from the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” and the “Bilateral Agreement Between the United States of America and the United Kingdom Regarding Insurance and Reinsurance” (collectively referred to as the Covered Agreement). He stated that while developing the blanks proposal to include reciprocal jurisdictions reinsurers, a needed change to the disclosure was identified. He stated that the purpose of this nonsubstantive agenda item is to revise one disclosure in SSAP No. 62R to reference “reciprocal jurisdictions.”

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

r. Agenda Item 2019-49

Mr. Bruggeman directed the Working Group to agenda item 2019-49: Retroactive Reinsurance Exception. Ms. Marcotte noted that at the Summer National Meeting, the Working Group, the Casualty Actuarial and Statistical (C) Task Force and the Surplus Lines (C) Task Force received a request from the Committee on Property and Liability Financial Reporting (COPLFR) of the American Academy of Actuaries (Academy) Working Group. She stated that the request was to clarify the accounting and reporting for retroactive reinsurance that meets the SSAP No. 62R exceptions to be accounted for as prospective reinsurance.

Ms. Marcotte stated that the request was for the various NAIC groups to develop guidance to address the inconsistencies in application of the reinsurance accounting and reporting guidance, particularly the impact on Schedule P – Analysis of Losses and Loss Expenses (Schedule P) and data that is used for RBC. She stated that the recommendation is to request comments and to ask for industry and state insurance regulator volunteers to assist with developing guidance. She stated that the request asks for guidance on both the accounting and reporting for retroactive contracts that are accounted for prospectively, including situations in which both the ceding entity and assuming entity are members of the same group and are consolidated in the same combined annual statement, as well as the reporting method to be used if the ceding entity and assuming entity are not in the same group.

Ms. Marcotte stated that comments are specially requested regarding the preferred approaches to reporting and the advantages and disadvantages to each approach being used, including both the Schedule P (and related loss analysis) and RBC impacts. She stated that a Working Group notification to the Casualty Actuarial and Statistical (C) Task Force of the request for comments and to highlight the need for coordination will occur with exposure.
In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

7. Considered Maintenance Agenda—Active Listing
   a. Agenda Item 2019-25

Mr. Bruggeman directed the Working Group to agenda item 2019-25: Working Capital Finance Notes. Ms. Marcotte noted that the materials contain the proposed substantive revisions incorporating the industry proposed language for the six specific items directed by the Working Group at the Summer National Meeting to SSAP No. 105—Working Capital Finance Investments. She stated that the revisions: 1) remove the requirement that the Securities Valuation Office (SVO) determine if the international finance agent is the functional equivalent of the U.S. state insurance regulator; 2) remove the finance agent prohibitions on commingling; 3) remove duplicative text regarding exercise of investor rights; 4) remove requirements, with revisions allowing the SVO to determine if a first priority perfected interest has been obtained; 5) lower the independent review requirements to allow independent review of the finance agent by either audit or through an internal control report; and 6) change the default provisions from 15 days to 30 days so the default date and the cure period are consistent.

Ms. Weaver made a motion, seconded by Mr. Bartlett, to expose the substantively revised SSAP No. 105 and direct NAIC staff to draft an issue paper. The motion passed unanimously.

8. Discussed Other Matters
   a. Agenda Item 2019-21: SSAP No. 43R – Equity Interests

Ms. Gann stated that a conference call to discuss agenda item 2019-21 is scheduled for Jan. 8, 2020. She stated a conference call was preferable so sufficient time can be dedicated to the topic and to allow multiple commenters the opportunity to participate in the discussion. Mr. Bruggeman stated that final resolution of this topic is not expected during the conference call.

   b. Agenda Item 2018-07: Surplus Notes

Mr. Pinegar stated that in response to the Working Group direction from the Summer National Meeting, a data call regarding “linked” surplus notes was developed and issued. He reminded the Working Group that a data call response is not required if reporting entities do not have issued surplus notes that meet the criteria detailed in the instructions and that submissions are due Dec. 31. Mr. Bruggeman stated this data call was issued as there was not sufficient time to data-capture the information in year-end 2019 statutory financial statements. He stated any questions should be directed to NAIC staff or state insurance regulators.

   c. Agenda Item 2016-20: Credit Losses

Mr. Pinegar stated that since the ASU regarding credit losses was originally released in 2016, numerous technical updates have been issued from the FASB and further updates continue as evidenced by a subsequent update issued in late November 2019. He stated that on Oct. 18, 2019, the FASB voted unanimously to delay the credit loss standard for most entities until 2023. While large SEC filers are required to follow the standard in 2020, all remaining entities were granted a reprieve until 2023. Mr. Pinegar stated NAIC staff recommend continual monitoring of FASB for updates and will keep the Working Group informed regarding developments. Mr. Bruggeman stated that only large SEC filers will be required to follow the credit loss standard in the near future and that the Working Group will continue to defer and monitor for updates.

   d. AP&P Update – Manual & Electronic Version

Mr. Pinegar stated that the reserving process to obtain a printed Accounting Practices and Procedures Manual will continue, and reservations must be made by Dec. 13, 2019 in order to secure a printed version. He stated those who do not reserve printed copies by this date may only have an electronic version available. Ms. Gann stated that members of the Working Group will receive complimentary printed versions, however if additional copies are requested, the reservation process should be utilized.
e. **U.S. GAAP Exposures**

Mr. Pinegar stated that NAIC staff have reviewed U.S. GAAP exposures and noted that comments during the exposure periods are not recommended, but a review will occur once issued as final ASUs under the statutory maintenance process. Mr. Pinegar briefly discussed two such items. First, he discussed an exposed ASU regarding proposed guidance for cash-flow hedges and the FASB’s proposal to allow prospective or retrospective review of hedged risk. The second topic he discussed was the FASB’s Reference Rate Reform project. This initiative is in conjunction with the move away from the London Interbank Offered Rate (LIBOR) as a primary reference rate. Mr. Pinegar stated that once the rate reform ASU is issued, NAIC staff will immediately review and will likely request an interim exposure of an applicable agenda item.

Mike Monahan (ACLI) stated that the ACLI is pleased with the Working Group’s attention to the Reference Rate Reform project as the FASB has indicated an expected release in early 2020. He stated this project provides temporary relief for certain hedging and contract modifications due to the discontinuance of LIBOR as a primary reference rate. He stated that the ACLI was supportive of the FASB proposal. Mr. Monahan also stated that the ACLI continues to work with FASB staff in an attempt to obtain additional temporary relief for *ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts*. He stated the ACLI’s concerns are large SEC filers will be required to follow the standard earlier than smaller reporting companies and entities, and this misalignment of accounting guidance could negatively affect the reinsurance marketplace. Due to the significant volume of reinsurance placed, the ACLI will continue to seek a favorable resolution with the FASB.

Mr. Bruggeman stated that Jan. 31, 2020, is the public comment deadline for all exposures other than the editorial agenda item (Ref #2019-44EP), which has a comment deadline of Dec. 20, 2019.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
1. **Considered Maintenance Agenda Item 2019-32**

Mr. Bruggeman directed the Working Group to agenda item 2019-32: Segregated Accounts. Ms. Gann stated this agenda item was drafted to clarify statutory accounting provisions for insurance and reinsurance operations reported within segregated accounts that are not captured in scope of *Statement of Statutory Accounting Principles (SSAP) No. 56—Separate Accounts or SSAP No. 74—Insurance-Linked Securities Issued Through a Protected Cell*. Ms. Gann stated that the term “segregated account” within this agenda item was intended to capture all scenarios in which a reporting entity has legally separated specific assets and liabilities for certain insurance risks. The legal classification and use of segregated accounts is determined based on domiciliary state law and state insurance regulator approval. Ms. Gann stated that while segregated accounts are considered separate and distinct from items captured in SSAP No. 56 or SSAP No. 74, the draft agenda item clarifies that all assets and liabilities within segregated accounts shall be captured within the principles detailed in the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual). Further, any departure from the AP&P Manual shall be captured as a permitted or prescribed practice as detailed in *SSAP No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures*. Ms. Gann stated that this agenda item was proposed for initial exposure to solicit comments and feedback from state insurance regulators and interested parties.

Ms. Gann stated that the primary focus of the proposed SSAP was to clarify that statutory accounting principles apply to segregated accounts. She stated that two reporting options were proposed within the SSAP. The first option was to report the segregated account aggregated into the general account. The second was to report the segregated account disaggregated from the general account. Ms. Gann stated the two reporting methods were proposed in order to comply with differing domiciliary laws that dictate a certain reporting method.

Mr. Smith stated the legal status of segregated accounts remains uncertain and questioned why an SSAP would be created before the legal questions were resolved. He stated that questions continue on whether segregated accounts should be used for insurance purposes and that the issuance of an SSAP addressing segregated accounts may be premature. Mr. Bruggeman stated that there are known situations where segregated accounts are being used. However, he said there is a current lack of direction on accounting and reporting, regardless of outstanding legal status questions. Mr. Bruggeman stated that the Restructuring Mechanisms (E) Subgroup should lead the legal discussion. However, he said the proposed SSAP exposure was intended to begin the process for obtaining feedback on how segregated accounts should be reported, irrespective of legal status.

Mr. Stolte stated he believes the issuance of an SSAP was getting ahead of the Restructuring Mechanisms (E) Subgroup as the legal status of this type of structure remains an outstanding question. Mr. Stolte stated that this type of structure may not be in the best interest of policyholders and that if an SSAP were issued, it may legitimize the practice. He stated that Virginia is concerned with moving forward until the legal questions regarding segregated accounts are addressed.

Ms. Gann stated that NAIC staff agreed with the comments mentioned. However, she said the SSAP was designed so that in the event a state has approved a segregated account structure, the reporting of assets and liabilities would be captured in existing statutory accounting principles. She stated that the proposed guidance was to clarify how segregated accounts should be reported until the Restructuring Mechanisms (E) Subgroup comes to a final conclusion regarding the use of segregated account structures. She stated that NAIC staff support referring the proposal to the Restructuring Mechanisms (E) Subgroup.

Mr. Stolte stated that statutory accounting, through Note 1, already provides guidance on reporting if practices deviate from current codified statutory accounting principles. He stated that if companies were using an existing SSAP for reporting such a structure, the domiciliary states should require a Note 1 disclosure for oversight and risk-based capital (RBC) purposes. In
response to an inquiry from Mr. Bruggeman, Mr. Stolte confirmed he was referring to the prescribed practice disclosure that should be completed when state laws permit segregated accounts.

Mr. Hudson stated that California was supportive of Mr. Stolte and Mr. Smith’s comments. He stated that while a segregated account’s assets and liabilities should be reported, the process of reviewing a segregated account should begin with a different group and agreed with a referral to the Restructuring Mechanisms (E) Subgroup. Ms. Malm stated that she agreed with Mr. Hudson’s comments and suggested that an annual statement blank instruction should be developed detailing how segregated accounts should be reported. Mr. Hudson agreed with Ms. Malm.

Mr. Bruggeman stated that he understands the comments and clarified that if a state law permits a segregated account to be formed, the reporting entity should be detailing the provision in Note 1 as a prescribed practice.

Ms. Gann stated that the annual statement blanks currently indicate a reporting line for “segregated accounts, protected cells, and separate accounts.” However, she said only protected cells and separate accounts are addressed by statutory accounting. She stated that NAIC staff agree with the comments made, but an SSAP update is warranted to clarify reporting for items that are not captured in SSAP No. 56 or SSAP No. 74. She stated that reporting “segregated accounts” on the noted reporting line results with distinct RBC effects that do not reflect the same RBC impact that would have occurred if the items were reported in the general account.

Mr. Smith inquired if an SSAP interpretation would be an appropriate method in lieu of the issuance of a new SSAP. Mr. Bruggeman stated that an interpretation may be an appropriate method, but it may not be substantial enough due to the nature of these structures and as interpretations are generally used to clarify an existing SSAP. Mr. Bruggeman said that due to the circumstances, specific guidance on how to report segregated accounts is warranted.

Ms. Gann stated that due to the comments noting concerns on the aggregated or disaggregated reporting options, the proposed SSAP could be modified to remove these options and clarify that segregated accounts are not captured within SSAP No. 56 or SSAP No. 74 and require disclosure of segregated accounts. Mr. Hudson stated support for this suggested edit.

Mr. Broccoli stated that while the legal status of segregated accounts remains in question, the proposed draft SSAP provides an appropriate reporting mechanism. He stated that the general account does not have legal access to the assets in the segregated account. As such, it is important for state insurance regulators to review the financial condition of the segregated account independent of the general account because if combined, a strong general account could mask an insolvent segregated account. Mr. Broccoli stated that the draft SSAP provides a transparent method of assessing the segregated account as its policyholders do not have access to general account assets in the event a segregated account becomes insolvent.

Mr. Bruggeman stated that a Note 1 option could be employed to capture all items not specifically identified in statutory accounting, detailing the segregated account effect on the reporting entity’s surplus and income. However, as assets from the general account and segregated account are not transferable between the two entities, increased reporting and disclosure could be beneficial for assessing the segregated account. Mr. Stolte stated Virginia has seen the surplus of segregated accounts being combined into the general account, even though the segregated account surplus is not free and unencumbered for use by the general account. He said that Note 1, if properly used, could properly report a segregated account.

In response to an inquiry from Mr. Bruggeman on next steps, Mr. Hudson and Ms. Malm stated they support the discussed editorial updates to the proposed SSAP for subsequent review by the Working Group. Mr. Bruggeman inquired if there were any objections to this approach. No objections were noted.

2. Discussed Other Matters

Ms. Gann stated that a data call template regarding surplus notes has been provided to members of the Working Group and that feedback should be provided by Sept. 13.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
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October 11, 2019

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Exposure Drafts Released for Comment During NAIC National Meeting with Comments due October 11

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the exposure drafts released for comment by the Statutory Accounting Principles (E) Working Group (the “Working Group”), during the NAIC Summer National Meeting in New York. We offer the following comments:

Ref #2017-28: Reinsurance Credit

The Working Group adopted, as final, Issue Paper No. 162—Property and Casualty to document for historical purposes the revisions related to SSAP No. 62R—Property and Casualty Reinsurance, which was adopted at the 2018 Fall National Meeting.

In addition to the issue paper adoption, on August 3, 2019, the Working Group also exposed for comment the following items applicable to SSAP No. 61R – Life, Deposit-Type and Accident and Health Reinsurance (SSAP No. 61R) and Appendix A-791 – Life and Health Reinsurance Agreements (A-791):

1. Disclosures, (previously exposed) and concurrent with the exposure, directed notification to the Financial Analysis (E) Working Group of the exposure as the disclosures were originally developed at their request.

2. The two A-791 QA items related to certain nonproportional reinsurance contracts” covered under the A-791 and medical loss ratios (previously exposed – the drafting group reviewed the comments).

3. Regulator proposed revisions to add A-791 QA under paragraph 2c regarding group term life YRT reinsurance contracts.
Interested parties appreciate the outreach the NAIC has made to the industry through the informal SSAP No. 61R Life and Health reinsurance drafting group. We believe the drafting group has allowed us to better understand the issues raised by regulators.

In summary, we do not have any concerns with the re-exposed disclosures and the two Q&A’s regarding short-duration health reinsurance treaties and offer the following comments.

With respect to the group term life YRT exposure, in general interested parties believe this draft exposure language addresses the concerns expressed by regulators in the drafting group and in prior exposures, and we would support this Q&A being added to 2.c in Appendix A-791, as long as the guidance does not impact contracts that do not raise such concerns as described below.

The proposed Q&A would deny risk transfer for specific group term life YRT reinsurance transactions if the reinsurer has the right to charge reinsurance premiums higher than the premiums received by the ceding company on the business reinsured. However, SSAP 61R and Appendix A-791 specifically exempt YRT reinsurance arrangements from paragraph 2.e of Appendix A-791, which denies risk transfer if the reinsurance agreement charges reinsurance premiums greater than the direct premiums collected by the ceding company.

There are specific circumstances where YRT reinsurance agreements do have reinsurance premiums greater than direct premiums, yet reinsurance accounting is appropriate, and this 2.e exemption has allowed those circumstances to meet risk transfer regulations. Examples of such reinsurance agreements include:

1. High level excess YRT agreements. High amount policies have higher volatility in claims. It is reasonable and appropriate for a reinsurer to charge a higher amount to cover these claims.
2. Level term premiums, where a true one-year risk premium in later years is likely to exceed the level premium.
3. In force business, where a ceding company has realized they are not charging sufficient premiums for the true risk. The ceding company may have to accept higher reinsurance premiums than they charge to appropriately discharge the risk going forward.
4. YRT for universal life. YRT premiums often will not have a direct or proportional relationship to either the premiums or cost of insurance rates charged by the ceding company.

The concerns about group term life YRT reinsurance raised by regulators are focused on reinsurance agreements with risk limiting features. As the exposure is phrased, the guidance here would be limited to group term life YRT reinsurance agreements where future experience refunds can be offset against current and prior year losses. Reinsurance agreements such as those in the examples above are unlikely to have such a loss carryforward provision, and thus should not be impacted by this guidance. Additionally, we would like to comment on the implementation/timing of the proposed exposure, when it is finalized. We believe that there are reinsurance transactions in place today which meet current regulations for risk transfer that would not meet risk transfer under this new guidance. This new Q&A may impact some company’s financial statements. Consideration should be given to grandfathering these transactions, or to establishing a prospective effective date that would provide enough time for these companies to make appropriate changes to their reinsurance agreements or to otherwise prepare for this impact. If a prospective effective date is the approach chosen, we recommend an effective date of 1/1/2021.
Ref #2018-26: SCA Loss Tracking – Accounting Guidance

The Working Group exposed revisions to SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, to revise the existing reporting requirements for when a reporting entity has a negative value in an SCA investment when the reporting entity has provided a financial commitment or guarantee. The illustration from the existing INT 00-24: EITF 98-13: Accounting by an Equity Method Investor for Investee Losses When the Investor Has Loans to and Investments in Other Securities of the Investee and EITF 99-10: Percentage Used to Determine the Amount of Equity Method Losses has also been moved to SSAP No. 97, in its entirety, as a new exhibit. This INT provides examples of how losses in an SCA shall be applied to other investments once the SCA equity investment has been halted at zero.

On August 3, 2019, the Working Group re-exposed revisions to SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, to require a financial commitment or guarantee for a subsidiary, controlled, or affiliated (SCA) entity to be recognized as a non-contingent guarantee liability. These proposed revisions differ from the prior exposure as they would capture the entire financial guaranty or commitment for an SCA within scope of SSAP No. 5R and report a zero value for SCAs with a negative equity value.

Interested parties believe that additional clarifications are necessary regarding the proposed revisions to paragraphs 18 and 24 of SSAP No. 5R. Regarding paragraph 18, we believe a parent’s guarantee on behalf of an SCA entity with negative equity could result in the recognition of either an initial guarantee liability or a liability subsequent to the initial recognition. Therefore, we propose more general wording to the end of paragraph 18 as follows:

18. The following types of guarantees are exempted from the initial liability recognition in paragraphs 20-25, but are subject to the disclosure requirements in paragraphs 29-32. For the guarantees addressed in paragraphs 18f and 18g, recognition of a contingent guarantee may be required subsequent to initial recognition in accordance with paragraph 24a:

   a. Guarantee that is accounted for as a derivative instrument, other than credit derivatives within SSAP No. 86;
   b. Guarantee for which the underlying is related to the performance of nonfinancial assets that are owned by the guaranteed party, including product warranties;
   c. Guarantee issued in a business combination that represents contingent consideration;
   d. Guarantee in which the guarantor’s obligation would be reported as an equity item;
   e. Guarantee by an original lessee that has become secondarily liable under a new lease that relieved the original lessee from being the primary obligator;
   f. Guarantees (as defined in paragraph 16) made to/or on behalf of directly or indirectly wholly-owned insurance or non-insurance subsidiaries; and
   g. Intercompany and related party guarantees that are considered “unlimited” (e.g., typically in response to a rating agency’s requirement to provide a commitment to support).

The exemptions for items f and g above do not apply in situations in which a reporting entity has provided a financial guarantee or commitment to support a subsidiary, controlled or affiliated entity (SCA), and the SCA’s equity is negative (see paragraph 24).
We find the new paragraph 24 wording confusing in that it tells the preparer in the first sentence to recognize the greater of the guarantee liability or the negative equity of the SCA. However, the third sentence clarifies that the guarantee liability shall not exceed the maximum amount of the guarantee. We propose condensing these items into one sentence in our recommended revisions below, and also clarifying that the “greater” term actually refers to the greater negative impact to the reporting entity’s financial statements. We also recommend that the new proposed paragraph be a stand-alone paragraph (i.e., new paragraph 25, with re-numbering of all subsequent paragraphs):

“In situations in which a reporting entity has provided a financial guarantee or commitment to support a subsidiary, controlled or affiliated entity (SCA), and the reporting entity’s share of losses in the SCA exceed the equity method carrying amount of the SCA (resulting in a negative equity value in the SCA), the reporting entity shall adjust the initially-recognized guarantee obligation to reflect the greater impact of (i) the then-current fair value liability for of the guarantee or (ii) the negative equity position, limited to the maximum amount of the financial guarantee or commitment provided by the reporting entity. (For This guidance requires the recognition of a guarantee liability for guarantees captured in paragraphs 18f and 18g this guidance requires recognition of a contingent guaranty when negative equity exists in an SCA.) The recognized guarantee liability shall not exceed the maximum amount of the financial guarantee or commitment provided by the reporting entity. The guidance in paragraphs 24 and 25 20 through 26 shall be followed for the recognition of recognizing a contingent liability and subsequent re-recognition of a noncontingent liability, as applicable.”

Ref #2019-04: SSAP No. 32 – Investment Classification Project

The Working Group exposed for comment Issue Paper No. 1XX—Preferred Stock to revise the definitions, measurement guidance and impairment guidance for preferred stock pursuant to the investment classification project.

Interested parties substantially agree with the objectives of the proposal to:

a. Improve preferred stock definitions, with inclusion of information from U.S. generally accepted accounting principles (GAAP) for classifying preferred stock as redeemable or perpetual. The revisions also incorporate a new exhibit to capture various terms prevalent in preferred stock.

b. Revise the measurement guidance to ensure appropriate, consistent measurement based on the type of preferred stock held and the terms of the preferred stock. The revisions also incorporate guidance for mandatory convertible preferred stock.

c. Incorporate revisions to clarify impairment guidance as well as guidance for dividend recognition and redemption of preferred stock with the issuer.

Interested parties have the following comments related to the issue paper:

Overall:

The issue paper refers to preferred stock throughout the document, at times the paper references the instruments as securities. For purposes of definitional clarity we do not believe the use of the term security is interchangeable as it pertains to preferred stock. As such, we recommend that all references to security be changed to interest or directly reference the type of stock under discussion.
Scope:

Interested parties note that the scope retains, albeit edited, the guidance that preferred stock of subsidiary, controlled and affiliated entities is included and therefore accounted for under the guidance for preferred stock regardless of their SCA character. Interested parties also note that preferred stock in SCAs other than preferred stock issued by domestic insurance entities is required to be filed with the NAIC pursuant to paragraph 50 of SSAP No. 97 Exhibit A – SCA Reporting Process. For the avoidance of doubt, interested parties suggest a clarifying sentence in double underline below. The existing wording in SSAP No. 32 and the exposed language for SSAP No. 32 is below with interested parties suggested clarifying sentence (underlined).

Existing language in SSAP No. 32

SCOPE OF STATEMENT

1. This statement establishes statutory accounting principles for preferred stock.

2. Investments in preferred stock of subsidiaries, controlled or affiliated entities, including preferred stock interests of certified capital companies (CAPCO) per INT 06-02: Accounting and Reporting for Investments in a Certified Capital Company (CAPCO) are included within the scope of this statement.

Exposed language in SSAP No. 32 and interested parties suggested clarifying sentence in underline

SCOPE OF STATEMENT

1. This statement establishes statutory accounting principles for preferred stock.

2. Investments in preferred stock of entities captured in SSAP No. 97—Investments in subsidiaries, controlled or affiliated entities or SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies, as well as preferred stock interests of certified capital companies per INT 06-02: Accounting and Reporting for Investments in a Certified Capital Company (CAPCO) are included within the scope of this statement. The requirement to file investments in preferred stock of certain subsidiaries, controlled or affiliated entities with the NAIC pursuant to SSAP No. 97 does not affect the application of the accounting under this statement.

Definitions:

The proposed definitional guidance could potentially change the scope of what is considered redeemable preferred stock vs perpetual preferred stock and create an inconsistency as to how the preferred stock would be treated. Under the previous guidance, redeemable preferred stock included stock that was mandatorily redeemable or redeemable at the option of the holder. This definition was consistent with how GAAP distinguishes between debt and equity security classification under ASC 321, Investments – Equity Securities. We believe the intention of the Staff was to align the definitions with the treatment under GAAP. However, using the language from ASC 480, which addresses the accounting from the issuer’s perspective, does not align with how the investor in the security accounts for the asset under GAAP. As such we propose the following revisions (indicated with edit marks) to the definitions:

3. Preferred stock shall include:

   a. Redeemable preferred stock, which is preferred stock subject to mandatory redemption requirements or whose redemption is outside the control of the issuer. Redeemable preferred stock is any stock which 1) the issuer undertakes to redeem at a fixed or determinable price on the fixed or determinable date or dates, whether by operation of a sinking fund or otherwise; 2) is redeemable
at the option of the holders; or 3) has conditions for redemption which are not solely within the control of the issuer, such as stock which must be redeemed out of future earnings. Preferred stock which meet one or more of these three criteria would be classified as redeemable preferred stock[1] regardless of other attributes such as voting rights or dividend rights. (Staff Note – this definition comes from FASB ASC 480-10-S99, modified to eliminate reference to conversion features as mandatory convertible preferred stock has special treatment under this SSAP.) ; and to be consistent with the description of redeemable preferred stock for a holder in the ASC Master Glossary definition of debt security.)

b. Perpetual preferred stock, which is preferred stocks which are not redeemable or are redeemable other than solely at the option of the issuer holder (non-redeemable preferred stock). Perpetual preferred stock is any preferred stock which does not meet the criteria to be classified as redeemable preferred stock pursuant to paragraph 3.a. Staff Note – this definition comes from FASB ASC 480-10-S99 modified to be made consistent with the description of redeemable preferred stock for a holder in the ASC Master Glossary definition of debt security.)

**Fair Value Cap for Callable Perpetual Preferred Stock:**

The issue paper broadly requires fair value measurement for redeemable preferred stock, perpetual preferred stock, mandatory convertible preferred stock and dividends (paras 16.a-d, para 18), depending on the quality rating expressed as an NAIC designation. Interested parties note that these assets may not have readily determinable fair values, and as such, fair value techniques using the cost approach, Level 3 inputs and practical expedients may be prevalent and necessary for these assets.

The issue paper discusses carrying perpetual preferred at fair value capped by any call price. However, it did not provide guidance on timing for application of the cap. Because the call may not be effective for a period of time, we propose the language be modified to state that “the measurement for these preferred stocks reflects fair value, not to exceed any currently effective buy back rates (call prices) that the issuer can utilize to redeem the stock.” These provisions would ensure that purchases of perpetual preferred stock could still be carried at values greater than par (assuming market values remain above par).

**Other Than Temporary Impairment (OTTI):**

For perpetual preferred stock, if the intent of the clarification is to provide OTTI guidance when the asset is already recorded at fair value then we would suggest OTTI language consistent with SSAP No. 30R, revised for preferred stock as follows:

For any decline in the fair value of a perpetual preferred stock, reported at fair value, for which the decline is determined to be other than temporary the perpetual preferred stock shall be written down to the new fair value basis and the amount of the write down shall be accounted for as a realized loss. For those reporting entities required to maintain an AVR, realized losses shall be accounted for in accordance with SSAP No. 7. Future declines in fair value which are determined to be other than temporary shall be recorded as realized losses. A decline in fair value which is other than temporary includes situations where a reporting entity has made a decision to sell a security at an amount below its carrying value.

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Ref #2019-08: Reporting Deposit-Type Contracts

The Working Group exposed this agenda item with the inclusion of the items and questions that were noted, with a request for additional comments from industry and state insurance regulators, and directed notifications of the exposure with a request for comments to the Financial Stability (EX) Task Force and the Life Actuarial (A) Task Force on the reporting of insurance contracts that do not have a mortality or morbidity risk.

This agenda item was initially drafted in response to questions identified by the Financial Stability Task Force (“FSTF”) in developing liquidity disclosure changes to the 2019 life blank. An agenda item was exposed with a request for comments on why guaranteed investment contracts (“GICs”), or other deposit-type contracts, are reported in Exhibit 5 – Life Contracts or Exhibit 6 – Accident and Health Contracts, instead of Exhibit 7 – Deposit Type Contracts.

On August 3, 2019, this agenda item was re-exposed with the inclusion of the items and questions noted below, with a request for additional comments from industry and state insurance regulators, and directed notifications of the exposure with a request for comments to the FSTF and the Life Actuarial Task Force on the reporting of insurance contracts that do not have a mortality or morbidity risk.

Before responding to the questions raised, interested parties note that the comments from the FSTF anticipates a classification system based on degree of risk. This is entirely new. The current classification is based strictly on mortality guarantees (Exhibit 5), morbidity guarantees (Exhibit 6), or neither (Exhibit 7). There is no concept of degree of risk in the current statutory classification. If the benefits of such fundamental changes to Exhibits 5, 6, and 7 were demonstrated to outweigh the costs, this would be a significant undertaking and companies would need significant lead time to implement systems changes. Please see the questions and interested parties (IP) responses below:

1. **Classification at Issuance** – The interested parties noted that because a contract was life-contingent at issue, it is reported in Exhibit 5, and then it remains in Exhibit 5 after the death of the annuitant.

   **Question** – Is it appropriate to classify products based on original issuance when the original risks are no longer present in the contract? Is this simply past industry practice, or is there direction that prevents reclassification to the category that most appropriately reflects the risk? Preliminary information received from the Financial Stability (EX) Task Force (FSTF) staff has noted that this practice will make it more difficult to properly aggregate and assess deposit-type contracts, and that this assessment is important as the payouts for deposit-type contracts are significantly different than payouts generated by an insured event. The Task Force has identified that information on liabilities, particularly those that can be called quickly with little or no surrender penalty, is of critical importance to liquidity assessments.

   **IP Response** - Tradition and SSAP No. 50 generally classify contracts with *any* life contingencies as life contracts. In practice, this “any life contingencies” is interpreted as those that are guaranteed.
SSAP No. 50, Paragraph 5, includes the statement, “Such classification shall be made at the inception of the contract and shall not change.” In practice, if there is a new contract, such as a supplementary contract to a life insurance benefit, the contract is re-evaluated as to whether it contains life contingency guarantees. For policyholder election of a payout benefit from a deferred annuity contract, re-evaluation varies depending on the Company’s valuation and risk policies. (For example, two-tiered policies are priced for annuitization, and the election of an annuitization option may be treated as a continuing contract and may not create a re-evaluation.)

For payout contracts issued as life contingent with a minimum guaranteed certain period, death of the original annuitant does not cause a change in contract. It is a change in payee for the remainder of the guaranteed certain period.

2. **State Approval** – The interested parties noted that state insurance departments have the discretion to approve or require a contract to be classified as a life or A/H insurance contract.

   **Question** – If a state directs reporting differently than what is stipulated in the AP&P Manual, is that being captured as a permitted or prescribed practice? (The provisions in SSAP No. 1 require permitted / prescribed practice reporting when it results in different statutory reporting. Examples included in SSAP No. 1 include gross or net presentation, financial statement reporting lines, etc.)

   **IP Response** - In our observation and experience, discretion exercised by state insurance departments on product classification is rare. When it happens, it is generally in the product filing process, generally applies to group products (e.g., association group), and where there is judgement as to whether the benefits should be classified as Exhibit 5 or Exhibit 6.

3. **Annuity Guidance** – The interested parties cited existing annuity guidance in paragraph 20 of SSAP No. 50 - Classifications of Insurance or Managed Care Contracts. Per this guidance, contracts containing well-defined class-based (e.g., age / gender) annuity purchase rates used in defining either a specific or maximum purchase rate guarantee would constitute an annuity contract containing a life contingency that would require it to be classified as a life contract.

   **Question** – NAIC staff agrees with the citation from interested parties on annuities in paragraph 20 of SSAP No. 50 - Classifications of Insurance or Managed Care Contracts. However, with the intent to have more explicit product breakouts to allow for better assessment, is it time to clarify / revise this guidance to result with the appropriate breakouts created by FSTF? It was noted that the current concepts were established a long time ago and there is a focus on non-traditional insurance liabilities (which includes funding agreements) for liquidity risk assessment as they can have higher run risk.

   **IP Response** – We believe the current guidance supports the classification of life annuity contracts within Exhibit 5 regardless of payout status. While we acknowledge the conceptual distinction noted by NAIC Staff with respect to a single life annuity contract for which the life status has changed, we do not believe this represents a significant change in the risk profile of a given block of annuity contracts, for which the majority may not reach term-certain status.
We would also highlight the administrative burden of the proposed changes. As a practical matter, it would be necessary to convert life annuity contracts to new plan codes on the death of the annuitant in order to capture the appropriate information in the Summary of Operations by Line of Business. This change must be implemented at the policy administration system level and would require significant time and effort on the part of industry. We do not believe the perceived benefits of this change justify the cost, particularly given recent significant annual statement changes for product reporting. Rather than implementing additional product granularity at this time, we suggest that regulators and staff work with industry to review the new Note 32 and Note 33 disclosures, which are specifically designed to communicate liquidity risk. We believe these disclosures will fulfill the regulatory objective in a more cost-efficient manner.

4. Materiality of Issue – Although the interested parties cite a “common” scenario, without information in the financial statements, there is no current ability to identify the extent contracts with no remaining mortality or morbidity risk are reflected as life contracts.

Question – To what extent are deposit-type contracts captured in an exhibit other than Exhibit 7? Is it possible to receive information from companies regarding this population for assessment purposes?

IP Response - We contend that by the guidance identified in SSAP No. 50, paragraph 20, a certain and life annuity, or a refund annuity, that continues payments to a surviving beneficiary after the death of the primary annuitant is not re-classified as a deposit-type contract. It is a life annuity contract where additional information on the life-status of the annuitant has become known.

Many deferred annuities contemplated by SSAP No. 50, paragraph 20a, are ultimately surrendered rather than electing a guaranteed lifetime income. These annuities are treated as investment contracts under US GAAP and re-evaluated at the time of election to annuitize. On the other hand, it is becoming more common for deferred annuities to include guaranteed minimum income benefits, minimum death benefits, or similar benefits (collectively GMxBs). A policyholder no longer has to annuitize for the contract to be subject to life contingent risks.

Ref #2019-12: ASU 2014-17, Business Combinations – Pushdown Accounting, a Consensus of the FASB Emerging Issues Task Force

Ref #2019-14: Attribution of Goodwill

The Working Group re-exposed Ref #2019-12 with a request for comments on whether pushdown accounting should be prohibited, permitted for noninsurance entities, or permitted only for U.S. Securities and Exchange Commission (SEC) registrants. The exposure also clarifies that goodwill resulting from an insurance reporting entity’s acquisition of an SCA when pushdown is applied shall be included in the reporting entity’s goodwill admittance limitation of 10% of surplus.

The Working Group re-exposed Ref #2019-14 to consider revisions to SSAP No. 97 – Investments in Subsidiary, Controlled and Affiliated Entities to require disclosure, upon acquisition of a holding company with downstream subsidiaries, of the carrying value, goodwill and admitted value of the acquired holding company as well as how the assignment of goodwill to the downstream entities was determined.
Interested parties reviewed the options exposed by the Working Group for consideration regarding pushdown accounting in Ref #2019-12. We do not recommend option 1 (“complete rejection of pushdown accounting”). With regard to the second and third options exposed for Working Group consideration, interested parties need additional time to evaluate whether these options are feasible. In our discussions, it was apparent that the proposed changes involve significant changes to insurers’ reporting and the complexities of the reporting mechanics of the annual statement will need to be addressed in applying the 10% goodwill admittance limitation and pushdown accounting. These complexities include the application of an aggregate 10% admittance limitation when multiple SCA entities carry GAAP goodwill on their individual balance sheets, as well as application to an acquired SCA holding company with subsidiaries (or layers of subsidiaries). Because annual statement reporting and disclosure includes considerable details on each investment in an SCA entity, specific guidance will likely be needed to address reporting issues such as presentation on the annual statement balance sheet and the related investment schedules, as well as interpretation related to current disclosures (including the proposed disclosures in Ref #2018-14). We believe these operational complexities need to be addressed before any proposal is considered for adoption by the Working Group.

Interested parties request additional time to evaluate various approaches for allowing pushdown accounting and working though the operational mechanics of a goodwill admittance limitation as well as evaluating the impact on insurers’ capital and surplus. Our goal is to present a recommendation for Ref # 2019-12 to the Working Group during the 2020 Spring National NAIC Meeting that addresses these complexities. Because the proposed disclosures in Ref #2019-14 includes specific SCA entity goodwill and admitted value amounts, interested parties would include those proposed disclosures in our evaluation and recommendation and, therefore, also request additional time to respond to that agenda item.

Given the need to work out clear examples that address the reporting complexities and the need for transition guidance, interested parties do not believe the proposed changes in Ref #2019-12 and Ref # 2019-14 are non-substantive nor do we believe these proposed changes can be applicable to year end 2019 reporting.

**Ref #2019-18: Accounting for “Other” Derivatives**

The Working Group re-exposed revisions to SSAP No. 86—Derivatives, to clarify that “other” derivatives not used in hedging, income generation or replication shall be reported at fair value and do not qualify as admitted assets.

Interested parties are still concerned about potential unintended consequences of the cliff effect (potential non-admission of a bond with a trivial embedded derivative) as capital markets develop. If and when problems develop, interested parties may re-examine this issue.

**Ref #2019-19: SIRI – Equity Interests**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions that clarify what should be captured in SIRI Line 13: 10 Largest Equity Interests, noting that a look-through should only occur for non-diversified funds. The revisions also exclude Securities Valuation Office (SVO)-Identified Bond Exchange-Traded Funds (ETFs) and SVO-Identified investments with underlying characteristics of fixed-income investments from this equity interrogatory.
With exposure, a referral was directed to the Capital Adequacy (E) Task Force with a request for clarification on the impact, if any, these changes may have to risk-based capital.

Interested parties have no comment on this item.

**Ref #2019-20: Rolling Short-Term Investments**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 2R—Cash, Drafts and Short-term Investments and SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, to incorporate additional principle concepts in classifying investments as cash equivalents or short-term investments.

Interested parties have concerns about the proposal to prohibit the reporting of certain short-term investments and cash equivalents as such. Certain short-term / cash equivalent investment structures have been identified by industry that are utilized in order to facilitate efficiencies and gain economies of scale and we believe they should continue to be reported as short-term or cash equivalents. While these investments may be regularly renewed, the risk profile continues to be commensurate with that of short-term investments or cash equivalents. Interested parties disagree with the broad-based language of the current exposure and believe there are more direct approaches to addressing concerns about inappropriate investment classification. We welcome the opportunity to discuss alternative approaches with staff.

**Short-Term Cash Pooling Arrangements:**

Many entities maintain short-term cash pooling arrangements. These arrangements have been instituted at insurance entities in order to more effectively invest enterprise cash, gain economies of scale, and reduce transaction costs; they have not been instituted in order to circumvent reporting requirements. Through the use of these arrangements, entities are able to generate higher returns for subsidiaries while reducing cost and personnel time required for investing on a short-term basis for all affiliated companies in an organization. These arrangements are often held within separate legal entities in which each participant invests or withdraws funds as needed on a short-term basis (sometimes daily), with their ownership interest in the arrangement fluctuating accordingly. However, participants maintain some level of interest in the pool for an extended period of time. These cash pooling arrangements have been permitted by model investment law; in addition, many insurers have received guidance from state regulators to report these investments as either short-term investments or cash equivalents depending upon the character of the underlying investments in the pool. We believe, although an insurer may own interest in the pools for longer than 3 months or a year, their investments in the short-term pools should continue to be reported as either short-term or cash equivalents, depending on the maturity dates of the underlying assets in the pool, because the risk of repayment is commensurate with the risk of repayment for the underlying assets.

In addition to the specific structures noted above, interested parties are concerned that the exposed guidance would result in misclassified assets on the balance sheet (e.g., BA asset for short-term pool arrangements instead of a cash equivalent), which would distort the level of cash, impacting liquidity ratios, RBC charges and presentation of cash flows. Thus, for these reasons, interested parties believe that short-term investment / cash equivalent reporting should continue for investments made at fair market terms with contractual maturities within the applicable time periods.

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Short-Term Lending:

Regarding short-term lending, interested parties believe that the reporting of the investment should continue to follow the form of the legal agreement, including the contractual maturity. These loans are structured for several important business reasons and have contractual maturities of less than one-year, often with the ability to renew. Upon initial evaluation, lender considerations include borrower repayment ability, value of any collateral provided, current market conditions and the presence of subordinated capital. Diligent underwriting and structuring are performed, with the completed loan agreement representing a binding contract with an unconditional obligation to repay upon contractual maturity (<12 months). Neither lender nor borrower has an obligation to extend the loan; however, at maturity, both lender and borrower have the ability to re-evaluate the transaction. If either or both parties wish to extend, the lender re-evaluates the financial position of the borrower, current value of existing collateral, and terms of the loan. If the lender decides to renew the loan, the terms are reviewed and renegotiated/re-underwritten with new terms reflecting then current market rates, consistent with the provisions of SSAP 25. Therefore, any extension should be considered a new loan transaction with a new maturity date. If extension is not mutually agreed upon, repayment to the lender is contractually required. Further, for short-term lending with affiliates over certain thresholds, prior regulatory approval may be required, providing additional opportunity for regulatory oversight. Thus, as long as these short-term loans have been made at fair market rates and with fair market conditions (which is required for loan admittance in accordance with SSAP No. 25 paragraph 9, if applicable), the economics and risk of the investment is commensurate with short-term investment reporting.

Interested parties recommend that the scope of the issue be identified prior to proposing any changes to the SSAPs. This should include identification of specific problematic investment structures, under which the economics of the transaction are not commensurate with the current classification. Once the scope and magnitude are identified, a decision can be made whether the targeted issue is widespread or limited to a few companies and whether a more direct approach may also have the desired result.

Ref #2019-22: Wash Sale Disclosure

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, to clarify that only investments that meet the definition of a wash sale in accordance with SSAP No. 103R that cross reporting period-end dates would be subject to the wash sale disclosure.

Interested parties support the proposed revisions.

Ref #2019-23: Going Concern

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, to clarify that if an unalleviated going concern is noted in audited financial statements or audit opinion, the SCA shall be nonadmitted.

Interested parties have no comment on this item.
Ref #2019-24: Levelized and Persistency Commission

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 71—Policy Acquisition Costs and Commissions, to clarify levelized commissions guidance and provide additional direction regarding commissions that are based on policy persistency. The revisions also clarify that the recognition of commission expense is based on experience to date.

The proposal as written will be a substantive change to the current guidance and to our industry, despite being categorized as nonsubstantive. The proposed changes do not merely clarify the current SSAP 71 regarding commissions, but substantially change a key point regarding persistency. During the SAP formulation process, there were two Issue Papers issued in 1996 (January and final paper in September 1996), the latter of which introduced the last sentence of paragraph 5 of the current SSAP 71. The addition of this sentence in the final issue paper from 1996 makes a distinction between the levelized commissions described as funding agreements and those which are based on persistency and other traditional elements. The effect of removing that distinction is substantive and requires the protocol of a substantive change. Additional comments and details are as follows:

1. The proposal makes substantive changes to the accounting paradigm for levelized commissions. As written, the proposed changes may have serious unintended consequences to statutory accounting. The nature of the exposed substantive changes separates the issue of “persistency” as a key element of the levelized commission payment mode of operation. This practice is engaged in by several insurers, specifically companies issuing variable life and annuity products. For example, per the exposed language, a liability for trail commissions over possibly decades would be required at policy issuance although not formally due. Persistency is a critical insurance risk. (See proposed language that the only obligating event is initial sale of a policy.) Ignoring persistency runs directly counter to various other principles of statutory accounting, most notably the definition of principle risks for reinsurance consideration in A-791.

2. The newly installed Principles-Based Reserving ("PBR") methodology allowed by regulators now includes the commission element. The effects of the proposal on PBR have not been reviewed or analyzed to determine if there are any unintended consequences, possibly double-counting, that inure to the proposal.

3. The effects of the proposal relative to reinsurance transactions have not been reviewed and analyzed inasmuch as reinsurance transactions must transfer risk, including persistency risk. (See note above regarding A-791.)

4. The issuance of a policy or contract is not the sole triggering event of a commission liability under a levelized commission mode of operation. Persistency requirements under the actual terms of the contract between the payor (the insurer) and the payee (the agent or broker receiving the levelized commission) is a key determinant as to when a liability is incurred. If a policy is issued but the persistency requirement is not met, then no commission liability is due.

5. The current accounting mode is standard in the industry, preceding the formulation of current SAP (reference the Accounting Practices and Procedures Manual-Life which was in force prior to the effective date of current SAP and which includes the same wording as current SSAP No. 71).
6. The proposal does not address policy fees, which can possibly be interpreted in a similar vein as commissions.

7. The proposal’s paradigm could possibly be applied to other items reflecting estimated predictable expenses that have yet to be incurred or for which benefits have not been received.

8. The proposal seems to be at odds with GAAP accounting rules as to the establishment of liabilities, specifically how GAAP treats commissions tied to persistency. Required persistency is deemed a “future” event negating the need for recording a current liability. This is differentiated where payments are merely extended (payment due solely based on passage of time) versus payments requiring ongoing commitments, persistency.

Conclusion

The proposal set forth is certainly substantial and requires additional in-depth analysis. Further, due to the substantive amendment currently proposed has broad and unintended implications, we ask the SAPWG to further consider and deliberate the issues.

Ref #2019-26: Appendix A-785 Revisions from U.S./EU and U.S./UK Covered Agreements

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix A-785, Credit for Reinsurance, related to the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance And Reinsurance” (Covered Agreement) adopted to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786).

Interested parties note that on page 17 of the exposure, paragraph 13.b refers to “paragraph 12.g” and should be “paragraph 13.g”

Ref #2019-27EP: Editorial and Maintenance Update

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed editorial revisions to SSAP No. 62R—Property and Casualty Reinsurance, SSAP No. 86—Derivatives, and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.

Interested parties have no comment on this item.

Ref #2019-28: ASU 2019-05, Targeted Transition Relief

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 100R—Fair Value, to reject ASU 2019-05, Targeted Transition Relief for statutory accounting.

Interested parties support the conclusion reached.
Ref #2019-29: **ASU 2019-06, Extending the Private Company Accounting Alternatives on Goodwill and Certain Identifiable Intangible Assets to Not-for-Profit Entities**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 68—*Business Combinations and Goodwill* and SSAP No. 97—*Investments in Subsidiary, Controlled and Affiliated Entities*, to reject ASU 2019-06, *Extending the Private Company Accounting Alternatives on Goodwill and Certain Identifiable Intangible Assets to Not-for-Profit Entities* for statutory accounting.

Interested parties support the proposed revisions.

Ref #2019-30: **ASU 2019-03, Updating the Definition of Collections**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—*Nonapplicable GAAP Pronouncements* to reject ASU 2019-03, *Updating the Definition of Collections* as not applicable to statutory accounting.

Interested parties have no comment on this item.

Ref #2019-31: **ASU 2018-08, Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—*Nonapplicable GAAP Pronouncements* to reject ASU 2018-08, *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made* as not applicable to statutory accounting.

Interested parties have no comment on this item.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell Rose Albrizio
October 25, 2019

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Exposure Draft Ref #2018-38: Prepayments to Service and Claims Adjusting Providers for Comment During NAIC National Meeting with Comments due October 11

Dear Mr. Bruggeman:

This item was initially exposed for comment in November 2018 in response to a regulator inquiry regarding prepayments to providers of claims and adjusting services for which the service provider is prepaid by the insurer. Interested parties provided comments to the original exposure draft, specifically regarding the treatment of the prepaid expenses as not being consistent with the classification of such amounts as miscellaneous underwriting expenses if the prepaid expense is for a covered peril in accordance with the underlying insurance contract.

During the 2019 Spring National Meeting, the Working Group incorporated these changes into the exposure draft and re-exposed this item for comment. The proposed accounting treatment would require prepayments for loss and loss adjustment expenses to be classified as a prepaid asset, and nonadmitted in accordance with SSAP No. 29, Prepaid Expenses. Upon payment of the claim to the policyholder, the prepaid asset would be reclassified as a loss or loss adjustment expense, in accordance with the terms of the contract.

As described in the issue summary, NAIC staff noted that this guidance is consistent with existing guidance instead of the approach to “expense and reclassify as amounts are paid” contained in the previous exposure draft. The more recent exposure draft retained the exclusion of this guidance to contracts subject to SSAP No. 84, Health Care and Government Insured Plan Receivables.

The Working Group made additional revisions to the exposure draft during the Summer National Meeting to “emphasize existing guidance that loss and loss adjusting expense liabilities are established regardless of payments to third parties. The liabilities are not recognized as paid until the losses are paid to claimants or claims are adjusted. Payments to third party administrators, which are not for claims or loss adjusting expense, are ‘miscellaneous underwriting expenses.’”

As noted in the 2019 Summer National Meeting minutes, these additional revisions were made in
conjunction with comments primarily from the health insurance industry as the previous exposure draft was not consistent with current accounting requirements.

Interested parties note that there are differences in the treatment of loss and loss adjusting expenses by different sectors of the industry. However, the current exposure removes important clarification from the 2019 Spring National Meeting exposure draft. To address these noted concerns, interested parties propose the following changes which are highlighted in yellow to the 2019 Summer National Meeting exposure draft – these changes incorporate industry specific guidance to address the differences in accounting by industry. Interested parties also propose moving exposed item 4.c. back to the last sentence of paragraph 4, along with proposed wording for the treatment of prepaid loss and loss adjusting expenses by specific sector of the industry. As reflected in the drafting note, there is already existing guidance which will remain unchanged; the additional clarifying guidance is proposed to be added to existing guidance.

**2019 Summer National Meeting exposure:**

**SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses:**

4. Claims, losses, and loss/claim adjustment expenses shall be recognized as expenses when a covered or insured event occurs. In most instances, the covered or insured event is the occurrence of an incident which gives rise to a claim or the incurring of costs. For claims-made type policies, the covered or insured event is the reporting to the entity of the incident that gives rise to a claim. Until claim payments and related expense payments are made subsequent to the occurrence of a covered or insured event, and in order to recognize the expense of a covered or insured event that has occurred, it is necessary to establish a liability. Liabilities shall be established for any unpaid claims and unpaid losses (loss reserves), unpaid loss/claim adjustment expenses (loss/claim adjustment expense reserves) and incurred costs, with a corresponding charge to income. Claims related extra contractual obligations losses and bad-faith losses shall be included in losses. See individual business types for the accounting treatment for adjustment expenses related to extra contractual obligations and bad-faith lawsuits, as well as the accounting treatment for prepaid expenses as it relates to specific industries.

   a. The liability for unpaid losses and claims shall be established regardless of any payments made to third-party administrators, management companies or other entities except for capitated payments under managed care contracts. The liability for claims on non-capitated payments under managed care contracts shall be established in an amount necessary to pay the losses/claims irrespective of payments made to third-party administrators, etc. The liability for claims on capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments to third parties with the exception that the liability is established net of capitated payments to providers. As loss or claims payments occur, from the third-party administrators, management companies or other entities, to the policyholder or claimant, (except for capitated payments for managed care contracts) paid claims, losses or paid loss/paid claim adjusting liabilities are reduced. Note that guidance regarding the admissibility of loans and advances to providers which apply to health insurance and managed care contracts are addressed in SSAP No. 84—
Health Care and Government Insured Plan Receivables.

b. Prepayments to third party administrators or management companies or other entities that do not relate to services or adjusting for the underlying direct policy benefits are reported as 1) Aggregate write ins for miscellaneous expenses – Property and Casualty (Underwriting and Investment Exhibit Part 3); 2) Aggregate write ins for expenses – Life/ Health (Exhibit 2 – General expenses) or 3) aggregate write ins for expenses (General Administrative Expenses) – health (Underwriting and Investment Exhibit Part 3).

c. Claims related extra contractual obligations losses and bad-faith losses shall be included in losses. See individual business types for the accounting treatment for adjustment expenses related.

5. The liability for unpaid LAE shall be established regardless of any payments made to third-party administrators, management companies or other entities except for capitated payments under managed care contracts for which the liability shall be reported net of capitated payments to providers. The liability for claims adjustment expenses on non-capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments made to third-party administrators, etc. The liability for claims adjustment expenses on capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments to third parties with the exception that the liability is established net of capitated payments to providers.

a. Prepayments to third party administrators or management companies or other entities that do not relate to services or adjusting for the underlying direct policy benefits are reported as 1) Aggregate write ins for miscellaneous expenses – Property and Casualty (Underwriting and Investment Exhibit Part 3); 2) Aggregate write ins for expenses – Life/ Health (Exhibit 2 – General expenses) or 3) aggregate write ins for expenses (General Administrative Expenses) – health (Underwriting and Investment Exhibit Part 3).

Property/Casualty

Drafting Note: the following is within existing guidance. There are no proposed changes to the guidance in pars. 6.a., 6.b., and 6.c. However, there is new guidance proposed in 6.d. and 6.e. that was in pars. 4.a., 4.b., and 5.a. of the previous exposure draft. This wording is underlined.

6. The following are types of future costs related to property and casualty contracts, as defined in SSAP No. 50, which shall be considered in determining the liabilities for unpaid losses and loss adjustment expenses.

d. All prepayments (i.e., variable, fixed or bundled amounts) to third party administrators, management companies, or other entities for unpaid claims, losses and losses/claims adjustment expenses, shall be initially reported as a prepaid asset and nonadmitted in accordance with SSAP No. 29 – Prepaid Expenses.
These payments shall not be offset against any amounts required to be reported in accordance with paragraphs 4 or 5 within this guidance.

Consistent with the recognition criteria in paragraph 4, when the covered or insured events occurs the associated prepayments to third party administrators, management companies or other entities are reclassified proportionately from the prepaid nonadmitted asset to claims, losses or loss/claim adjustment expenses based on the amount of losses/claims or loss/claims adjustment expenses incurred to provide the benefit.

e. Prepayments to third party administrators or management companies or other entities that do not relate to services or adjusting for the underlying direct policy benefits are reported as miscellaneous underwriting benefits and are not included within the scope of SSAP No. 55.

Life, Accident and Health

Drafting Note: the following is within existing guidance. There are no proposed changes to the guidance in pars. 7.a., 7.b., 7.c. and 7.d. However, there is new guidance proposed in 7.e. that was in pars. 4.a., 4.b., and 5.a. of the previous exposure draft. This wording is underlined.

7. The following future costs relating to life and accident and health indemnity contracts, as defined in SSAP No. 50, shall be considered in determining the liability for unpaid claims and claim adjustment expenses:

e. In cases where insurers advance funds to third-party administrators, management companies or other entities prior to the occurrence of the claim who then, on behalf of the insurer, adjudicate the claim and make payments to insureds or other claimants, the guidance in paragraph 9 applies.

Managed Care

Drafting Note: the following is within existing guidance. There are no proposed changes to the guidance in pars. 8.a., 8.b., 8.c. and 8.d. However, there is new guidance proposed in 8.e. that was in pars. 4.a., 4.b., and 5.a. of the previous exposure draft. This wording is underlined.

8. The following costs relating to managed care contracts as defined in SSAP No. 50 shall be considered in determining the claims unpaid and claims adjustment expenses:

e. In cases where insurers advance funds to third-party administrators, management companies or other entities prior to the occurrence of the claim who then, on behalf of the insurer, adjudicate the claim and make payments to insureds or other claimants, the guidance in paragraph 9 applies.
Managed Care and Accident and Health

Drafting Note: New guidance is issued within par. 9, which is underlined. Existing par 9 is renumbered to par. 10, and all other pars within existing guidance (i.e., pars. 10 – 23, will be renumbered to 11 – 24, respectively.

9. In some instances, insurers advance funds to third-party administrators, management companies or other entities prior to the occurrence of the claim who then, on behalf of the insurer, adjudicate the claim and make payments to insureds or other claimants. In such cases the following guidance applies:

   a. For capitated payments under managed care contracts, the liability for claims and claim adjusting expenses shall be established in an amount necessary to adjudicate and pay all unpaid claims irrespective of payments to third-party administrators, management companies or other entities, and is reported net of capitated payments to providers.

   b. For non-capitated advance payments, the liability for unpaid losses/claims and related adjustment expenses shall be established regardless of any payments made to third-party administrators, management companies or other entities, and such payments shall be reported by the insurer as prepayments. Only when loss/claim and related adjusting expense payments are made by the third-party administrators, management companies or other entities, to the policyholder or claimant, shall the insurer’s liability (loss/claim or loss/claim adjustment expense reserves) be reduced. Prepayments to third party administrators or management companies or other entities that do not relate to services or adjusting for the underlying direct policy benefits are reported as (1) Aggregate write ins for expenses - Life/Health (Exhibit 2 – General expenses) or (2) Aggregate write ins for expenses (General Administrative Expenses) - Health (Underwriting and Investment Exhibit Part 3)

   Note that this guidance in paragraph 9 does not alter existing guidance regarding the admissibility of loans and advances to providers which apply to health insurance and managed care contracts which is addressed in SSAP No. 84—Health Care and Government Insured Plan Receivables.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell                      Rose Albrizio
Statutory Accounting Principles (E) Working Group

We have reviewed the proposed changes to SSAP No. 71 – Policy Acquisition Costs and Commissions as outlined in Ref. #2019-24. We question several elements of the proposal and strongly object to the revisions for the following reasons:

1. This is very much a substantive change to existing policy, contrary to the characterization in the published exposure draft.

2. The proposal dramatically alters the fundamental premise of statutory accounting by creating a situation in which certain historically period expenses, trail commission payments, are to be treated differently from other period expenses by way of an accrual methodology. This leads to:
   a. A hybrid of statutory, GAAP and tax accounting.
   b. Fundamentally and permanently different economics for products designed with trail commission payments, leading to the need for significant effort at primary writers to redesign and/or reprice such products, presumably at a cost to the consumer.
   c. Guaranteed renewable products, like Long Term Care Insurance, could be exposed to further rate increases if the fundamental profit dynamics of the products change as a result of the new reserving practices.
   d. New uncertainty within the statutory accounting framework as to which other period expenses should also be accrued or might be targeted for similar treatment.
   e. A situation whereby trail commission expenses have a greater impact on statutory capital than other, similar expenses.
   f. A disincentive for primary writers to align the interests of the writer, broker/agent and policyholder through trail commissions because of the unique treatment and resulting capital implications.

3. Should the proposed changes be adopted, primary writers will be exposed to new and substantial accounting and actuarial workload relating to the determination of accrual methodologies for each effected product and the related periodic ‘true-up’ required to adjust the new statutory reserves for actual performance. All this with no apparent benefit for the consumer, primary writer, investment community, or regulatory bodies.

cc: Julie Gann (jgann@naic.org), Robin Marcotte (rmarcotte@naic.org), Jim Pinegar (jpinegar@naic.org), Fatima Sediqzad (fsediqzad@naic.org), Jake Stultz (jstultz@naic.org)

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The members of the AICPA NAIC Task Force (Task Force, which is a task force of the AICPA) would like to informally request clarifications on the following exposed Statutory Accounting Principles Working Group documents:

Ref No. 2019-12: ASU 2014-17, Business Combinations - Pushdown Accounting, a Consensus of the FASB EITF
Consistent with our comments submitted June 14 on the draft exposed at the 2019 Spring National Meeting, the Task Force believes the proposed revisions could be a significant change to current SAP and requests clarification as to what is meant by "audited reconciliation" and "audited support" in the proposed new paragraph 20 of SSAP 97. Would this be similar to adjustments made to the audited U.S. GAAP carrying value for par. 8.b.ii and 8.b.iv entities? For these adjustments, there is no "audited reconciliation" included in any financial statements. An insurance entity prepares a schedule to determine the required adjustments for purposes of its carrying value of the SCA, which is subject to audit procedures in relation to the insurer’s financial statements taken as a whole, but there is no reconciliation included in the audited financial statements of the SCA.

In the re-exposed document we note that the working group clarified, for companies that receive approval from their domiciliary commissioner to continue to admit the existing goodwill that has been pushed down on or before December 31 2019, that this goodwill would be subject to the 10% of surplus limitation. We suggest that specific transition guidance be provided for companies that have not previously included this goodwill in the goodwill limitation calculation. We also suggest that the working group clarify whether this GAAP goodwill is subject to amortization under SSAP 68 (as it is not amortized under U.S. GAAP). We also request that specific transition guidance be added for companies that do not obtain approval from their domiciliary regulator to continue to admit goodwill pushed down from acquisitions prior to January 1, 2020. Given the proximity of these discussions to year-end 2019, the SAP Working Group may also want to consider whether it is too near year-end to adopt any changes for 2019, since a December 2019 adoption would likely not provide adequate time for capital planning for affected companies.
October 10, 2019

Dale Bruggeman, Chair
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street
Kansas City, MO 64106

Re: SSAP No. 71—Policy Acquisition Costs and Commissions

Dear Mr. Bruggeman:

Thank you for the opportunity to provide comments on Proposal 2019-24 from the Statutory Accounting Principles Working Group regarding Policy Acquisition Costs and Commissions. The Working Group voted to expose revisions to SSAP 71 – *Policy Acquisition Costs and Commissions* - for comment at the NAIC Summer Meeting on August 3, 2019, categorized as non-substantive, to clarify levelized commission guidance and to provide additional direction regarding certain commission obligations. I offer comments on behalf of our client, DRB Insurance Solutions, LLC, a licensed insurance producer (“DRB”).

SSAP No. 71 provides that levelized commissions occur in situations in which a third party, such as a funding agent, pays agents non-levelized commissions and the reporting entity pays the third party by levelized payments. The Working Group notes that it is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third-party would ultimately be repaid to the third-party from the reporting entity. SSAP No. 71 identifies such arrangements as “funding agreements” between the reporting entity and the third-party. SSAP No. 71 further provides that the use of a commission arrangement where commission payments are not linked to traditional elements (such as premium payments and policy persistency) requires the establishment of a liability for the full amount of the unpaid principal and accrued interest which is payable to a third-party related to levelized commissions.

The accounting issue is whether levelized commission arrangements that are linked to traditional elements (such as premium payments and policy persistency) should require the establishment of a liability for the full amount of the unpaid principal and accrued interest which may be paid to a third-party in the future based upon the occurrence of defined events outside the control of the parties involved. However, the persistency commission expense should be accrued proportionately over the policy period to which the commission relates and it should accrue only when fully earned and unavoidable, specifically since the payments to the funding agent are theoretically unavoidable until the policy passes the anniversary year-end date.
NAIC Staff indicates that this proposal is to recommend clarifications to the existing levelized commissions guidance and provide additional guidance regarding commission obligations that are based on policy persistency. Questions received by NAIC staff relate to the use of levelized commission arrangements and when the liability for a commission structure that is based on annual persistency is required to be recorded as a liability in accordance with SSAP No. 5R-Liabilities, Contingencies and Impairments of Assets. Staff made the following recommendations:

1. A levelized commission arrangement (whether linked to traditional or nontraditional elements) require the establishment of a liability for the full amount of the unpaid principal and accrued interest payable to a third-party at the time the policy is issued.

2. The persistency commission is accrued proportionately over the policy period in which the commission relates to and is not deferred until fully earned.

However, we respectfully suggest that requiring the expensing at policy issuance of future levelized commission payments that are contingent upon policy persistency will likely establish a dangerous precedent requiring the accrual of liabilities for other predictable future expense payments for services or other benefits that are not yet payable. Examples may include payroll costs, commissions and expense allowances on reinsurance assumed, non-vested postemployment benefits and compensated absences and/or lease obligations.

Further, in accordance with SSAP No. 5R, key characteristics of a liability include: (1) a present duty or responsibility that entails settlement by probable future transfer of assets, (2) with little or no discretion to avoid the future sacrifice, and (3) the obligating event has already occurred. With respect to recognition of commission expense, the proposed revisions to SSAP No. 71 include the justifying statement that “The issuance of the policy is the obligating event under SSAP No. 5R.” However, this statement is factually inaccurate. The insurance company is not contractually obligated to pay future levelized commissions if the policy does not persist. No subsequent levelized commission ever becomes due unless the policy remains in-force through each subsequent anniversary date. Until the policy reaches each anniversary date, the insurance company is not obligated and has no present duty or responsibility to pay the commission.

Statutory Accounting and Principle-Based Reserving

The fundamental objective of statutory accounting is to measure solvency, as expressed in the Preamble to the Accounting Practices and Procedures Manual. Statutory Accounting Principles require expensing current amounts that are no longer available to pay policyholder claims in the future or that will have no value in liquidation. However, probable future levelized commission payments are payments that have not yet been made. Accordingly, the insurance company still has the cash or other assets that will ultimately be used to make those payments should the policies persist. Therefore, required accrual of levelized commissions appears inconsistent with the fundamental objective of measuring solvency.

Principle-Based Reserving (PBR) is a new shift in reserving approach and is expected to include consideration of commission payments within policy reserves. The addition of an accrual for levelized commissions would duplicate expenses on the Statement of Operations and again, function inconsistently with the assumptions contained in PBR.
Non-Substantive Change
Levelized commission programs began over thirty years ago, before the 1998 publication of Statutory Issue Paper No. 71 and the January 1, 2001 codification of Statutory Accounting Principles. The primary objectives of a levelized commission structure include aligning the interests of the customer, the agent, and the company and improved persistency from providing ongoing customer service. There is a duty to act in the best interests of the policyholder, as well as a compensation incentive, to make sure policies are well serviced so they stay in-force.

The proposed revisions to SSAP No. 71 are designated as non-substantive and deemed to be a clarification of intent of the codified statutory guidance. However, levelized commission programs were implemented more than a decade before the codification in 2001. Therefore, this is a material change to historical accounting practices and not a clarification of original intent. Even after codification, levelized commission programs continued for years and were not identified as applying statutory accounting incorrectly.

In conclusion, the proposed revision to SSAP 71 is clearly not “non-substantive” and would have substantial unintended consequences only some of which I have mentioned here. Accordingly, the proposal requires further substantive and policy analysis prior to consideration by the Working Group. Additionally, the expansive effect of this policy decision should be subject to open deliberation and public comment as the Working Group considers further action. Thank you for the opportunity to comment.

Very truly yours
GREENBERG TRAURIG, P.A.

Julie Mix McPeak

Julie Mix McPeak
October 11, 2019

Submitted electronically to jgann@naic.org; rmarcotte@naic.org; jpinegar@naic.org; fsedizqad@naic.org; and, jstultz@naic.org.

Mr. Dale Bruggeman
Chair of the Statutory Accounting Principles Working Group
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Dear Mr. Bruggeman,

We appreciate the opportunity to comment on the Statutory Accounting Principles Working Group (the “SAPWG”) exposure regarding NAIC’s Ref #2019-20 - Rolling Short-Term Investments (the “exposure”).

We agree that SSAP No. 2R – Cash, Cash Equivalents, Drafts and Short-Term Investments should not be utilized to mischaracterize long-term investments as short-term investments. We thus support revisions to exclude from SSAP No. 2R short-term investment structures purposely designed to mature at or around 364 days (often with affiliates) with full expectation that the investment structure will be renewed (rolled). We propose modest modifications to the recommendation, however, that we believe will support eliminating abuses of SSAP No. 2R while also ensuring that legitimate short-term investment activity continues under SSAP No. 2R.

The exposure sets forth “an overall principle that investments are permitted for short-term and cash equivalent reporting only if the reporting entity reasonably expects the investment duration to be realized (e.g., terminate / mature) on the designated maturity date” (the “overall principle”). We fully support the overall principle and believe it is essential that it be preserved. We believe, however, that certain elements of the exposure are not fully consistent with the overall principle – namely, commentary and scoping around 1) all affiliated SSAP No. 26R - Bonds investments and 2) the reacquisition of the same or substantially similar short-term investment immediately after maturity of a prior short-term investment. We address each of these items in greater detail below.

**Item 1 - all affiliated SSAP No. 26 investments**

The exposure states that: “by excluding all non-affiliated ‘bonds’ from the new guidance, the ‘normal’ recurring short-term / cash equivalent investments are not expected to be impacted.” This implies that “normal” recurring short-term / cash equivalent investments can only occur between unaffiliated entities. We disagree; we believe that the overall principle should apply to all investments, not just those that are affiliated. We also believe the concern that including unaffiliated investments would inadvertently scope in U.S. Treasury-bills, commercial paper, certificates of deposit, etc., where a reporting entity may continuously reacquire the same or a substantially similar short-term investment of such nature immediately after maturity of such a prior short-term investment, can and should be addressed otherwise (see below).
**Item 2 - the reacquisition of the same or substantially similar short-term investment immediately after maturity of a prior short-term investment**

The exposure states that “the sale or maturity of an investment, with a reacquisition of the same or substantially similar security within a 1-year timeframe, would preclude the reporting entity from reporting the currently held security as a cash equivalent or short-term investment regardless of the maturity date. (This one-year timeframe prevents reporting of recurring ‘re-acquisitions’ as cash equivalents or short-term investments.) (This provision is similar to the one regarding ‘rolled’ securities but clarifies that the ‘settlement’ of a security with a reacquisition does not prevent application of the new concepts in determining cash equivalent or short-term reporting.) (NAIC staff highlights that this restriction is necessary particularly with the use of “net settlement” structures with affiliates in which no cash is exchanged.)

The reacquisition of the same or a substantially similar short-term investment immediately after the maturity of a prior short-term investment should be permitted as long as the following proposed conditions are met that substantiate and evidence that the overall principle has been factually satisfied:

1. The prior short-term investment / cash equivalent has been fully, contractually settled in cash on or prior to a maximum original maturity date of 364 days (this provision would exclude “net settlement” structures from being eligible under SSAP No. 2R).

2. The cash used to satisfy the prior short-term investment / cash equivalent cannot have been directly or indirectly (i.e., through a separate entity) provided by the same reporting entity.

We believe that incorporating the above elements would effectively exclude unaffiliated cash equivalent / short-term investments such as U.S. Treasury bills, commercial paper, certificates of deposits, and other legitimate short-term investment activity from the exposed provisions, but in a manner consistent with the overall principle and the application of SSAP No. 2R.

* * * * * *

We look forward to continue to work with the SAPWG to refine this proposal to help achieve appropriate regulatory objectives while preserving the original principle of SSAP No. 2R for the betterment of the insurance industry, its reporting entities and its policyholders. We welcome any questions you may have for us.

Sincerely,  

__________________
Joseph W. Wittrock
Senior Vice President and Chief Investment Officer
October 11, 2019

Mr. Dale Bruggeman
Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Exposure Draft Released for Comment During NAIC National Meeting, Ref. #2019-12

Dear Mr. Bruggeman:

Teachers Insurance and Annuity Association of America (“TIAA”) appreciates the opportunity to comment on the exposure drafts released for comment by the Statutory Accounting Principles (E) Working Group (the “Working Group”) during the National Association of Insurance Commissioners (“NAIC”) Summer National Meeting in New York. We respectfully submit the following comments and suggestions for modifications to Exposure Draft Ref. #2019-12, ASU 2014-17, Business Combinations – Pushdown Accounting, a Consensus of the FASB Emerging Issues Task Force (the “Exposure Draft”).

I. About TIAA

Founded in 1918 in the state of New York, TIAA’s initial mission was to improve the quality of life for teachers in retirement. Today, TIAA is the leading provider of retirement and financial services for those in academic, research, medical, and cultural fields. Over our century-long history, TIAA’s mission has always been to aid and strengthen the institutions and participants we serve and to provide financial products that meet their needs. Today, TIAA is a Fortune 100 company with over $1 trillion in assets under management and administration, and our

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investment model and long-term approach aim to benefit the five million retirement plan participants we serve across more than 15,000 institutions. We are among the highest rated insurance companies in the U.S. by the four leading rating agencies: A.M. Best, Fitch, Moody’s Investors Service, and Standard & Poor’s. With our strong nonprofit heritage, we remain committed to the mission we embarked on in 1918 of serving the financial needs of those who serve the greater good.

To carry out this mission, our enterprise has evolved to include a diverse group of entities offering our customers a range of financial services, including asset management, retail and banking services. These diverse groups of companies help us serve customers and clients more effectively.

II. Proposed Revisions in the Exposure Draft

The Exposure Draft includes the following proposed revisions (with proposed changes to SSAP No. 68, Section 9):

**Issue:** ASU 2014-17, Business Combinations – Pushdown Accounting, a Consensus of the FASB Emerging Issues Task Force

**Status:** On April 6, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No 68—Business Combinations and Goodwill and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities to reject ASU 2014-17, Business Combinations – Pushdown Accounting for statutory accounting as well as explicitly prohibit the use of pushdown accounting under statutory accounting, which includes all entities accounted for under SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies and SSAP No. 97.

On August 3, 2019, the Statutory Accounting Principles (E) Working Group exposed this agenda item with a request for comments on the three options listed below. Additionally, to ensure that goodwill resulting from an insurance reporting entity’s acquisition of an SCA when pushdown is applied is captured within the goodwill admittance limitation, the exposure includes limited revisions to reference this goodwill in SSAP No. 68—Business Combinations and Goodwill, paragraph 9. (Note: Information provided during the Summer National Meeting on the history of pushdown and information from AICPA and industry representatives has been captured within this agenda item under the “Activity to Date” section.)

**The options for Working Group consideration include:**

1) **Complete rejection of pushdown accounting.** As pushdown is now an election for SEC / U.S. GAAP filers, reporting entities can avoid use of pushdown if prohibited for statutory accounting. (NAIC staff

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2 Data are as of June 30, 2019.
3 For stability, claims-paying ability, and overall financial strength, TIAA is one of only three insurance groups in the United States to currently hold the highest possible rating from three of the four leading insurance company rating agencies: A.M. Best (A++ rating affirmed as of June 2019), Fitch (AAA rating affirmed as of May 2019) and Standard & Poor’s (AA+ rating affirmed as of October 2018), and the second-highest possible rating from Moody’s Investors Service (Aa1 rating affirmed as of September 2018).
would propose a prospective effective date if electing this option to avoid restatement of those entities that have previously elected pushdown.)

2) Permission to use pushdown for all non-insurance entities. This option would increase optionality into the statutory financial statements. If permitted, this approach would result in different SCA values and goodwill calculations for those that follow the guidance in SSAP No. 68 and those that utilize pushdown. Under SSAP No. 68, acquired SCAs do not write-up their assets or liabilities to fair value and goodwill is calculated as the difference between purchase price and book value. Under U.S. GAAP, pushdown, acquired SCAs write-up their assets and liabilities to fair value, and goodwill is calculated as the difference between the purchase price and the fair value of the acquired entity. With pushdown, the goodwill is reported at the SCA level. As such, goodwill will be an indefinite asset unless it is identified as impaired. (Under U.S. GAAP, private entities and not-for-profit entities can elect to amortize goodwill over a 10-year period, but this is not an election for public entities.) If this option is supported, NAIC staff would recommend that the goodwill admittance limitation capture goodwill from an insurance entity’s acquisition of an SCA that is reported on the SCA financial statements. (This option would not permit pushdown for insurance SCAs (8.b.i entities).)

(If this option is considered, NAIC staff would propose restrictions on the use of pushdown that differ from U.S. GAAP. For example, under U.S. GAAP, a reporting entity could subsequent elect pushdown accounting in any reporting period after original acquisition. If pushdown was permitted, NAIC staff would propose to require the election at original acquisition and not allow subsequent elections.)

3) Permit pushdown if elected by SEC Registrants, excluding non-insurance entities. Although this option would introduce different accounting by type of reporting entity, it is consistent with when pushdown would have been applied under prior statutory accounting guidance. (Under the old SEC provisions, pushdown was only permitted when meeting certain SEC requirements.) This would seemingly allow the companies that have historically utilized pushdown under the SEC rules to continue acquisitions under that prior approach. If this option is supported, NAIC staff would recommend that the goodwill admittance limitation capture goodwill from the acquisition of an SCA that is reported on the SCA financial statements. (Also, NAIC staff would propose restrictions to the provisions to ensure the election is made at the time of original acquisition.) (This option would not permit pushdown for insurance SCAs (8.b.i entities).

Exposed Edits to SSAP No. 68—Business Combinations and Goodwill:

8. For those acquired SCA entities accounted for in accordance with paragraph 8.b.i. of SSAP No. 97 under the statutory purchase method, the historical bases of the acquired entity shall continue to be used in preparing its statutory financial statements. Therefore, pushdown accounting is not permitted.

9. Positive goodwill recorded under the statutory purchase method of accounting shall be admitted subject to the following limitation: Positive goodwill from all sources, including life, accident and health, and deposit-type assumption reinsurance and goodwill resulting from the acquisition of an SCA by the insurance reporting entity that is reported on the SCA’s financial statements (resulting from the application of pushdown accounting), is limited in the aggregate to 10% of the acquiring entity’s capital and surplus as required to be shown on the statutory balance sheet of the reporting entity for its most recently filed statement with the domiciliary state commissioner adjusted to exclude any net positive goodwill, EDP equipment and operating system software, and net deferred tax assets. Additionally, all positive goodwill shall be nonadmitted when the underlying investment in the SCA or partnership, joint venture and limited liability company is nonadmitted. When negative goodwill exists, it shall be recorded as a contra-asset. Positive or negative goodwill resulting from the purchase of an SCA, joint venture, partnership or limited liability company shall be amortized to unrealized capital gains and losses on investments over the period in which the acquiring entity benefits economically, not to exceed 10 years. Positive or negative goodwill resulting from life, accident and health, and deposit-type assumption reinsurance shall be amortized to operations as a component of general insurance expenses over the period in which the assuming entity benefits economically, not to exceed 10 years. Goodwill shall be evaluated separately for each transaction. [INT 01-18]
III. TIAA Comments on Proposed Revisions

TIAA strongly encourages the NAIC to thoroughly engage with the industry on Exposure Draft Ref. #2019-12 Business Combinations – Pushdown Accounting and the classification of the proposal as substantive or non-substantive.

We note that the NAIC classifies as “substantive listings” those items that require a new issue paper and SSAP to address the issue. Once items are placed on this listing, they are prioritized and the formal maintenance policy is followed. Conversely, “nonsubstantive listings” are those items that are considered editorial or technical in nature and for which a new SSAP will therefore not be developed. In other words, a revision to a SSAP for these items will not be deemed to modify its conclusion or original intent.4

While the NAIC categorized the revisions in the Exposure Draft as “nonsubstantive,” without industry analysis and further clarity in application, we believe the proposed changes to SSAP No. 68, paragraph 9, which would apply a 10% limitation on goodwill, could represent a substantive change in accounting. Without conducting an impact assessment and publishing a more thorough issue paper, we feel it is difficult for the NAIC to conclude that the proposed revisions do not modify the conclusion or original intent of the guidance with regards to all admitted Subsidiary, Controlled and Affiliated Entities (“SCAs”).

We acknowledge the NAIC staff’s concerns with goodwill; however, we believe staff can gain insight through deeper engagement with the industry regarding the structure of insurance entities, and the creation, accounting, and reporting of goodwill. Additionally, while we understand there are concerns with regards to goodwill treatment to non-insurance entities, we believe the NAIC can more thoroughly consider the purpose of those entities and their support of the insurance parent as these entities typically provide operational support as well as dividends that directly support policyholder obligations.

TIAA supports pushdown accounting Option 2 as proposed by the NAIC.

TIAA does not support a complete rejection of pushdown accounting (Option 1), nor do we believe that pushdown should be permitted if elected by SEC registrants (excluding non-insurance entities) (Option 3), as we predict this approach would create competitive disadvantages and unnecessary inconsistencies in the treatment of goodwill among entities.

owned by an insurer. We recommend that the NAIC continue allowing pushdown for all non-insurance entities (Option 2).

_TIAA recommends the NAIC partner with industry to conduct an impact assessment._

Given the potential substantive nature of the proposal, we recommend that industry participants partner with the NAIC to evaluate the Exposure Draft, including conducting an industry impact assessment. The assessment will include an analysis of the types of insurance entities impacted by the NAIC’s proposal and the potential effects on these entities’ organizational structure and domicile. The information gathered as a result of the impact assessment can assist in preventing the formation of competitive disadvantages and other unintended negative consequences among the affected entities. We welcome the opportunity to assist the NAIC in identifying, evaluating and driving such assessment.

_TIAA encourages the NAIC to discuss transitional guidance with the industry, and consider responses to FASB’s proposed treatment of goodwill._

As noted above, given the potential substantive nature of the NAIC’s proposed accounting changes, and in light of our view that an industry impact assessment be conducted before these changes are finalized, we believe transitional guidance, in any form (i.e., disclosure, prospective, effective dates, etc.), be carefully discussed with all interested parties before proposal.

Additionally, we recognize that the Financial Accounting Standards Board (“FASB”) is also considering the treatment of goodwill and, as such, we recommend that NAIC consider the responses to the FASB Invitation to Comment on File Reference No. 2019-720, Identifiable Intangible Assets and Subsequent Accounting for Goodwill. As many of the SCAs within scope of the NAIC proposal report goodwill on a GAAP basis, any future changes to GAAP could impact or potentially address the NAIC’s concerns.

**IV. Conclusion**

TIAA applauds the NAIC’s continued focus on this issue, and we appreciate the opportunity to comment on the Exposure Draft. We recommend that the NAIC classify Exposure Draft Ref. #2019-12 Business Combinations – Pushdown Accounting as **substantive** and work with the industry to perform an impact assessment that would inform an issue paper. We welcome the

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opportunity to discuss our views and recommendations in greater detail and any questions you have.

Sincerely,

Oluseun Salami
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

**Issue:** SIRI – Equity Interests

**Check (applicable entity):**

- Modification of existing SSAP: P/C, Life, Health
- New Issue or SSAP: No, No, No
- Interpretation: No, No, No

**Description of Issue:**
This agenda item has been drafted pursuant to direction received during the 2019 Spring National Meeting to clarify what shall be captured in **Line 13: 10 Largest Equity Interests** of the Supplemental Investment Risks Interrogatories (SIRI). The intent of the SIRI is to assist regulators in reviewing compliance with state investment limitations and analyzing the risks inherent in an entity’s investment portfolio. However, from questions received on certain categories, it has been identified that clarity is needed to ensure consistent reporting and that the desired aggregation of risks is reported.

This agenda item is being considered subsequent to revisions incorporated to SIRI **Line 2: 10 Largest Exposures to a Single Issuer / Borrower / Investment** and the proposal of a new reporting category for “fund managers.” These clarification items were exposed by the Blanks (E) Working Group during the 2019 Spring National Meeting and adopted for 2019 year-end reporting during the Blanks (E) Working Group June 24 conference call.

Pursuant to the revisions previously recommended, it is suggested that the following concepts be followed in aggregating investments for SIRI:

- Investments held in diversified funds do not need to be separately aggregated with other investments due to the fund diversification. For this exclusion, only funds in which the issuer can assert that the fund is diversified in accordance with the 1940 Investment Act are excluded from aggregation.

- Investments held in non-diversified funds shall be aggregated with other exposures for reporting in SIRI. This aggregation shall be based on the underlying investments in funds (or other commingled investment structures). For example, if a non-diversified was issued by BlackRock, the investment exposure is not to BlackRock, but the investments captured within the non-diversified fund. To further expand, if the non-diversified fund held investments from Exxon Mobile, then those investments shall be aggregated with other investments held from Exxon Mobile (held directly or in a non-diversified fund) to determine the overall aggregate exposure to Exxon Mobile. (This requires a look-through into non-diversified funds.)

During the 2019 Spring National Meeting, two options were presented to clarify the aggregation of equity interests in Line 13. Pursuant to informal comments received, as well as the concepts noted above, this agenda item proposes revisions in accordance with the proposed “Option 2”. This approach excludes diversified funds from the look-through/ aggregation requirement and clarifies that a look-through is required to non-diversified equity funds for aggregation and reporting. It also clarifies that any equity interest (regardless of diversification) that individually qualifies as one of the largest equity interests shall be captured in SIRI Line 13.
Existing Authoritative Literature:

Supplemental Investment Risk Interrogatories (SIRI)

This set of Supplemental Interrogatories is to assist regulators in identifying and analyzing the risks inherent in the entity’s investment portfolio. The Supplemental Investment Risks Interrogatories apply only to general account assets. These lines were determined based upon the investment categories contained in the NAIC Statutory Statement and considered as invested assets. The reported amounts are to be consistent with net admitted amounts reported by the entity in the statement and supporting schedules, not on a consolidated basis. Compute the percentage calculations by dividing the reported amount by the total admitted assets reported in Line 1 of the Interrogatories unless otherwise indicated. It is recommended that the first step in responding to this set of Interrogatories is for the person preparing this document to read through the Interrogatories to gain an understanding of the reporting requirements.

Line 13.02 through 13.11 Report the amounts and percentages of admitted assets held in the ten largest equity interests (including investments in the shares of mutual funds, preferred stocks, publicly traded equity securities, and other equity securities (including Schedule BA equity interests), and excluding money market and bond mutual funds listed in Part Six, Sections 2(f) and (g) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office as exempt or NAIC 1).

Determine the ten largest equity interests by first aggregating investments included in this line by issuer. For example, the reporting entity owns preferred stock of the XYZ Company of $600,000 and common stock of the XYZ Company of $300,000. The total is $900,000 ($600,000+$300,000). The reporting entity also owns bonds issued by the XYZ Company of $500,000 that are excluded from this calculation because bonds are debt instruments. Other equity securities include partnerships and Limited Liability Companies (LLC) and any other investments reported in Schedule BA classified as equity.

SIRI – As Modified Following the Blanks (E) Working Group June 2019 Conference Call – 2019-13BWG:

Line 2 Report the single 10 largest exposures to a single issuer/borrower/investment.

Determine the ten largest exposures by first, aggregating investments from all investment categories (except the excluded categories) by issuer. The first six digits of the CUSIP number can be used as a starting point; however, please note that the same issuer may have more than one unique series of the first six digits of the CUSIP. For example, the reporting entity owns bonds issued by the XYZ Company of $500,000 and common stock of the XYZ Company of $600,000. In addition, the reporting entity has a mortgage loan to the XYZ Company of $300,000. The total exposure to Issuer XYZ Company is $1.4 million ($500,000+$600,000+$300,000).

For funds that are not diversified within the meaning of the Investment Company Act of 1940, insurance reporting entities are required to identify actual exposures and aggregate those exposures with directly held investments to determine the 10 largest exposures. For example, if a reporting entity directly holds a significant number of investments in Exxon Mobil and holds a non-diversified closed-end fund with a high concentration of Exxon Mobil, the reporting entity shall aggregate the direct investments with the investments in the closed-end funds to determine the aggregate investment risk to Exxon Mobile.
Excluding: U.S. government securities (Part Six, Section 2(e)), U.S. government agency securities (Part Six, Section 2(e)), those U.S. Government money market funds (Part Six, Section 2(f)) listed in the Purposes and Procedures Manual of the NAIC Investment Analysis Office as exempt; property occupied by the company; and policy loans.

Also exclude asset types that are investment companies (mutual funds) and common trust funds that are diversified within the meaning of the Investment Company Act of 1940 [Section 5(b) (1)].

All SEC and foreign registered funds (open-end, closed-end, UIT and ETFs) and common trust funds that are diversified within the meaning of the Investment Company Act of 1940 [Section 5(b) (1)].

Report the investments held in the ten largest fund managers, with allocation between funds that are diversified or non-diversified in accordance with the meaning of the Investment Company Act of 1940. This should include all “funds” regardless of the type of fund (private placement, mutual fund, exchange-traded fund, closed-end fund, money market mutual fund, etc.), reporting schedule or underlying investments captured in a fund.

Determine the ten largest fund managers by aggregating all “fund” investments by fund manager. For example, if a reporting entity holds a BlackRock SVO-Identified Bond ETF (diversified within the meaning of the Investment Company Act of 1940) reported on Schedule D-1 at $500,000, four BlackRock diversified mutual funds reported on Schedule D-2 at $2,200,000 and two BlackRock non-diversified closed-end funds totaling $1,500,000, the reporting entity shall report their aggregated investment in BlackRock funds of $4,200,000, with $2,700,000 in diversified funds and $1,500,000 in non-diversified funds.

Activity to Date (issues previously addressed by the Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

During the 2019 Spring National Meeting, the Statutory Accounting Principles (E) Working Group sponsored a blanks proposal (2019-13BWG) to clarify the instructions for Line 2: 10 Largest Exposures and to incorporate a new category for fund managers (Line 14). These revisions were adopted during the Blanks (E) Working Group June 24, 2019 conference call. (The revisions are detailed above.) Also, during the 2019 Spring National Meeting, the Working Group received two options to consider revisions to Line 13: 10 Largest Equity Interests. These proposed revisions would clarify that reporting entities should always look-through funds for aggregation (option one) or add provisions that would remove diversified funds from the look-through requirement (option two):

- **Option One**: Further expansion of the instruction to identify that reporting entities shall always look-through all funds (except for the money market mutual funds and SVO-Identified bond funds) to aggregate equity interests, with explicit identification of any equity fund that qualifies as one of the 10 largest interests. (This option would not be a change in guidance but would explicitly clarify the existing requirement.)
Report the amounts and percentages of admitted assets held in the ten largest equity interests (including equity funds that qualify individually as one of the largest equity interests, and a look-through of investments in the shares of mutual funds, preferred stocks, publicly traded equity securities, and other security securities (including Schedule BA equity interests), and excluding money market and bond mutual funds listed in Part Six, Section 2(f) and (g) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office as exempt or NAIC 1.

Determine the ten largest equity interests by first aggregating investments included in this line by issuer. For example, the reporting entity owns preferred stock of the XYZ Company of $600,000 and common stock of XYZ Company of $300,000 and $100,000 of XYZ identified through a look-through of a diversified stock mutual fund reported on Schedule D-2-2. The total is $91,000,000 (600,000+300,000+100,000). The reporting entity also owns bonds issued by XYZ Company of $500,000 that are excluded from this calculation because bonds are debt instruments. Other equity securities include partnerships and Limited Liability Companies (LLC) and any other investments reported in Schedule BA as equity.

- **Option Two:** Incorporate revisions to exclude aggregation of equity interests in diversified funds.

  With this approach, an entity would only need to look-through funds that are not diversified in accordance with the Investment Company Act of 1940 to aggregate their ten largest equity interests. (This change would still require explicit identification of any equity funds that qualifies as one of the 10 largest interests.)

Report the amounts and percentages of admitted assets held in the ten largest equity interests (including equity funds that qualify individually as one of the largest equity interests, and a look-through of investments in the shares of non-diversified mutual funds and ETFs, preferred stocks, publicly traded equity securities, and other security securities (including Schedule BA equity interests), and excluding money market and bond mutual funds listed in Part Six, Section 2(f) and (g) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office as exempt or NAIC 1. Equity interests in all funds that are diversified in accordance with the Investment Company Act of 1940 do not need to be individually assessed and aggregated to determine the ten largest equity interests. For funds that are not diversified within the meaning of the Investment Company Act of 1940, insurance reporting entities are required to identify actual equity interests within the fund and aggregate those equity interests to determine their ten largest equity interests.

Determine the ten largest equity interests by first aggregating investments included in this line by issuer. For example, the reporting entity owns preferred stock of the XYZ Company of $600,000 and common stock of XYZ Company of $300,000 and $50,000 of XYZ identified through a look-through of a non-diversified stock closed-end fund reported on Schedule D-2-2. The total is $9650,000 (600,000+300,000+50,000). The reporting entity also owns bonds issued by XYZ Company of $500,000 that are excluded from this calculation because bonds are debt instruments. The reporting entity may also have exposure to equity interests in XYZ through mutual funds that are excluded from this calculation as the funds are diversified within the meaning of the Investment Company Act of 1940. Other equity securities include partnerships and Limited Liability Companies (LLC) and any other investments reported in Schedule BA as equity.

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** None

**Convergence with International Financial Reporting Standards (IFRS):** Not Applicable.
Staff Recommendation: NAIC staff recommends that the Working Group expose this agenda item with the intent to sponsor a blanks proposal to clarify what should be captured in SIRI Line 13: 10 Largest Equity Interests. These proposed blanks revisions clarify that a look-through should only occur for non-diversified funds, and that investments within a diversified fund investment shall be excluded from an aggregation requirement to other equity investments. It also clarifies that any equity interest (regardless of diversification) that individually qualifies as one of the largest equity interests shall be captured in SIRI Line 13. This is consistent with the Option 2 approach presented at the 2019 Spring National Meeting. Additionally, the revisions expand the guidance to include SVO-Identified Bond ETFs, and SVO-Identified investments with characteristics of fixed-income investments as specific exclusions from the listing. (The exclusions for money market mutual funds and SVO bond mutual funds are currently in the guidance.) Comments from regulators are specifically requested on these exclusions.

Proposed Revisions to the annual statement instructions for SIRI Line 13: Ten Largest Equity Interests:

Report the amounts and percentages of admitted assets held in the ten largest equity interests (including equity funds that qualify individually as one of the largest equity interests, and a look-through of investments in the shares of non-diversified mutual funds and ETFs, preferred stocks, publicly traded equity securities, and other security securities (including Schedule BA equity interests), and excluding money market and bond mutual funds listed in Part Six, Section 2(f) and (g) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office as exempt or NAIC 1. Equity interests in all funds that are diversified in accordance with the Investment Company Act of 1940 do not need to be individually assessed and aggregated to determine the ten largest equity interests. For funds that are not diversified within the meaning of the Investment Company Act of 1940, insurance reporting entities are required to identify actual equity interests within the fund and aggregate those equity interests to determine their ten largest equity interests.

Determine the ten largest equity interested by first aggregating investments included in this line by issuer. For example, the reporting entity owns preferred stock of the XYZ Company of $600,000, and common stock of XYZ Company of $300,000 and $50,000 of XYZ identified through a look-through of a non-diversified stock closed-end fund reported on Schedule D-2-2. The total is $9950,000 (600,000+300,000+50,000). The reporting entity also owns bonds issued by XYZ Company of $500,000 that are excluded from this calculation because bonds are debt instruments. The reporting entity may also have exposure to equity interests in XYZ through mutual funds that are excluded from this calculation as the funds are diversified within the meaning of the Investment Company Act of 1940. Other equity securities include partnerships and Limited Liability Companies (LLC) and any other investments reported in Schedule BA as equity.

The following funds shall also be excluded from aggregation as equity interests: SVO-Identified U.S. Direct Obligations / Full Faith And Credit Exempt List of Money Market Mutual Funds, SVO-Identified Bond ETFs, SVO-Identified Bond Mutual Funds and SVO Identified fund investments with underlying characteristics of fixed-income instruments, which do not contain underlying equities and that are outlined within the Purposes and Procedures Manual of the NAIC Investment Analysis Office.

Staff Review Completed by: Julie Gann – May 2019

Status:
On August 3, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions that clarify what should be captured in SIRI Line 13: 10 Largest Equity Interests, noting that a look-through should only occur for non-diversified funds. The revisions
also exclude Securities Valuation Office (SVO)-Identified Bond Exchange-Traded Funds (ETFs) and SVO-Identified investments with underlying characteristics of fixed-income investments from this equity interrogatory. With exposure, a referral was directed to the Capital Adequacy (E) Task Force with a request for clarification on the impact, if any, these changes may have to risk-based capital.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group adopted the exposed revisions to SIRI Line 13: 10 Largest Equity Interests of the blanks, as final, to clarify that a look-through should only occur for non-diversified funds, and that investments within a diversified fund investment shall be excluded from an aggregation requirement to other equity investments. Additionally, the revisions expand the guidance to include SVO-Identified Bond ETFs, and SVO-Identified investments with characteristics of fixed-income investments as specific exclusions from the listing. These revisions do not change the Accounting Practices and Procedures Manual, but will be forwarded to the Blanks (E) Working Group.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Wash Sale Disclosure

Check (applicable entity):

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Description of Issue: This agenda item has been drafted to consider revisions to the wash sale disclosure captured in SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities. The wash sale guidance was revised in 2017 to 1) clarify what types of investment are subject to the wash sale disclosure, 2) respond to several comments from interested parties, and 3) clarify what investments are subject to and what investments were exempt from this disclosure.

NAIC staff have been informed by industry that the tracking of wash sales can be very time-consuming and uses a large amount of resources while not necessarily responding to the main risks associated with these transactions. Investments sold and repurchased during the same reporting period, such as sold on May 1 and repurchased on May 20 and then held at the reporting date do not pose any greater risk than if the investments had been held throughout that period and at the period end date. The real risk with these transactions is investments that are sold prior to the end of a reporting period and then repurchased shortly after that date.

Existing Authoritative Literature:

- SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities provides the definition of a wash sale and the disclosure requirements.

- U.S. GAAP provides limited guidance on wash sales, mostly to identify that wash sales are captured as “sales” unless there is a concurrent contract to repurchase or redeem the transferred financial asset. (There is no definition or required disclosure for wash sales under U.S. GAAP.)

- The SEC defines a wash sale as follows:

  A wash sale occurs when you sell or trade securities at a loss and within 30 days before or after the sale you:

  - Buy substantially identical securities,
  - Acquire substantially identical securities in a fully taxable trade, or
  - Acquire a contract or option to buy substantially identical securities.

  Internal Revenue Service rules prohibit you from deducting losses related to wash sales. For more information about wash sales, read IRS Publication 550, Investment Income and Expenses (Including Capital Gains and Losses).

- The IRS has a similar definition to the SEC and disallows the recognition of losses for wash sales:

  A wash sale occurs when you sell or trade stock or securities at a loss and within 30 days before or after the sale you:
Buy substantially identical stock or securities,

Acquire substantially identical stock or securities in a fully taxable trade,

Acquire a contract or option to buy substantially identical stock or securities, or

Acquire substantially identical stock for your individual retirement account (IRA) or Roth IRA.

If you sell stock and your spouse or a corporation you control buys substantially identical stock, you also have a wash sale.

If your loss was disallowed because of the wash sale rules, add the disallowed loss to the cost of the new stock or securities (except in (4) above). The result is your basis in the new stock or securities. This adjustment postpones the loss deduction until the disposition of the new stock or securities. Your holding period for the new stock or securities includes the holding period of the stock or securities sold.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):**

Agenda item 2017-23 included clarification that money market mutual funds are excluded from the wash sale disclosure. Further, agenda item 2017-31 clarified that all cash equivalents, derivative instruments and short-term investments with credit assessments equivalent to an NAIC 1-2 designation are excluded from the disclosure.

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** None

**Convergence with International Financial Reporting Standards (IFRS):** None

**Staff Recommendation:**
It is recommended that the Working Group move this agenda item to the active listing, categorized as nonsubstantive, and expose draft revisions to clarify that only investments that meet the definition of a wash sale in accordance with SSAP No. 103R, which are purchased or sold prior to a reporting period end and sold or repurchased after that reporting date would be subject to the wash sale disclosure. This will eliminate the need to report transactions that meet the wash sale criteria in SSAP No. 103R that are sold and purchased within the same reporting period. Wash sales that cross either a quarterly or annual reporting period must be disclosed.

**Proposed Revisions to SSAP No. 103R:**

28.l. A reporting entity shall disclose the following information for wash sales, as defined in paragraph 12, involving transactions for securities with an NAIC designation of 3 or below, or that do not have an NAIC designation (excluding all cash equivalents, derivative instruments as well as short-term investments with credit assessments equivalent to an NAIC 1-2 designation). This disclosure shall be included in the financial statements for when the investment was initially sold and is only applicable for sales and purchases that cross quarter-end or year-end reporting periods. For example, if the investment was sold December 20, 2017, and reacquired on January 10, 2018, the transaction shall be captured in the wash sale disclosure included in the year-end 2017 financial statements, while an investment sold on May 1, 2019 and reacquired on May 20, 2019 would not be required to be disclosed:

i. A description of the reporting entity’s objectives regarding these transactions;
ii. An aggregation of transactions by NAIC designation 3 or below, or that do not have an NAIC designation;

iii. The number of transactions involved during the reporting period;

iv. The book value of securities sold;

v. The cost of securities repurchased; and

vi. The realized gains/losses associated with the securities involved.

Staff Review Completed by:
Jake Stultz—June 2019

Status:
On August 3, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, as illustrated above, to clarify that only investments that meet the definition of a wash sale in accordance with SSAP No. 103R that cross reporting period-end dates would be subject to the wash sale disclosure.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group adopted the exposed revisions to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, as final, to clarify that only investments that meet the definition of a wash sale in accordance with SSAP No. 103R that cross reporting periods are subject to the wash sale disclosure. This eliminates the need to report transactions that meet the wash sale criteria in SSAP No. 103R that are within the same reporting period. Wash sales that cross either a quarterly or annual reporting period must be disclosed.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Going Concern

Check (applicable entity):

- Modification of existing SSAP
- New Issue or SSAP
- Interpretation

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Description of Issue:
This agenda item has been drafted due to the prevalence of SCAs being identified as a “going concern” in 2018 audit reports for SCA Sub 2 filings. The going concern principle is the assumption that a company will continue into the foreseeable future, unless there is evidence to the contrary. During a financial statement audit, the auditor has an obligation to review the company’s ability to continue as a going concern. If there is substantial doubt about the company’s ability to continue in the future, a going concern qualification is supposed to be included in the auditor’s opinion of the company’s financial statements. Indicators of going concern can include the following:

- Negative trends such as declining sales, increasing costs, recurring losses, adverse financial ratios, etc.
- Legal proceedings against the company, which may include pending liabilities and penalties related to the violation of environmental or other laws
- Loss or expiration of a key license or patent
- Default on a loan or inability to secure new financing
- Loss of a major customer or key supplier

Under statutory accounting, the investment in a company with a going concern audit opinion must be nonadmitted in the reporting insurance entity’s financial statements. However, statutory accounting procedures do not specify any action to be taken in the event that a going concern is noted in any other part of the audit report aside from the audit opinion. Over the last year there have been a few instances in which the audit opinions did not explicitly detail the going concern, but the notes in the audited financial statements identified that there was a going concern. (In one situation, the audit opinion originally reflected a going concern, but the audit opinion was refiled with the NAIC to eliminate the reference from the audit opinion. In this resubmission, the going concern for the company was still detailed in the audited financial statements.)

One of the key foundation concepts of statutory accounting is conservatism. Conservative valuation procedures provide protection to policyholders against adverse fluctuations in financial condition or operating results. Statutory accounting should be reasonably conservative over the span of economic cycles and in recognition of the primary responsibility to regulate for financial solvency. As such, if an unalleviated going concern is mentioned in any part of the audit report or accompanying financial statements / notes, the value of the SCA should be nonadmitted.

Existing Authoritative Literature:
SSAP No. 97:

Paragraph 8
   c. The following provides guidance regarding the audits for entities covered under paragraph 8.b.:
       i. The investment in the SCA shall be nonadmitted if the audited financial statements include substantial doubt about the entity's ability to continue as a going concern. Additionally, the investment shall be nonadmitted on the basis/contents of the audit opinion as detailed in paragraph 21.

Paragraph 21
   e. The investment shall be nonadmitted if the audit opinion contains explanatory language indicating that there is substantial doubt about the investee's ability to continue as a going concern.

Exhibit C – Implementation Questions and Answers

5. Q - Does the audit opinion provided on the subsidiaries financial statements have to be clean or unqualified in order for the SCA investment to be admitted?

5.1 A – Paragraph 21 addresses various opinions that can be issued in which an entity can record certain investments under the GAAP Equity method of accounting. In certain cases, such as when the audit opinion is a disclaimer of opinion or there is indication that there is substantial doubt about the entity's ability to continue as a going concern, the guidance states the investment shall be nonadmitted. In addition, if there is a qualified opinion due to a departure from GAAP (or an adverse opinion) or due to a scope limitation, the investment shall be nonadmitted unless the impact of the departure is quantified within the audit opinion (see quantification exception related to the valuation of a U.S. insurance entity on the basis of U.S. statutory accounting principles discussed below). In cases where the departure is quantified, the reporting entity would admit the amount after adjusting for the quantified departure from GAAP. An audit report that contains a qualified or adverse opinion for any other reason than for what is stated within paragraph 21 would result in the nonadmissibility of the investment within that subsidiary. There is no need to quantify the impact of a departure from GAAP in either the auditor's report or the footnotes to the financial statements if a qualified audit opinion is issued due to a departure from GAAP and the departure is related to the valuation of an U.S. insurance entity on the basis of U.S. statutory accounting principles. In such cases, the investment shall be admitted without quantifying the departure.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): None

Staff Recommendation:
Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as detailed below, to expand the parameters for nonadmittance of entities with going concern.

Proposed Revisions:
SSAP No. 97:

Paragraph 8

c. The following provides guidance regarding the audits for entities covered under paragraph 8.b.:

i. The investment in the SCA shall be nonadmitted if the audited financial statements include substantial doubt about the entity’s ability to continue as a going concern. Additionally, the investment shall be nonadmitted on the basis/contents of the audit opinion as detailed in paragraph 21.

Paragraph 21

e. The investment shall be nonadmitted if the audit opinion report or accompanying financial statements / notes contains explanatory language indicating that there is an unalleviated substantial doubt about the investee’s ability to continue as a going concern.

5. Q - Does the audit opinion provided on the subsidiaries financial statements have to be clean or unqualified in order for the SCA investment to be admitted?

5.1 A – Paragraph 21 addresses various opinions that can be issued in which an entity can record certain investments under the GAAP Equity method of accounting. In certain cases, such as when the audit opinion is a disclaimer of opinion or there is indication that there is substantial doubt about the entity’s ability to continue as a going concern, the guidance states the investment shall be nonadmitted. In instances where there is a substantial doubt about the entity’s ability to continue as a going concern listed in any part of the audit report or accompanying financial statements / notes, the investment shall be nonadmitted. In addition, if there is a qualified opinion due to a departure from GAAP (or an adverse opinion) or due to a scope limitation, the investment shall be nonadmitted unless the impact of the departure is quantified within the audit opinion (see quantification exception related to the valuation of a U.S. insurance entity on the basis of U.S. statutory accounting principles discussed below). In cases where the departure is quantified, the reporting entity would admit the amount after adjusting for the quantified departure from GAAP. An audit report that contains a qualified or adverse opinion for any other reason than for what is stated within paragraph 21 would result in the nonadmissibility of the investment within that subsidiary. There is no need to quantify the impact of a departure from GAAP in either the auditor's report or the footnotes to the financial statements if a qualified audit opinion is issued due to a departure from GAAP and the departure is related to the valuation of an U.S. insurance entity on the basis of U.S. statutory accounting principles. In such cases, the investment shall be admitted without quantifying the departure.

Staff Review Completed by:
Fatima Sediqzad - NAIC Staff
July 2019

Status:
On August 3, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as illustrated above, to clarify that if an unalleviated going concern is noted in audited financial statements or audit opinion, the SCA shall be nonadmitted.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group adopted the exposed revisions to SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as final, to clarify that if an unalleviated going concern is noted in the audited financial statements or audit opinion, the SCA shall be nonadmitted.
## Issue: Appendix A-785 Revisions from U.S./EU and U.S./UK Covered Agreements

**Check (applicable entity):**

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**Description of Issue:**

On June 25, 2019, NAIC Executive Committee and Plenary adopted revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) to incorporate relevant provisions from the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” and the “Bilateral Agreement Between the United States of America and the United Kingdom Regarding Insurance and Reinsurance” (collectively referred to as the Covered Agreement). The purpose of this agenda item is to incorporate those revisions into Appendix A-785, Credit for Reinsurance.

**Existing Authoritative Literature:**

The Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786), as they are adopted by the states are the primary legal guidance for credit for reinsurance, and relevant excerpts from Model #785 and Model #786 are included in Appendix A-785.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** None

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** None

**Convergence with International Financial Reporting Standards (IFRS):** None

**Staff Recommendation:**

NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to Appendix A-785 to incorporate the updates from the adopted Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) that incorporate the relevant provisions from the Covered Agreement. The proposed revisions to the full Appendix A-785 are included in the subsequent pages. With this exposure, NAIC staff request input from regulators and interested parties on how best to establish effective dates for these revisions in Appendix A-785.

**Staff Review Completed by:**

Jake Stultz—July 2019

**Status:**

On August 3, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix A-785, Credit for Reinsurance, as illustrated below, related to the “Bilateral Agreement Between the United States of America and the European..."
Union on Prudential Measures Regarding Insurance And Reinsurance” (Covered Agreement) adopted to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786).

On December 7, 2019, the Statutory Accounting Principles (E) Working Group adopted the exposed revisions, with a paragraph reference change in paragraph 13.b. from 12.g. to be 13.g., to Appendix A-785, Credit for Reinsurance, as final, to incorporate the updates from the adopted Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) that incorporate the relevant provisions from the Covered Agreement.
Appendix A-785

Credit For Reinsurance

Relevant SSAPs:
SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance
SSAP No. 62R—Property and Casualty Reinsurance
SSAP No. 66—Retrospectively Rated Contracts

Definitions

Note: There are references to where the changes came from in the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) in the paragraphs below. These are only to assist in reviewing and will be removed from the final version of Appendix A-785 when it is adopted.

1. “Commissioner” refers to the commissioner of insurance in the state where credit or a reduction from liability is taken.

2. “Jurisdiction” refers to any state, district or territory of the United States and also to territories, provinces or jurisdictions other than the United States.

3. “Liabilities” shall mean the assuming insurer’s gross liabilities attributable to reinsurance ceded by U. S. domiciled insurers that are not otherwise secured by acceptable means.

4. “Beneficiary” means the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

5. “Grantor” means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

6. “Obligations,” as used in paragraph 3029 of this appendix means:
   a. Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;
   b. Reserves for reinsured losses reported and outstanding;
   c. Reserves for reinsured losses incurred but not reported; and
   d. Reserves for allocated reinsured loss expenses and unearned premiums.

Credit Allowed a Domestic Ceding Insurer

7. Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of paragraphs 8, 9, 10, 11, 12, or 13 or 14 of this appendix. Credit shall be allowed under paragraphs 8, 9, or 10 of this appendix only as respects cessions of those kinds or classes of business which the assuming insurer is licensed or otherwise allowed to write or assume in its state of domicile or, in the case of a U.S. branch of an alien assuming insurer, in the state...
through which it is entered and licensed to transact insurance or reinsurance. Credit shall be allowed under paragraphs 10 or 11 of this appendix only if the applicable requirements of paragraph 1544 have been satisfied.

8. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in the domiciliary state of the ceding insurer.

9. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer by the domiciliary state of the ceding insurer. In order to be eligible for accreditation, a reinsurer must:
   a. File with the commissioner evidence of its submission to the domiciliary state’s jurisdiction;
   b. Submit to the domiciliary state’s authority to examine its books and records;
   c. Be licensed to transact insurance or reinsurance in at least one state, or in the case of a U.S. branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;
   d. File annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and
   e. Demonstrate to the satisfaction of the commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than $20,000,000 and its accreditation has not been denied by the commissioner within ninety (90) days after submission of its application.

10. a. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled in, or in the case of a U.S. branch of an alien assuming insurer is entered through, a state that employs standards regarding credit for reinsurance substantially similar to those of the domiciliary state of the ceding insurer and the assuming insurer or U.S. branch of an alien assuming insurer:
   i. Maintains a surplus as regards policyholders in an amount not less than $20,000,000; and
   ii. Submits to the authority of the domiciliary state to examine its books and records.
   b. The requirement of paragraph 10.a.i. does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

11. a. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified U.S. financial institution, as defined in paragraph 5453, for the payment of the valid claims of its U.S. ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually information substantially the same as that required to be reported on the NAIC Annual Statement form by licensed insurers. The assuming insurer shall submit to examination of its books and records by the commissioner and bear the expense of examination.
   b. i. Credit for reinsurance shall not be granted under this paragraph 11 unless the form of the trust and any amendments to the trust have been approved by:
      (a) The commissioner of the state where the trust is domiciled; or
      (b) The commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.
   ii. The trust instrument shall provide that:
Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied thirty (30) days after entry of the final order of any court of competent jurisdiction in the United States;

Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor’s U.S. ceding insurers, their assigns and successors in interest;

The trust shall be subject to examination as determined by the commissioner;

The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust; and

No later than February 28 of each year the trustee of the trust shall report to the commissioner in writing setting forth the balance in the trust and listing the trust’s investments at the preceding year-end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the following December 31.

c. The following requirements apply to the following categories of assuming insurer:

i. The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer’s liabilities attributable to reinsurance ceded by U.S. ceding insurers, and, in addition, the assuming insurer shall maintain a trusted surplus of not less than $20,000,000, except as provided in paragraph 11.c.ii. of this appendix.

ii. At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusted surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of U.S. ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer’s liquidity or solvency. The minimum required trusted surplus may not be reduced to an amount less than thirty percent (30%) of the assuming insurer’s liabilities attributable to reinsurance ceded by U.S. ceding insurers covered by the trust.

iii. (a) In the case of a group including incorporated and individual unincorporated underwriters:

(1) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, the trust shall consist of a trusted account in an amount not less than the respective underwriters’ several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any underwriter of the group;

(2) For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after
that date, not-withstanding the other provisions contained herein, the trust shall consist of a trusteed account in an amount not less than the respective underwriters’ several insurance and reinsurance liabilities attributable to business written in the United States; and

(3) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the U.S. domiciled ceding insurers of any member of the group for all years of account; and

(b) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group’s domiciliary regulator as are the unincorporated members.

(c) Within ninety (90) days after its financial statements are due to be filed with the group’s domiciliary regulator, the group shall provide to the commissioner an annual certification by the group’s domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

iv. In the case of a group of incorporated underwriters under common administration, the group shall:

(a) Have continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to making application for accreditation;

(b) Maintain aggregate policyholders’ surplus of at least $10,000,000,000;

(c) Maintain a trust fund in an amount not less than the group’s several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;

(d) In addition, maintain a joint trusteed surplus of which $100,000,000 shall be held jointly for the benefit of U.S. domiciled ceding insurers of any member of the group as additional security for these liabilities; and

(e) Within ninety (90) days after its financial statements are due to be filed with the group’s domiciliary regulator, make available to the commissioner an annual certification of each underwriter member’s solvency by the member’s domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.

d. For the purposes of this paragraph 11., the term “liabilities” shall mean the assuming insurer’s gross liabilities attributable to reinsurance ceded by U.S. domiciled insurers excluding liabilities that are otherwise secured by acceptable means, and shall include:

i. For business ceded by domestic insurers authorized to write accident and health, and property and casualty insurance:
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(a) Losses and allocated loss expenses paid by the ceding insurer, recoverable from the assuming insurer;

(b) Reserves for losses reported and outstanding;

(c) Reserves for losses incurred but not reported;

(d) Reserves for allocated loss expenses; and

(e) Unearned premiums.

ii. For business ceded by domestic insurers authorized to write life, health and annuity insurance:

(a) Aggregate reserves for life policies and contracts net of policy loans and net due and deferred premiums;

(b) Aggregate reserves for accident and health policies;

(c) Deposit funds and other liabilities without life or disability contingencies; and

(d) Liabilities for policy and contract claims.

12. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified as a reinsurer in the domestic state of the ceding insurer and secures its obligations in accordance with the requirements of this paragraph 12.

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

i. The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the domestic state of the ceding insurer pursuant to paragraphs 12.c. and 12.k. of this subsection;

ii. The assuming insurer must maintain minimum capital and surplus, or its equivalent, in an amount as provided in paragraph 12.i.iii.(b) of this appendix;

iii. The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the domestic state of the ceding insurer, as provided in paragraph 12.i.iii.(c) of this appendix;

iv. The assuming insurer must agree to submit to the jurisdiction of the domestic state of the ceding insurer, appoint the commissioner of the domestic state of the ceding insurer as its agent for service of process in that state, and agree to provide security for 100 percent of the assuming insurer’s liabilities attributable to reinsurance ceded by U.S. ceding insurers if it resists enforcement of a final U.S. judgment;

v. The assuming insurer must agree to meet applicable information filing requirements as determined by the domestic state of the ceding insurer, both with respect to an initial application for certification and on an ongoing basis; and
vi. The assuming insurer must satisfy any other requirements for certification deemed relevant by the domestic state of the ceding insurer.

b. An association including incorporated and individual unincorporated underwriters may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying requirements of paragraph 12.a. of this appendix:

i. The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents (net of liabilities) of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the domestic state of the ceding insurer to provide adequate protection;

ii. The incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association’s domiciliary regulator as are the unincorporated members; and

iii. Within ninety (90) days after its financial statements are due to be filed with the association’s domiciliary regulator, the association shall provide to the domestic state of the ceding insurer an annual certification by the association’s domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

c. The domestic state of the ceding insurer shall create and publish a list of qualified jurisdictions, under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the domestic state of the ceding insurer as a certified reinsurer.

i. In order to determine whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the domestic state of the ceding insurer shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. jurisdiction to reinsurers licensed and domiciled in the U.S. A qualified jurisdiction must agree to share information and cooperate with the domestic state of the ceding insurer with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the domestic state of the ceding insurer has determined that the jurisdiction does not adequately and promptly enforce final U.S. judgments and arbitration awards. Additional factors may be considered in the discretion of the domestic state of the ceding insurer.

ii. A list of qualified jurisdictions shall be published through the NAIC Committee Process. The domestic state of the ceding insurer shall consider this list in determining qualified jurisdictions. If the domestic state of the ceding insurer approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the state shall provide thoroughly documented justification in accordance with criteria to be developed under regulations.
iii. U.S. jurisdictions that meet the requirement for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

iv. If a certified reinsurer’s domiciliary jurisdiction ceases to be a qualified jurisdiction, the domestic state of the ceding insurer has the discretion to suspend the reinsurer’s certification indefinitely, in lieu of revocation.

d. The domestic state of the ceding insurer shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the commissioner pursuant to regulation. The domestic state of the ceding insurer shall publish a list of all certified reinsurers and their ratings.

e. A certified reinsurer shall secure obligations assumed from U.S. ceding insurers under this subsection at a level consistent with its rating, as specified in paragraph 12.h.i. of this appendix.

i. In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the domestic state of the ceding insurer and consistent with the provisions of paragraph 1918 of this appendix, or in a multibeneficiary trust in accordance with paragraph 11 of this appendix, except as otherwise provided in paragraph 12.e.ii. through 12.e.v. of this appendix.

ii. If a certified reinsurer maintains a trust to fully secure its obligations subject to paragraph 11 of this appendix, and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by paragraph 12, or comparable laws of other U.S. jurisdictions, and for its obligations subject to paragraph 11 of this appendix. It shall be a condition to the grant of certification under paragraph 12 of this appendix that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

iii. The minimum trusteed surplus requirements provided in paragraph 11 of this appendix are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection, except that such trust shall maintain a minimum trusteed surplus of $10,000,000.

iv. With respect to obligations incurred by a certified reinsurer under paragraph 12 of this appendix, if the security is insufficient, the allowable reinsurance credit shall be reduced by an amount proportionate to the deficiency, and the domestic state of the ceding insurer has the discretion to impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer’s obligations will not be paid in full when due.

v. For purposes of paragraph 12, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure 100 percent of its obligations.
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(a) As used in paragraph 12.e.v., the term “terminated” refers to revocation, suspension, voluntary surrender and inactive status.

(b) If the domestic state of the ceding insurer continues to assign a higher rating as permitted by other provisions of paragraph 12, this requirement does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

f. If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the domestic state of the ceding insurer has the discretion to defer to that jurisdiction’s certification, and has the discretion to defer to the rating assigned by that jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in the domestic state of the ceding insurer.

g. A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of paragraph 12, and the domestic state of the ceding insurer shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

h. The credit allowed under paragraph 12 shall be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the commissioner. The security shall be in a form consistent with the provisions of paragraph 12 and paragraph 1948 of this appendix, and paragraphs 20-5149-50 of this appendix, as applicable. The amount of security required in order for full credit to be allowed shall correspond with the following requirements:

i. **Ratings**  | **Security Required**
--- | ---
Secure – 1 | 0%
Secure – 2 | 10%
Secure – 3 | 20%
Secure – 4 | 50%
Secure – 5 | 75%
Vulnerable – 6 | 100%

ii. Affiliated reinsurance transactions shall receive the same opportunity for reduced security requirements as all other reinsurance transactions.

iii. The commissioner shall require the certified reinsurer to post one hundred percent (100%), for the benefit of the ceding insurer or its estate, security upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer.

iv. In order to facilitate the prompt payment of claims, a certified reinsurer shall not be required to post security for catastrophe recoverables for a period of one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the commissioner. The one year deferral period is contingent upon the certified reinsurer continuing to pay claims in a timely manner. Reinsurance recoverables for only the following lines of business as
reported on the NAIC annual financial statement related specifically to the catastrophic occurrence will be included in the deferral:

(a) Line 1: Fire
(b) Line 2: Allied Lines
(c) Line 3: Farmowners multiple peril
(d) Line 4: Homeowners multiple peril
(e) Line 5: Commercial multiple peril
(f) Line 9: Inland Marine
(g) Line 12: Earthquake
(h) Line 21: Auto physical damage

v. Credit for reinsurance under paragraph 12 of this appendix shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance contract entered into prior to the effective date of the certification of the assuming insurer that is subsequently amended after the effective date of the certification of the assuming insurer, or a new reinsurance contract, covering any risk for which collateral was provided previously, shall only be subject to this section with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract.

vi. Nothing in paragraph 12 of this appendix shall prohibit the parties to a reinsurance agreement from agreeing to provisions establishing security requirements that exceed the minimum security requirements established for certified reinsurers under this section.

i. Certification Procedure

i. The commissioner of the domestic state of the ceding insurer shall post notice on the insurance department’s website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The commissioner may not take final action on the application until at least thirty (30) days after posting the notice required by this paragraph.

ii. The commissioner of the domestic state of the ceding insurer shall issue written notice to an assuming insurer that has made application and been approved as a certified reinsurer. Included in such notice shall be the rating assigned the certified reinsurer in accordance with paragraph 12.h. of this appendix. The commissioner shall publish a list of all certified reinsurers and their ratings.

iii. In order to be eligible for certification, the assuming insurer shall meet the following requirements:
(a) The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction, as determined by the commissioner pursuant to paragraph 12.c. and 12.k. of this appendix.

(b) The assuming insurer must maintain capital and surplus, or its equivalent, of no less than $250,000,000 calculated in accordance with paragraph 12.i.iv.(h) of this appendix. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

(c) The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. These financial strength ratings will be one factor used by the commissioner in determining the rating that is assigned to the assuming insurer. Acceptable rating agencies include the following:

(1) Standard & Poor’s;
(2) Moody’s Investors Service;
(3) Fitch Ratings;
(4) A.M. Best Company; or
(5) Any other Nationally Recognized Statistical Rating Organization.

(d) The certified reinsurer must comply with any other requirements reasonably imposed by the commissioner of the domestic state of the ceding insurer.

iv. Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following:

(a) The certified reinsurer’s financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in the table below. The commissioner shall use the lowest financial strength rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies will result in loss of eligibility for certification:
<table>
<thead>
<tr>
<th>Ratings</th>
<th>Best</th>
<th>S&amp;P</th>
<th>Moody’s</th>
<th>Fitch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure – 1</td>
<td>A++</td>
<td>AAA</td>
<td>Aaa</td>
<td>AAA</td>
</tr>
<tr>
<td>Secure – 2</td>
<td>A+</td>
<td>AA+, AA, AA-</td>
<td>Aa1, Aa2, Aa3</td>
<td>AA+, AA, AA-</td>
</tr>
<tr>
<td>Secure – 3</td>
<td>A</td>
<td>A+, A</td>
<td>A1, A2</td>
<td>A+, A</td>
</tr>
<tr>
<td>Secure – 4</td>
<td>A-</td>
<td>A-</td>
<td>A3</td>
<td>A-</td>
</tr>
<tr>
<td>Secure – 5</td>
<td>B++, B+</td>
<td>BBB+, BBB, BBB-</td>
<td>Baa1, Baa2, Baa3</td>
<td>BBB+, BBB, BBB-</td>
</tr>
</tbody>
</table>

(b) The business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations;

c) For certified reinsurers domiciled in the U.S., a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/casualty reinsurers) or Schedule S (for life and health reinsurers);

d) For certified reinsurers not domiciled in the U.S., a review annually of Form CR-F (for property/casualty reinsurers) or Form CR-S (for life and health reinsurers);

e) The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers’ Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than ninety (90) days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership;

(f) Regulatory actions against the certified reinsurer;

(g) The report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in paragraph (h) below;

(h) For certified reinsurers not domiciled in the U.S., audited financial statements (audited U.S. GAAP basis if available, audited IFRS basis statements are allowed but must include an audited footnote reconciling equity and net income to a U.S.
GAAP basis, or, with the permission of the state insurance commissioner, audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company), regulatory filings, and actuarial opinion (as filed with the non-U.S. jurisdiction supervisor, with a translation into English). Upon the initial application for certification, the commissioner will consider audited financial statements for the last two/three (23) years filed with its non-U.S. jurisdiction supervisor; \(\text{(Model \#786, Section 8B(4)(h))}\)

(i) The liquidation priority of obligations to a ceding insurer in the certified reinsurer’s domiciliary jurisdiction in the context of an insolvency proceeding;

(j) A certified reinsurer’s participation in any solvent scheme of arrangement, or similar procedure, which involves U.S. ceding insurers. The commissioner shall receive prior notice from a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement; and

(k) Any other information deemed relevant by the commissioner.

v. Based on the analysis conducted under paragraph 12.i.iv.(e) of a certified reinsurer’s reputation for prompt payment of claims, the commissioner may make appropriate adjustments in the security the certified reinsurer is required to post to protect its liabilities to U.S. ceding insurers, provided that the commissioner shall, at a minimum, increase the security the certified reinsurer is required to post by one rating level under paragraph 12.h. if the commissioner finds that:

(a) more than fifteen percent (15%) of the certified reinsurer’s ceding insurance clients have overdue reinsurance recoverables on paid losses of ninety (90) days or more which are not in dispute and which exceed $100,000 for each cedent; or

(b) the aggregate amount of reinsurance recoverables on paid losses which are not in dispute that are overdue by ninety (90) days or more exceeds $50,000,000.

vi. The assuming insurer must submit a properly executed Form CR-1 as evidence of its submission to the jurisdiction of this state, appointment of the commissioner as an agent for service of process in this state, and agreement to provide security for one hundred percent (100%) of the assuming insurer’s liabilities attributable to reinsurance ceded by U.S. ceding insurers if it resists enforcement of a final U.S. judgment. The commissioner shall not certify any assuming insurer that is domiciled in a jurisdiction that the commissioner has determined does not adequately and promptly enforce final U.S. judgments or arbitration awards.

vii. The certified reinsurer must agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis. All information submitted by certified reinsurers which are not otherwise public information subject to disclosure shall be exempted from disclosure under [cite state law equivalent of Freedom of Information Act] and shall be withheld from public disclosure. The applicable information filing requirements are, as follows:
(a) Notification within ten (10) days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license or any change in rating by an approved rating agency, including a statement describing such changes and the reasons therefore;

(b) Annually, Form CR-F or CR-S, as applicable;

(c) Annually, the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in paragraph 12.i.vii.(d) below;

(d) Annually, the most recent audited financial statements (audited U.S. GAAP basis if available, audited IFRS basis statements are allowed but must include an audited footnote reconciling equity and net income to a U.S. GAAP basis, or, with the permission of the state insurance commissioner, audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company), regulatory filings, and actuarial opinion (as filed with the certified reinsurer’s supervisor, with a translation into English). Upon the initial certification, audited financial statements for the last two/three (2/3) years filed with the certified reinsurer’s supervisor; *(Model #786, Section 8B(7)(d))*

(e) At least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers;

(f) A certification from the certified reinsurer’s domestic regulator that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction’s highest regulatory action level; and

(g) Any other information that the commissioner may reasonably require.

j. Change in Rating or Revocation of Certification

i. In the case of a downgrade by a rating agency or other disqualifying circumstance, the commissioner shall upon written notice assign a new rating to the certified reinsurer in accordance with the requirements of paragraph 12.i.

ii. The commissioner shall have the authority to suspend, revoke, or otherwise modify a certified reinsurer’s certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this section, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, lead the commissioner to reconsider the certified reinsurer’s ability or willingness to meet its contractual obligations.

iii. If the rating of a certified reinsurer is upgraded by the commissioner, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the commissioner shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the commissioner, the commissioner shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.
iv. Upon revocation of the certification of a certified reinsurer by the commissioner, the assuming insurer shall be required to post security in accordance with paragraph 1918 in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with paragraph 11, the commissioner may allow additional credit equal to the ceding insurer’s pro rata share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer’s rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of three (3) months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the commissioner to be at high risk of uncollectibility.

k. Qualified Jurisdictions

i. If, upon conducting an evaluation with respect to the reinsurance supervisory system of any non-U.S. assuming insurer, the commissioner of the domestic state of the ceding insurer determines that the jurisdiction qualifies to be recognized as a qualified jurisdiction, the commissioner shall publish notice and evidence of such recognition in an appropriate manner. The commissioner may establish a procedure to withdraw recognition of those jurisdictions that are no longer qualified.

ii. In order to determine whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner shall evaluate the reinsurance supervisory system of the non-U.S. jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. jurisdiction to reinsurers licensed and domiciled in the U.S. The commissioner shall determine the appropriate approach for evaluating the qualifications of such jurisdictions, and create and publish a list of jurisdictions whose reinsurers may be approved by the commissioner as eligible for certification. A qualified jurisdiction must agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. Additional factors to be considered in determining whether to recognize a qualified jurisdiction, in the discretion of the commissioner, include but are not limited to the following:

(a) The framework under which the assuming insurer is regulated.

(b) The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance.

(c) The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction.

(d) The form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used.

(e) The domiciliary regulator’s willingness to cooperate with U.S. regulators in general and the commissioner in particular.

(f) The history of performance by assuming insurers in the domiciliary jurisdiction.
(g) Any documented evidence of substantial problems with the enforcement of final U.S. judgments in the domiciliary jurisdiction. A jurisdiction will not be considered to be a qualified jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

(h) Any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors or successor organization.

(i) Any other matters deemed relevant by the commissioner.

iii. A list of qualified jurisdictions shall be published through the NAIC Committee Process. The commissioner shall consider this list in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification with respect to the criteria provided under paragraphs 12.k.ii.(a) to (i).

iv. U.S. jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

l. Recognition of Certification Issued by an NAIC Accredited Jurisdiction

i. If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the commissioner has the discretion to defer to that jurisdiction’s certification, and to defer to the rating assigned by that jurisdiction, if the assuming insurer submits a properly executed Form CR-1 and such additional information as the commissioner requires. The assuming insurer shall be considered to be a certified reinsurer in this State.

ii. Any change in the certified reinsurer’s status or rating in the other jurisdiction shall apply automatically in this State as of the date it takes effect in the other jurisdiction. The certified reinsurer shall notify the commissioner of any change in its status or rating within 10 days after receiving notice of the change.

iii. The commissioner may withdraw recognition of the other jurisdiction’s rating at any time and assign a new rating in accordance with paragraph 12.j. of this appendix.

iv. The commissioner may withdraw recognition of the other jurisdiction’s certification at any time, with written notice to the certified reinsurer. Unless the commissioner suspends or revokes the certified reinsurer’s certification in accordance with paragraph 12.j. of this appendix, the certified reinsurer’s certification shall remain in good standing in the domestic state of the ceding insurer for a period of three (3) months, which shall be extended if additional time is necessary to consider the assuming insurer’s application for certification in this State.

m. Mandatory Funding Clause. In addition to the clauses required under SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance and SSAP No. 62R—Property and Casualty Reinsurance, reinsurance contracts entered into or renewed under paragraph 12 of this appendix shall include a proper funding clause, which requires the certified reinsurer to provide and
maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this section for reinsurance ceded to the certified reinsurer.

n. The commissioner shall comply with all reporting and notification requirements that may be established by the NAIC with respect to certified reinsurers and qualified jurisdictions.

13. Credit shall be allowed when the reinsurance is ceded to an assuming insurer meeting each of the conditions set forth in paragraphs 13.a through 13.h. Credit shall be allowed for reinsurance ceded by a domestic insurer to an assuming insurer that is licensed to write reinsurance by, and has its head office or is domiciled in, a Reciprocal Jurisdiction, and which meets the other requirements of paragraph 13. *(Model #786, Section 9A)*

a. The assuming insurer must have its head office or be domiciled in, as applicable, and be licensed in a Reciprocal Jurisdiction. A “Reciprocal Jurisdiction” is a jurisdiction that meets one of the following: *(Model #785, Section 2F(1)(a) Model #786, Section 9B)*

i. A non-U.S. jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union. For purposes of this subsection, a “covered agreement” is an agreement entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

ii. A U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or

iii. A qualified jurisdiction, as determined by the commissioner, which is not otherwise described in paragraphs 13.a.i or 13.a.ii. above and which the commissioner determines meets all of the following additional requirements:

(a) Provides that an insurer which has its head office or is domiciled in such qualified jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance is received for reinsurance assumed by insurers domiciled in such qualified jurisdiction;

(b) Does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by the non-U.S. jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

(c) Recognizes the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in such qualified jurisdiction, that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group
supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the commissioner or the commissioner of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the qualified jurisdiction; and

(d) Provides written confirmation by a competent regulatory authority in such qualified jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such qualified jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.

b. The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction, and confirmed as set forth in paragraph 13.g, according to the methodology of its domiciliary jurisdiction, in the following amounts: (Model #786, Section 9C(2))

i. No less than $250,000,000; or

ii. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters:

(a) Minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000; and

(b) A central fund containing a balance of the equivalent of at least $250,000,000.

c. The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, as follows: (Model #786, Section 9C(3))

i. If the assuming insurer has its head office or is domiciled in a Reciprocal Jurisdiction as defined in paragraph 13.a.i., the ratio specified in the applicable covered agreement;

ii. If the assuming insurer is domiciled in a Reciprocal Jurisdiction as defined in paragraph 13.a.ii, a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, calculated in accordance with the formula developed by the NAIC; or

iii. If the assuming insurer is domiciled in a Reciprocal Jurisdiction as defined in paragraph 13.a.iii, after consultation with the Reciprocal Jurisdiction and considering any recommendations published through the NAIC Committee Process, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency.

d. The assuming insurer must agree and provide adequate assurance to the commissioner, in a form of a properly executed Form RJ-1, as follows: (Model #786, Section 9C(4))
i. The assuming insurer must provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in paragraphs 13.b. or 13.c., or if any regulatory action is taken against it for serious noncompliance with applicable law;

ii. The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. The commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement. Nothing in this provision shall limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

iii. The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

iv. Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the assuming insurer’s liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate; and

v. The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement which involves this state’s ceding insurers, and agree to notify the ceding insurer and the commissioner and to provide security in an amount equal to one hundred percent (100%) of the assuming insurer’s liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of paragraph 12 and paragraph 19. The term “solvent scheme of arrangement” means a foreign or alien statutory or regulatory compromise procedure subject to requisite majority creditor approval and judicial sanction in the assuming insurer’s home jurisdiction either to finally commute liabilities of duly noticed classed members or creditors of a solvent debtor, or to reorganize or restructure the debts and obligations of a solvent debtor on a final basis, and which may be subject to judicial recognition and enforcement of the arrangement by a governing authority outside the ceding insurer’s home jurisdiction.

vi. The assuming insurer must agree in writing to meet the applicable information filing requirements as set forth in paragraph 13.e.

e. The assuming insurer or its legal successor must provide, if requested by the commissioner, on behalf of itself and any legal predecessors, the following documentation to the commissioner: *(Model #786, Section 9C(5))*

i. For the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer’s annual audited financial statements, in accordance with
the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report;

ii. For the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer’s supervisor;

iii. Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States; and

iv. Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer’s assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer to allow for the evaluation of the criteria set forth in paragraph 13.f.

f. The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met: (Model #786, Section 9C(6))

i. More than fifteen percent (15%) of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the commissioner;

ii. More than fifteen percent (15%) of the assuming insurer’s ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer $100,000, or as otherwise specified in a covered agreement; or

iii. The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds $50,000,000, or as otherwise specified in a covered agreement.

g. The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction, that the assuming insurer complies with the requirements set forth in paragraphs 13.b. and 13.c. (Model #786, Section 9C(7))

h. Nothing in this provision precludes an assuming insurer from providing the commissioner with information on a voluntary basis. (Model #786, Section 9C(8))

i. The commissioner shall timely create and publish a list of Reciprocal Jurisdictions. (Model #785, Section 2F(2) and Model #786, Section 9D)

i. A list of Reciprocal Jurisdictions is published through the NAIC Committee Process. The commissioner’s list shall include any Reciprocal Jurisdiction as defined under paragraphs 13.a.i. and 13.a.ii., and shall consider any other Reciprocal Jurisdiction included on the NAIC list. The commissioner may approve a jurisdiction that does not appear on the NAIC list of Reciprocal Jurisdictions.
ii. The commissioner may remove a jurisdiction from the list of Reciprocal Jurisdictions upon a determination that the jurisdiction no longer meets one or more of the requirements of a Reciprocal Jurisdiction, except that the commissioner shall not remove from the list a Reciprocal Jurisdiction as defined under paragraphs 13.a.i. and 13.a.ii. Upon removal of a Reciprocal Jurisdiction from this list credit for reinsurance ceded to an assuming insurer domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to this appendix.

i. The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in paragraph 13 and to which cessions shall be granted credit in accordance with paragraph 13. *(Model #786, Section 9E)*

i. If an NAIC accredited jurisdiction has determined that the conditions set forth in paragraph 13 have been met, the commissioner has the discretion to defer to that jurisdiction’s determination, and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit in accordance with this subsection. The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirements of paragraph 13.b., 13.c. and 13.d.

ii. When requesting that the commissioner defer to another NAIC accredited jurisdiction’s determination, an assuming insurer must submit a properly executed Form RJ-1 and additional information as the commissioner may require. A state that has received such a request will notify other states through the NAIC Committee Process and provide relevant information with respect to the determination of eligibility.

k. If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this section, the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this section. *(Model #786, Section 9F)*

i. While an assuming insurer’s eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer’s obligations under the contract are secured in accordance with paragraph 19.

ii. If an assuming insurer’s eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer’s obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of paragraph 19.

l. Before denying statement credit or imposing a requirement to post security with respect to paragraph 13.k. or adopting any similar requirement that will have substantially the same regulatory impact as security, the commissioner shall. *(Model #786, Section 9G)*

i. Communicate with the ceding insurer, the assuming insurer, and the assuming insurer’s supervisory authority that the assuming insurer no longer satisfies one of the conditions listed in paragraphs 13.a., 13.b. and 13.c.;
ii. Provide the assuming insurer with 30 days from the initial communication to submit a plan to remedy the defect, and 90 days from the initial communication to remedy the defect, except in exceptional circumstances in which a shorter period is necessary for policyholder and other consumer protection;

iii. After the expiration of 90 days or less, as set out in paragraph 13.l.ii., if the commissioner determines that no or insufficient action was taken by the assuming insurer, the commissioner may impose any of the requirements as set out in this subsection; and

iv. Provide a written explanation to the assuming insurer of any of the requirements set out in paragraph 13.l.

m. If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding liabilities. (Model #786, Section 9H)

o. Nothing in this subsection shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this appendix. (Model #785, Section 2F(6))

p. Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements pursuant to paragraphs 13.a through 13.h., and (ii) the effective date of the new reinsurance agreement, amendment, or renewal. (Model #785, Section 2F(7))

i. This paragraph does not alter or impair a ceding insurer’s right to take credit for reinsurance, to the extent that credit is not available under this subsection, as long as the reinsurance qualifies for credit under any other applicable provision of this appendix.

ii. Nothing in this subsection shall authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

iii. Nothing in this subsection shall limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

1413. Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraphs 8, 9, 10, 11, or 12 of this appendix, but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

1544. If the assuming insurer is not licensed, accredited or certified to transact insurance or reinsurance in the domiciliary state of the ceding insurer, the credit allowed by paragraphs 10 and 11 of this appendix shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

a. i. That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court
jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal.

ii. To designate the commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding insurer.

b. This paragraph 1544 is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

1615. If the assuming insurer does not meet the requirements of paragraphs 8, 9 or 10, the credit allowed by paragraph 11 or 12 of this appendix shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

a. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by paragraph 11 c. of this appendix, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

b. The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

c. If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the U.S. ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

d. The grantor shall waive any right otherwise available to it under U.S. law that is inconsistent with this provision.

1746. If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the domestic state of the ceding insurer may suspend or revoke the reinsurer’s accreditation or certification.

a. The domestic state of the ceding insurer must give the reinsurer notice an opportunity for hearing. The suspension or revocation may not take effect until after the state’s order on hearing, unless:

i. The reinsurer waives its right to hearing;

ii. The state’s order is based on regulatory action by the reinsurer’s domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer’s eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under paragraph 12.f. of this appendix; or

iii. The domestic state of the ceding insurer finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the state’s action.

b. While a reinsurer’s accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer’s obligations under the contract are secured in accordance with paragraph 1948. If a reinsurer’s accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer’s obligations under the contract are secured in accordance with paragraph 12.e. or paragraph 1948.

Valuation of and Requirements for Trust Assets

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1847. Assets deposited in the trust shall be valued according to their current fair market value and shall consist only of cash in U.S. dollars, certificates of deposit issued by a U.S. financial institution as defined in paragraph 5352, clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified U.S. financial institution, as defined in paragraph 5352, and investments of the type specified in this paragraph, but investments in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust shall not exceed five percent (5%) of total investments. No more than twenty percent (20%) of the total of the investments in the trust may be foreign investments authorized under paragraphs 1847.a.v., c., f.ii. or g. of this paragraph, and no more than ten percent (10%) of the total of the investments in the trust may be securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in U.S. dollars and representing rights conferred by a foreign security shall be classified as a foreign investment denominated in a foreign currency. The assets of a trust shall be invested only as follows:

a. Government obligations that are not in default as to principal or interest, that are valid and legally authorized and that are issued, assumed or guaranteed by:
   
   i. The United States or by any agency or instrumentality of the United States;
   
   ii. A state of the United States;
   
   iii. A territory, possession or other governmental unit of the United States;
   
   iv. An agency or instrumentality of a governmental unit referred to in paragraphs 1847.a.i. and 1847.a.ii. if the obligations shall be by law (statutory of otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for making these payments, but shall not be obligations eligible for investment under this paragraph if payable solely out of special assessments on properties benefited by local improvements; or
   
   v. The government of any other country that is a member of the Organization for Economic Cooperation and Development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

b. Obligations that are issued in the United States, or that are dollar denominated and issued in a non-U.S. market, by a solvent U.S. institution (other than an insurance company) or that are assumed or guaranteed by a solvent U.S. institution (other than an insurance company) and that are not in default as to principal or interest if the obligations:
   
   i. Are rated A or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC, or if not so rated, are similar in structure and other material respects to other obligations of the same institution that are so rated;
   
   ii. Are insured by at least one authorized insurer (other than the investing insurer or a parent, subsidiary or affiliate of the investing insurer) licensed to insure obligations in this state and, after considering the insurance, are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC; or
   
   iii. Have been designated as Class One or Class Two by the Securities Valuation Office of the NAIC;
c. Obligations issued, assumed or guaranteed by a solvent non-U.S. institution chartered in a country that is a member of the Organization for Economic Cooperation and Development or obligations of U.S. corporations issued in a non-U.S. currency, provided that in either case the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

d. An investment made pursuant to the provisions of paragraph 1847.a., b. or c. shall be subject to the following additional limitations:

i. An investment in or loan upon the obligations of an institution other than an institution that issues mortgage-related securities shall not exceed five percent (5%) of the assets of the trust;

ii. An investment in any one mortgage-related security shall not exceed five percent (5%) of the assets of the trust;

iii. The aggregate total investment in mortgage-related securities shall not exceed twenty-five percent (25%) of the assets of the trust; and

iv. Preferred or guaranteed shares issued or guaranteed by a solvent U.S. institution are permissible investments if all of the institution’s obligations are eligible as investments under paragraphs 1847.b.i. and b.iii. of this paragraph, but shall not exceed two percent (2%) of the assets of the trust.

e. As used in this appendix:

i. “Mortgage-related security” means an obligation that is rated AA or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC and that either:

(a) Represents ownership of one or more promissory notes or certificates of interest or participation in the notes (including any rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of the notes, certificates, or participation of amounts payable under, the notes, certificates or participation), that:

(1) Are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in 42 U.S.C.A. Section 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located; and

(2) Were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution that is supervised and examined by a federal or state housing authority, or by a mortgagee approved by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. Sections 1709 and 1715-b, or, where the notes involve a lien on the manufactured home, by an institution or by a financial institution approved for insurance by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. Section 1703; or
(b) Is secured by one or more promissory notes or certificates of deposit or participations in the notes (with or without recourse to the insurer of the notes) and, by its terms, provides for payments of principal in relation to payments, or reasonable projections of payments, or notes meeting the requirements of paragraphs 1847.e.i.(a)(1) and 1847.e.i.(a)(2);

ii. “Promissory note,” when used in connection with a manufactured home, shall also include a loan, advance or credit sale as evidenced by a retail installment sales contract or other instrument.

e. Equity interests

i. Investments in common shares or partnership interests of a solvent U.S. institution are permissible if:

(a) Its obligations and preferred shares, if any, are eligible as investments under this paragraph; and

(b) The equity interests of the institution (except an insurance company) are registered on a national securities exchange as provided in the Securities Exchange Act of 1934, 15 U.S.C. §§ 78a to 78kk or otherwise registered pursuant to that Act, and if otherwise registered, price quotations for them are furnished through a nationwide automated quotations system approved by the Financial Industry Regulatory Authority, or successor organization. A trust shall not invest in equity interests under this paragraph an amount exceeding one percent (1%) of the assets of the trust even though the equity interests are not so registered and are not issued by an insurance company.

ii. Investments in common shares of a solvent institution organized under the laws of a country that is a member of the Organization for Economic Cooperation and Development, if:

(a) All its obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC; and

(b) The equity interests of the institution are registered on a securities exchange regulated by the government of a country that is a member of the Organization for Economic Cooperation and Development.

iii. An investment in or loan upon any one institution’s outstanding equity interests shall not exceed one percent (1%) of the assets of the trust. The cost of an investment in equity interests made pursuant to this paragraph, when added to the aggregate cost of other investments in equity interests then held pursuant to this paragraph, shall not exceed ten percent (10%) of the assets in the trust;

g. Obligations issued, assumed or guaranteed by a multinational development bank, provided the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC.

h. Investment companies:

i. Securities of an investment company registered pursuant to the Investment Company Act of 1940, 15 U.S.C. § 802, are allowable investments if the investment company:
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(a) Invests at least ninety percent (90%) of its assets in the types of securities that qualify as an investment under paragraphs 1847.a., 1847.b., or 1847.c., or invests in securities that are determined to be substantively similar to the types of securities set forth in paragraphs 1847.a., 1847.b., or 1847.c.; or

(b) Invests at least ninety percent (90%) of its assets in the types of equity interests that qualify as an investment under paragraph 1847.f.i.;

ii. Investments made by a trust in investment companies under this paragraph shall not exceed the following limitations:

(a) An investment in an investment company qualifying under paragraph 1847.h.i. (a) shall not exceed ten percent (10%) of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall not exceed twenty-five percent (25%) of the assets in the trust; and

(b) Investments in an investment company qualifying under paragraph 1847.h.i. (b) of this paragraph shall not exceed five percent (5%) of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall be included when calculating the permissible aggregate value of equity interests pursuant to paragraph 1847.f.i.

i. Letters of Credit

   i. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the commissioner), to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

   ii. The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.

Asset or Reduction from Liability for Reinsurance Ceded by a Domestic Insurer to an Assuming Insurer not Meeting the Requirements detailed above under “Credit Allowed a Domestic Ceding Insurer” (paragraphs 7-1847)

1948. An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements under “Credit Allowed a Domestic Ceding Insurer” (paragraphs 7-1847) shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified U.S. financial institution, as defined under “Qualified U.S. Financial Institutions” at paragraph 5453. This security may be in the form of:

a. Cash;

b. Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the NAIC Securities Valuation Office, and qualifying as admitted assets;
Drafting Note: The Purposes and Procedures Manual of the NAIC Securities Valuation Office has been renamed the Purposes and Procedures Manual of the NAIC Investment Analysis Office, however, the Model law refers to the previous name.

c. i. Clean, irrevocable, unconditional and evergreen letters of credit, issued or confirmed by a qualified U.S. financial institution, as defined in paragraph 5352, effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement;

ii. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution’s subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs.

d. An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to this appendix shall be allowed only when the requirements of paragraph 1514 and the applicable portions under the sections below titled “Trust Agreements Qualified under Paragraph 1918”, “Letters of Credit Qualified under Paragraph 1918”, and “Other Security” at paragraph 5150.

**Trust Agreements Qualified under Paragraph 1918**

2049. The trust agreement shall be entered into between the beneficiary, the grantor and a trustee, which shall be a qualified U.S. financial institution as defined in paragraph 5453.

2120. The trust agreement shall create a trust account into which assets shall be deposited.

2224. All assets in the trust account shall be held by the trustee at the trustee’s office in the United States.

2322. The trust agreement shall provide that:

a. The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;

b. No other statement or document is required to be presented to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

c. It is not subject to any conditions or qualifications outside of the trust agreement; and

d. It shall not contain references to any other agreements or documents except as provided for in paragraph 3029.

2423. The trust agreement shall be established for the sole benefit of the beneficiary.

2524. The trust agreement shall require the trustee to:

a. Receive assets and hold all assets in a safe place;

b. Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

c. Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

d. Notify the grantor and the beneficiary within ten (10) days, of any deposits to or withdrawals from the trust account;

e. Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and
f. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

2625. The trust agreement shall provide that at least thirty (30) days, but not more than forty-five (45) days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

2726. The trust agreement shall be made subject to and governed by the laws of the state in which the trust is domiciled.

2827. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement, as duly approved by the commissioner, to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

2928. The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.

3029. Notwithstanding other provisions of this appendix, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

a. To pay or reimburse the ceding insurer for the assuming insurer’s share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

b. To make payment to the assuming insurer of any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer’s obligations under the specific reinsurance agreement; or

c. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer’s entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U.S. financial institution as defined in paragraph 5423 apart from its general assets, in trust for such uses and purposes specified in paragraphs 3028.a. and b. above as may remain executory after such withdrawal and for any period after the termination date.

3130. Notwithstanding other provisions of this appendix, when a trust agreement is established to meet the requirements of paragraph 1948 in conjunction with a reinsurance agreement covering life, annuities or accident and health risks, where it is customary to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

a. To pay or reimburse the ceding insurer for:
i. The assuming insurer’s share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies; and

ii. The assuming insurer’s share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provisions of the policies reinsured under the reinsurance agreement;

b. To pay to the assuming insurer amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer; or

c. Where the ceding insurer has received notification of termination of the trust and where the assuming insurer’s entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the assuming insurer’s share of liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U. S. financial institution apart from its general assets, in trust for the uses and purposes specified in paragraphs 3130.a. and b. as may remain executory after withdrawal and for any period after the termination date.

3231. Either the reinsurance agreement or the trust agreement must stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash in United States dollars, certificates of deposit issued by a United States bank and payable in United States dollars, and investments permitted by the Insurance Code or any combination of the above, provided investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed five percent (5%) of total investments. The agreement may further specify the types of investments to be deposited. If the reinsurance agreement covers life, annuities or accident and health risks, then the provisions required by this paragraph must be included in the reinsurance agreement.

3332. Notwithstanding any other provisions in the trust instrument, if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight or other designated receiver all of the assets of the trust fund. The assets shall be applied in accordance with the priority statutes and laws of the state in which the trust is domiciled applicable to the assets of insurance companies in liquidation. If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy claims of the U.S. beneficiaries of the trust, the assets or any part of them shall be returned to the trustee for distribution in accordance with the trust agreement.

3433. The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than ninety (90) days after the beneficiary and grantor receive the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than ninety (90) days after the trustee and the beneficiary receive the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

3534. The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor’s name.
3625. The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions that the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in paragraph 3928.b.

3726. The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

3837. The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

3938. A reinsurance agreement may contain provisions that:

a. Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;

b. Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;

c. Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and

d. Stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

i. To pay or reimburse the ceding insurer for:

(a) The assuming insurer’s share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

(b) The assuming insurer’s share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement; and

(c) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer;

ii. To make payment to the assuming insurer of amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

4039. The reinsurance agreement also may contain provisions that:

a. Give the assuming insurer the right to seek approval from the ceding insurer, which shall not be unreasonably or arbitrarily withheld, to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:
i. The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a current fair market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount; or

ii. After withdrawal and transfer, the current fair market value of the trust account is no less than 102 percent of the required amount.

b. Provide for the return of any amount withdrawn in excess of the actual amounts required for paragraph 3938.d., and for interest payments at a rate not in excess of the prime rate of interest on such amounts;

c. Allow the award by any arbitration panel or court of competent jurisdiction of:

   i. Interest at a rate different from that provided in paragraph 4039.b.;

   ii. Court or arbitration costs;

   iii. Attorney’s fees; and

   iv. Any other reasonable expenses.

4140. Financial Reporting - A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in statutory financial statements when established on or before the date of filing of the statutory financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

4241. The failure of any trust agreement to specifically identify the beneficiary as defined in paragraph 4 shall not be construed to affect any actions or rights that the commissioner may take or possess pursuant to the provisions of the laws of the domiciliary state.

Letters of Credit Qualified under Paragraph 1948

4342. The letter of credit must be clean, irrevocable, unconditional and issued or confirmed by a qualified U.S. financial institution as defined in paragraph 5352. The letter of credit shall contain an issue date and expiration date and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit also shall indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in paragraph 5049.a. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

4443. The heading of the letter of credit may include a boxed section containing the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

4544. The letter of credit shall contain a statement to the effect that the obligation of the qualified U.S. financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

4645. The term of the letter of credit shall be for at least one year and shall contain an “evergreen clause” that prevents the expiration of the letter of credit without due notice from the issuer. The “evergreen clause” shall provide for a period of no less than thirty (30) day notice prior to expiration date or nonrenewal.
4746. The letter of credit shall state whether it is subject to and governed by the laws of the ceding insurers state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), or any successor publication, and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified U.S. financial institution.

4847. If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), or any successor publication, then the letter of credit shall specifically address and provide for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 36 of Publication 600 or any other successor publication, occur.

4948. If the letter of credit is issued by a financial institution authorized to issue letters of credit, other than a qualified U.S. financial institution as described in paragraph 4342, then the following additional requirements shall be met:

a. The issuing financial institution shall formally designate the confirming qualified U.S. financial institution as its agent for the receipt and payment of the drafts; and

b. The “evergreen clause” shall provide for thirty (30) days notice prior to expiration date for nonrenewal.

5049. Reinsurance agreement provisions:

a. The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions that:

i. Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover;

ii. Stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

(a) To pay or reimburse the ceding insurer for:

   (1) The assuming insurer’s share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

   (2) The assuming insurer’s share, under the specific reinsurance agreement, of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurers, under the terms and provisions of the policies reinsured under the reinsurance agreement; and

   (3) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer;

(b) Where the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and where the assuming insurer’s entire
obligations under the reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the assuming insurer’s share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and exceed the amount of any reduced or replacement letter of credit, and deposit those amounts in a separate account in the name of the ceding insurer in a qualified U.S. financial institution apart from its general assets, in trust for such uses and purposes specified in paragraph 5049.a.ii.(a) as may remain after withdrawal and for any period after the termination date.

iii. All of the provisions of paragraph 5049.a. shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

b. Nothing contained in paragraph 5049.a. shall preclude the ceding insurer and assuming insurer from providing for:

i. An interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to paragraph 5049.a.ii.; or

ii. The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or any amounts that are subsequently determined not to be due.

Other Security

5150. A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.

5254. Credit will not be granted, nor an asset or reduction from liability allowed, to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of this appendix or otherwise in compliance with this appendix unless the reinsurance agreement:

a. Includes a proper insolvency clause, which stipulates that reinsurance is payable directly to the liquidator or successor without diminution regardless of the status of the ceding company;

b. Includes a provision pursuant to Section [cite state law equivalent to Section 2 of the Credit for Reinsurance Model Law] whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give the court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of the court or panel; and

c. Includes a proper reinsurance intermediary clause, if applicable, which stipulates that the credit risk for the intermediary is carried by the assuming insurer.

Qualified U.S. Financial Institutions

5352. For purposes of paragraphs 1847, 1948.c., 4342 and 4948, a “qualified U.S. financial institution” means an institution that:

a. Is organized or (in the case of a U.S. office of a foreign banking organization) licensed, under the laws of the United States or any state thereof;

b. Is regulated, supervised and examined by U.S. federal or state authorities having regulatory authority over banks and trust companies; and
c. Has been determined by either the commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

5453. A “qualified U.S. financial institution” means, for purposes of those provisions of this appendix specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

a. Is organized, or in the case of a U.S. branch or agency office of a foreign banking organization, licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

b. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.
Maintenance updates provide revisions to the *Accounting Practices and Procedures Manual*, such as editorial corrections, reference changes and formatting.

<table>
<thead>
<tr>
<th>SSAP/Appendix</th>
<th>Description/Revision¹</th>
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<tr>
<td>SSAP No. 62—Revised Property and Casualty Reinsurance</td>
<td>Clarify wording in an existing disclosure, paragraph 116. This does not change the content of the disclosure just eliminates redundant phrase and breaks up two long sentences for readability.</td>
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<tr>
<td>SSAP No. 86—Derivatives</td>
<td>Proposes to reference SSAP No. 26R for the structured note definition instead of duplicating the definition in SSAP No. 86.</td>
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<tr>
<td>SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities</td>
<td>Adds two new suffixes for SVO filings that have been carried over from the prior year.</td>
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**Status:**
On August 3, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed editorial revisions to SSAP No. 62R—Property and Casualty Reinsurance, SSAP No. 86—Derivatives, and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as illustrated below.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group adopted the exposed editorial revisions to SSAP No. 62R—Property and Casualty Reinsurance, SSAP No. 86—Derivatives, and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as final.

1. **SSAP No. 62R, paragraph 116**

   *The below revisions are for readability and are not intended to change the content of the disclosure.*

   116. Disclose if the reporting entity during the period covered by the statement ceded any risk under any reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates) for which during the period covered by the statement it recorded a positive or negative underwriting result greater than 5% of prior year-end surplus as regards policyholders or it reported calendar year written premium ceded or year-end loss and loss expense reserves ceded greater than 5% of prior year-end surplus as regards policyholders. This disclosure is limited to reinsurance contracts with written premium cessions or loss and loss expense reserve cessions described in this paragraph that meet the criteria of paragraph 95.a. or paragraph 95.b. This disclosure excludes cessions to approved pooling arrangements or to captive insurance companies that are directly or indirectly controlling, controlled by, or under common control with (i) one or more unaffiliated policyholders of the reporting entity, or (ii) an association of which one or more unaffiliated policyholders of the reporting entity is a member. where:

   a. The written premium ceded to the reinsurer by the reporting entity or its affiliates represents fifty percent (50%) or more of the entire direct and assumed premium written by the reinsurer based on its most recently available financial statement; or

   b. Twenty-five percent (25%) or more of the written premium ceded to the reinsurer has been retroceded back to the reporting entity or its affiliates in a separate reinsurance contract.
2. **SSAP No. 86, Exhibit A, paragraph 5g:**

Derivative instruments include, but are not limited to; options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures, structured notes with risk of principal/original investment loss based on the terms of the agreement (in addition to default risk), and any other agreements or instruments substantially similar thereto or any series or combination thereof.

5g. “Structured Notes” in scope of this statement are instruments defined in SSAP No. 26R (often in the form of debt instruments), in which the amount of principal repayment or return of original investment is contingent on an underlying variable/interest. Structured notes that are “mortgage-referenced securities” are captured in SSAP No. 43R—Loan-backed and Structured Securities.

Footnote 1: The “structured notes” captured within scope of this statement is specific to instruments in which the terms of the agreement make it possible that the reporting entity could lose all or a portion of its original investment amount (for other than failure of the issuer to pay the contractual amounts due). These instruments incorporate both the credit risk of the issuer, as well as the risk of an underlying variable/interest (such as the performance of an equity index or the performance of an unrelated security). Securities that are labeled “principal-protected notes” are captured within scope of this statement if the “principal protection” involves only a portion of the principal and/or if the principal protection requires the reporting entity to meet qualifying conditions in order to be safeguarded from the risk of loss from the underlying linked variable. Securities that may have changing positive interest rates in response to a linked underlying variable or the passage of time, or that have the potential for increased principal repayments in response to a linked variable (such as U.S. Treasury Inflation-Indexed Securities) that do not incorporate risk of original investment /principal loss (outside of default risk) are not captured as structured notes in scope of this statement.

3. **SSAP No. 97, Exhibit A, paragraph 49**

By August 31 or one month after the audit report date of each year, the NAIC shall initiate a review of all SCA investments for which new Sub 2 form filings have been received as well as an annual update review of Sub 2 SCA investments already logged in the VISION database. The NAIC review shall encompass a review of the most recent annual statutory reporting by the parent insurance company's Schedule Y (to ascertain the identity of the members of the holding company system and to ensure that information for all SCA companies has been submitted), a review of the parent's financial statement blank to review the last reported value for the SCA investments and a review of the VISION database to determine whether SCA debt and SCA preferred securities have been assigned NAIC designations. As part of its analysis, the NAIC shall review the portion of the bond investments carried by the parent or a subsidiary insurer with a Z notation. If the NAIC determines that the portion of the Z bonds shown on the documentation is significant, the NAIC shall not process the Sub 2 filing until the insurance company reports the bonds to permit removal of the Z notation. Beginning with year-end 2019, two new suffixes will apply: YE and IF. YE means that the security is a properly filed annual update that the SVO has determined will not be assigned an NAIC Designation by the close of the year-end reporting cycle. The symbol YE is assigned by the SVO pursuant to the carryover administrative procedure described in Part One, Section 3 f) (iii) of this Manual. When the SVO assigns the symbol YE it also assigns the NAIC Designation in effect for the previous reporting year. IF means that the security is an initial filing that has been properly filed with the SVO but which the SVO has determined will not be assigned an NAIC Designation by the close of the year-end reporting cycle. The symbol IF is assigned by the SVO and communicates that the insurer should self-designate the security for year-end and identify it with the symbol IF. IF therefore also communicates to the regulator that the NAIC Designation reported by the insurance company was not derived by or obtained from the SVO, but has been determined analytically by a reporting insurance company.
**Statutory Accounting Principles (E) Working Group**  
**Maintenance Agenda Submission Form**  
**Form A**

**Issue:** *ASU 2019-05, Targeted Transition Relief*

**Check (applicable entity):**

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**Description of Issue:** In June 2016, the FASB issued *ASU 2016-13, Financial Instruments—Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*, which introduced the expected credit losses methodology for the measurement of credit losses on financial assets measured at amortized cost basis, replacing the previous incurred loss methodology. *ASU 2016-13* also modified the accounting for available-for-sale debt securities, which must be individually assessed for credit losses when fair value is less than the amortized cost basis.

The FASB noted that financial statement preparers have begun to elect the fair value option on newly originated or purchased financial assets, although those entities historically have measured similar financial assets at an amortized cost basis. This adoption would require the maintenance of dual measurement methodologies for identical or similar financial instruments that are being managed in a similar manner. With this approach, users would not have decision useful information because the financial statements would not be comparable (i.e., a portion of an entity’s financial instruments measured at fair value versus other identical instruments measured at amortized costs that are owned by the same entity).

The amendments in this update provide an alternative accounting treatment to elect the fair value option for certain financial assets previously measured at amortized cost basis. The fair value option in this update does not apply to GAAP classified held-to-maturity debt securities.

**Existing Authoritative Literature:**
The existing guidance for the fair value is captured *SSAP 100R—Fair Value*. However, pursuant to statutory accounting, assets are required to be reported at the measurement method stipulated under the applicable SSAP. An election to utilize fair value in lieu of the stipulated measurement method (e.g., amortized cost) is not allowed under statutory accounting.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** Significant activity has taken place regarding the analysis of *ASU 2016-13: Financial Instruments – Credit Losses*. Additional review and consideration is included in agenda item 2016-20.

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** None

**Convergence with International Financial Reporting Standards (IFRS):** The IASB issued *IFRS 9, Financial Instruments* in July 2014 as a response to concerns identified pertaining to the delayed recognition of credit losses; however, the IASB’s stakeholders strongly preferred an impairment model that uses a dual measurement approach, while U.S. stakeholders strongly preferred the current expected credit loss model.
Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to SSAP No. 100R to reject ASU 2019-05 for statutory accounting.

This item is proposed to be rejected as ASU 2019-05 provides an alternative accounting treatment for certain financial assets (excluding held-to-maturity debt securities) previously measured at amortized cost. Pursuant to statutory accounting, assets are required to be reported at the measurement method stipulated under the applicable SSAP. An election to utilize fair value in lieu of the stipulated measurement method (e.g., amortized cost) is not allowed under statutory accounting.

Proposed Revisions to SSAP No. 100R:


Staff Review Completed by: Jim Pinegar – June 2019

Status:
On August 3, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 100R—Fair Value, as illustrated above, to reject ASU 2019-05, Targeted Transition Relief for statutory accounting.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group adopted the exposed revisions to SSAP 100R—Fair Value, as final, to reject ASU 2019-05, Financial Instruments—Credit Losses: Targeted Transition Relief for statutory accounting.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: ASU 2019-06, Extending the Private Company Accounting Alternatives on Goodwill and Certain Identifiable Intangible Assets to Not-for-Profit Entities.

Check (applicable entity):

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<th>Modification of existing SSAP</th>
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Description of Issue:
In 2014, the FASB issued 1) ASU 2014-02, Intangibles—Goodwill and Other (Topic 350): Accounting for Goodwill, and 2) ASU 2014-18, Business Combinations (Topic 805): Accounting for Identifiable Intangible Assets in a Business Combination, which simplify the subsequent accounting for goodwill and certain identifiable intangible assets in business combinations. Those amendments were in response to concerns expressed by private companies regarding the cost and complexity of goodwill impairment tests and the accounting for certain identifiable intangible assets. When FASB issued both updates, it acknowledged that the issues addressed were not limited to private companies; they also pertain to not-for-profit entities.

Accordingly, FASB received feedback questioning the relevance and benefit of an impairment-only approach to goodwill and the accounting for identifiable intangible assets acquired in an acquisition by a not-for-profit entity. By providing an accounting alternative, this update will reduce the cost and complexity associated with the accounting for goodwill and the measurement of certain acquired identifiable intangible assets without significantly diminishing decision-useful information in not-for-profit financial statements.

The amendments in this update extend the private company alternatives from Topic 350 (ASU 2014-02) and Topic 805 (ASU 2014-18) to not-for-profit entities. Under this update, an alternative accounting treatment is offered to where if elected, a not-for-profit entity shall amortize goodwill on a straight-line basis over the lesser of 10 years or the demonstrated useful life. Additionally, a not-for-profit entity that elects this accounting alternative is required to make an accounting policy election to test goodwill for impairment at either the entity level or the reporting unit level. A not-for-profit entity is required to test goodwill for impairment when a triggering event occurs that indicates that the fair value of the entity may be below its carrying amount. Finally, certain identifiable intangible assets such as customer related intangibles (i.e. mortgage servicing rights) and noncompete agreements would no longer be separately recognized from goodwill.

Existing Authoritative Literature:
The existing guidance for goodwill and subsequent amortization is referenced in SSAP No. 68—Business Combinations and Goodwill and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None
Convergence with International Financial Reporting Standards (IFRS):
IFRS standards do not provide industry guidance for not-for-profit entities regarding goodwill. However, the IASB is currently reviewing if it should retain the existing impairment only model for the subsequent accounting of goodwill, or reintroduce an amortization method, as noted in IFRS Agenda Paper 18B.

Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to SSAP No. 68 and SAP No. 97 to reject ASU 2019-06 for statutory accounting.

While the initial calculation of goodwill was not in scope of ASU 2019-06, this update provides optionality of an alternative accounting treatment for the straight-line amortization of goodwill for not-for-profit entities over the lesser of 10 years or the demonstrated useful life, subject to an impairment analysis performed in the event a triggering event occurs. Additionally, certain other identifiable intangible assets are no longer separately recorded and shall be combined into goodwill. As a point of reference, ASU 2019-06 is an extension of ASU 2014-02 to not-for-profit entities; ASU 2014-02 was previously rejected for SSAP.

This item is proposed to be rejected as ASU 2019-06 provides alternative accounting treatments for goodwill. Optionality treatment is not consistent with SSAP 68, specifically paragraphs 7 & 8, and SAP 97; however current SSAP guidance is similar as goodwill shall be amortized over the period in which the acquiring entity benefits economically, not to exceed 10 years. Additionally, impairment analysis shall occur in the event that a decline in an acquired entity’s fair value, that is other than temporary, may be below its carrying amount.

Proposed Revisions to SSAP No. 68:

20. This statement rejects ASU 2019-06, Intangibles—Goodwill and Other Business Combinations, and Non-for-Profit Entities, ASU 2017-04, Simplifying the Test for Goodwill Impairment, ASU 2016-03, Intangibles—Goodwill and Other, Business Combinations, Consolidation, Derivatives and Hedging, ASU 2014-02, Accounting for Goodwill (a consensus of the Private Company Council), ASU 2012-02, Testing Indefinite-Lived Intangible Assets for Impairment, ASU 2011-08, Testing Goodwill for Impairment and ASU 2010-28, When to Perform Step 2 of the Goodwill Impairment Test for Reporting Units with Zero or Negative Carrying Amounts; Accounting Principles Board Opinion No. 16, Business Combinations; FASB Statement No. 38, Accounting for Preacquisition Contingencies of Purchased Enterprises, an amendment of APB Opinion No. 16; Accounting Principles Board Opinion No. 17, Intangible Assets; FASB Statement No. 79, Elimination of Certain Disclosures for Business Combinations by Nonpublic Enterprises; FASB Statement No. 141, Business Combinations; and FASB Statement No. 142, Goodwill and Other Intangible Assets. The following related interpretative pronouncements are also rejected.

Proposed Revisions to SSAP No. 97:

48. This statement rejects ASU 2019-06, Intangibles—Goodwill and Other Business Combinations, and Non-for-Profit Entities, ASU 2011-10, Derecognition of in Substance Real Estate, APB Opinion No. 18, The Equity Method of Accounting for Investments in Common Stock, AICPA Accounting Interpretations APB 18, The Equity Method of Accounting for Investments in Common Stock: Accounting Interpretations of APB Opinion No. 18, FASB Technical Bulletin No. 79-19, Investor’s Accounting for Unrealized Losses on Marketable Securities Owned by an Equity Method Investee, FASB Emerging Issues Task Force No. 87-21, Change of Accounting Basis in Master Limited Partnership Transactions, FASB Emerging Issues Task Force No. 96-16, Investor’s Accounting for an Investee When the Investor Has a Majority of the Voting Interest but the Minority Shareholder or Shareholders Have Certain Approval or Veto Rights, FASB Emerging Issues Task Force No. 98-2: Accounting by a Subsidiary or Joint Venture for an Investment in the stock of Its Parent Company or Joint Venture Partner and FASB Staff Position No. APB 18-1, Accounting by an Investor for Its
Proportionate Share of Accumulated Other Comprehensive Income of an Investee Accounted for under the Equity Method in Accordance with APB Opinion No. 18 upon a Loss of Significant Influence.

Staff Review Completed by: Jim Pinegar – June 2019

Status:
On August 3, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 68—Business Combinations and Goodwill and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as illustrated above, to reject ASU 2019-06, Extending the Private Company Accounting Alternatives on Goodwill and Certain Identifiable Intangible Assets to Not-for-Profit Entities for statutory accounting.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group adopted the exposed revisions to SSAP No. 68—Business Combinations and Goodwill and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as final, to reject ASU 2019-06, Extending the Private Company Accounting Alternatives on Goodwill and Certain Identifiable Intangible Assets to Not-for-Profit Entities for statutory accounting.
**Statutory Accounting Principles (E) Working Group**

**Maintenance Agenda Submission Form**

**Form A**

**Issue:** ASU 2019-03, Updating the Definition of Collections

**Check (applicable entity):**

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<td>Interpretation</td>
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**Description of Issue:**
The term “collections” in the Master Glossary of the FASB Accounting Standards Codification is not fully aligned with the definition used in the American Alliance of Museums’ (AAM) Code of Ethics for Museums. Collections are to be defined as works of art, historical treasures, or similar assets that meet certain criteria: 1) held for public exhibition / education / research; 2) are protected, cared for, and preserved; 3) are subject to the organization’s policy that requires the use of proceeds from the sale of such items be used to acquire new collection items, the direct care of existing collections, or both.

The AAM definition used, which served as the basis for the guidance on collections in FASB Statement No. 116, Accounting for Contributions Received and Contributions Made, was revised by the AAM after the issuance of Statement 116. The FASB is issuing this update to improve the definition of collections in the Master Glossary by realigning it with the definition used by the AAM. The FASB also is making a technical correction in Topic 360, Property, Plant, and Equipment, to clarify that the accounting and disclosure guidance for collections in Subtopic 958-360, Not-for-Profit Entities—Property, Plant, and Equipment.

**Existing Authoritative Literature:**
There is no current SAP guidance for business entities that maintain collections. U.S. GAAP guidance for collections, primarily an issue for certain not-for-profit entities, is included in Topic 958.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** None

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** None

**Convergence with International Financial Reporting Standards (IFRS):**
IFRS standards do not provide industry guidance for entities that maintain collections.

**Staff Recommendation:**
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2019-03, Updating the Definition of Collections as not applicable to statutory accounting.

This item is proposed to be rejected as not applicable as ASU 2019-03 provides specific guidance, primarily for certain not-for-profit entities that maintain collections, which is not applicable for statutory accounting purposes.

**Staff Review Completed by: Jim Pinegar – June 2019**
Status:
On August 3, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2019-03, Updating the Definition of Collections as not applicable to statutory accounting.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group adopted the exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements, as final, to reject ASU 2019-03, Updating the Definition of Collections as not applicable to statutory accounting.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: ASU 2018-08, Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made

Check (applicable entity):

- Modification of existing SSAP
- New Issue or SSAP
- Interpretation

P/C  Life  Health

Modification of existing SSAP  ☒  ☐  ☒
New Issue or SSAP  ☐  ☒  ☐
Interpretation  ☐  ☐  ☐

Description of Issue:
The FASB issued ASU 2018-08, Not-for-Profit Entities - Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made (ASU 2018-08) in June 2018. Its intent is to clarify and improve the scope and accounting guidance for contributions received and contributions made. ASU 2018-08 should assist entities in evaluating whether transactions should be accounted for as contributions (nonreciprocal transactions) or exchange (reciprocal) transactions and in determining whether the contribution is conditional. Distinguishing between contributions and exchange transactions is important as it determines which guidance to apply.

Diversity in application exists for grants and other similar contracts but is most prevalent for government grants and contracts. It has also been noted that it can be difficult to determine when a contribution is conditional, especially when an entity receives assets accompanied by certain stipulations but with no specified return requirement for when the stipulations are not met. There also isn’t uniformity in assessments of whether the likelihood of failing to meet a condition is remote and in evaluating whether and how remote provisions affect the timing of when a contribution is recognized.

Although accounting for contributions is primarily an issue for not-for-profit entities, the amendments in ASU 2018-08 are applicable to all entities, including business entities, that receive or make contributions of cash and other assets, including promises to give and contributions made. However, the amendments herein do not apply to transfers of assets from government entities to business entities. Contribution revenue may be presented in the financial statements of an entity using different terms (i.e. gift, grant, donation, etc.), but this should not be a factor for determining whether an agreement is within the scope of this guidance.

The amendments in this ASU clarify and improve the current guidance regarding whether a transfer of assets (or the reduction, settlement, or cancellation of liabilities) is a contribution or an exchange transaction. The amendments clarify how an entity determines whether a resource provider is participating in an exchange transaction by evaluating whether the resource provider is receiving commensurate value in return for the resources transferred based on the following:

1. A resource provider is not synonymous with the general public. A benefit received by the public as a result of the assets transferred is not equivalent to commensurate value received by the resource provider.

2. Execution of a resource provider’s mission or the positive sentiment from acting as a donor does not constitute commensurate value received by a resource provider for purposes of determining whether a transfer of assets is a contribution or an exchange.
Existing Authoritative Literature:

SSAP No. 67—Other Liabilities

Amounts Withheld or Retained by Company as Agent or Trustee
7. A reporting entity may, in the normal course of its business, withhold funds as an agent or trustee which will ultimately be paid to others.

8. Amounts withheld or retained by an entity as trustee or agent shall be recorded as a liability when the salaries or other compensation are expensed (paragraphs 8.a. and 8.b.) or the funds are received (paragraphs 8.c. through 8.e.). Examples of such occurrences are:
   
   a. As an employer, the reporting entity deducts and withholds federal and state income taxes, social security taxes, charitable contributions, savings plan deductions, garnishments, employee contributions to pension plans, employee share of group life and health insurance premiums, and other employee salary withholdings or deductions;

   b. Amounts due under deferred compensation arrangements shall be accrued in accordance with the provisions of SSAP No. 92—Postretirement Benefits Other Than Pensions (SSAP No. 92). Segregated funds (i.e., Rabbi trusts and similar arrangements) shall not be netted against the accrued liability unless the requirements of SSAP No. 64—Offsetting and Netting of Assets and Liabilities (SSAP No. 64) are met.

   c. For a reporting entity that invests in commercial and residential mortgages, the entity may require the mortgagor to prepay real estate taxes and property insurance premiums which the entity will hold in escrow and pay when due;

   d. The reporting entity holds deposits in connection with leases of investment property; and

   e. The reporting entity may receive and hold other funds in a fiduciary capacity.

Remittances and Items Not Allocated
9. Cash receipts cannot always be identified for a specific purpose or, for other reasons, applied to a specific account when received. The reporting entity shall record a liability for these cash receipts when the funds are received. These liability accounts are generally referred to as suspense accounts. Examples include:

   a. Premium payments received with the application for policies which have not yet been issued;

   b. Premium payments in an amount different than the amount billed by the reporting entity; and

   c. Unidentified cash receipts.

Interest Payable
10. Interest payable includes interest on debt, interest on real estate obligations, and approved interest on surplus notes. It also includes interest on funds held as a deposit or security, such as those held by a ceding company against a reinsurer. The amount to be reported is the amount which has accrued and is unpaid at the balance sheet date.

Payable to Parent, Subsidiaries and Affiliates
11. A liability shall be recognized and identified as due to affiliates for expenditures incurred on behalf of the reporting entity by a parent, affiliates, or subsidiaries or for amounts owed through other intercompany transactions. Amounts due to or from affiliates shall be offset and reported net only when the provisions of SSAP
No. 64 are met. Examples of these expenses are executive salaries, workers’ compensation insurance premiums, and pension contributions.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS):

Staff Recommendation:
Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2018-08, Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made as not applicable to statutory accounting.

Staff Review Completed by:
Fatima Sediqzad – June 2019

Status:
On August 3, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2018-08, Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made as not applicable to statutory accounting.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group adopted the exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2018-08, Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made as not applicable to statutory accounting.
Ref #2019-18

Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Accounting for “Other” Derivatives

Check (applicable entity):

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Description of Issue:
This agenda item has been drafted to consider statutory accounting guidance for derivatives that are not used in hedging transactions, income generation transactions or replication (synthetic asset) transactions. This agenda item was directed with the adoption of agenda item 2018-18, Structured Notes, as it was noted that structured notes captured within scope of SSAP No. 86—Derivatives, would be unlikely to be used in the transactions with existing recognition and measurement guidance in SSAP No. 86.

Although the guidance of SSAP No. 86 is limited to the derivatives captured in the noted transactions (hedging, income generation or replication), the reporting schedule for derivatives (Schedule DB) currently includes an “other” derivative reporting category. Although this agenda item clarifies the accounting (measurement) value for these derivatives, as detailed within the proposed revisions, “other” derivatives do not qualify as admitted assets under the SSAP. Derivatives classified as “other” shall only be admitted in accordance with state investment laws that provide prescribed practices that permit admittance. These prescribed practices shall be detailed in Note 1. Derivatives reported in the “hedging-other” are derivatives subject to the “hedging” guidance in SSAP No. 86 and are not intended to be captured by this agenda item. This agenda item is strictly for the derivatives reported as “other” derivatives.

Existing Authoritative Literature:
SSAP No. 86—Derivatives establishes statutory accounting principles for derivative instruments and hedging, income generation and replication (synthetic asset) transactions using selected concepts outlined in FASB Statement No. 133, Accounting for Derivative Instruments and Hedging Activities.

Although the scope of SSAP No. 86 references “all derivative instruments” recognition and measurement provisions are only provided for specific transactions identified in paragraph 3:

3. This statement addresses the recognition of derivatives and measurement of derivatives used in:
   a. Hedging transactions;
   b. Income generation transactions; and
   c. Replication (synthetic asset) transactions.

4. “Derivative instrument” means an agreement, option, instrument or a series or combination thereof:
   a. To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or
b. That has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests.

Activity to Date (issues previously addressed by the Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): Revisions have recently adopted to SSAP No. 86 and additional revisions are expected to consider ASU 2017-12, Derivatives and Hedging. Recent revisions include:

- Ref #2016-48 – Incorporated disclosures for financing derivatives.
- Ref# 2018-08 – Incorporate guidance to include structured notes in scope.
- Ref #2018-30 – Incorporated hedge documentation and assessment efficiencies from ASU 2017-12.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): U.S. GAAP and IFRS are consistent that all derivatives are reported at fair value, with changes recognized through income unless there is an election to apply hedge accounting. With hedge accounting, under IFRS and U.S. GAAP, derivatives are still reported at fair value, but the gain/loss may be recognized through other comprehensive income (instead of income).

Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to SSAP No. 86—Derivatives to include recognition and measurement guidance for derivatives that do not qualify as hedging, income generation or replication transactions. In addition to the proposed revisions specific for “other” derivatives, revisions are reflected in the headers to separate the application of existing guidance.

Working Group Question – With the language proposed, admittance of “other” derivatives under state investment laws will require a prescribed practice disclosure in Note 1. Working Group comments are requested on whether the language in the SSAP should permit admittance under state investment law. If this language was included, then a prescribed practice detailed in Note 1 would not be required.

Proposed Revisions to SSAP No. 86—Derivatives:

3. This statement addresses the recognition of derivatives and measurement of derivatives used in:
   a. Hedging transactions;
   b. Income generation transactions; and
   c. Replication (synthetic asset) transactions.
   d. Other Derivatives – (Derivatives that are not used in hedging, income generation or replication transactions.)

Impairment

17. This statement adopts the impairment guidelines established by SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets (SSAP No. 5R) for the underlying financial assets or liabilities.
Recognition of Derivatives Recognition and Measurement of Derivatives Used in Hedging Transactions

18. Derivative instruments represent rights or obligations that meet the definitions of assets (SSAP No. 4—Assets and Nonadmitted Assets) or liabilities (SSAP No. 5R) and shall be reported in financial statements. In addition, derivative instruments also meet the definition of financial instruments as defined in SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures (SSAP No. 27). Should the cost basis of the derivative instrument be undefined (i.e., no premium is paid), the instrument shall be disclosed in accordance with paragraphs 44-48 of SSAP No. 100R—Fair Value (SSAP No. 100R). Derivative instruments used in hedging, income generation or replication (synthetic asset) transactions shall be recognized and measured in accordance with the specific provisions within this statement and are admitted assets to the extent they conform to the requirements of this statement.

19. Derivative instruments that are not used in hedging, income generation or replication (synthetic asset) transactions shall be considered “Other” derivatives. These derivatives shall be accounted for at fair value and the changes in fair value shall be recorded as unrealized gains or losses. These derivatives do not qualify as admitted assets.

Derivatives Used in Hedging Transactions

49-20. Derivative instruments used in hedging transactions that meet the criteria of a highly effective hedge shall be considered an effective hedge and are permitted to be valued and reported in a manner that is consistent with the hedged asset or liability (referred to as hedge accounting). For instance, assume an entity has a financial instrument on which it is currently receiving income at a variable rate but wishes to receive income at a fixed rate and thus enters into a swap agreement to exchange the cash flows. If the transaction qualifies as an effective hedge and a financial instrument on a statutory basis is valued and reported at amortized cost, then the swap would also be valued and reported at amortized cost. Derivative instruments used in hedging transactions that do not meet or no longer meet the criteria of an effective hedge, or that meet the required criteria but the entity has chosen not to apply hedge accounting, shall be accounted for at fair value and the changes in the fair value shall be recorded as unrealized gains or losses (referred to as fair value accounting).

Recognition and Measurement of Derivatives Used in Income Generation Transactions

General

43-44. Income generation transactions are defined as derivatives written or sold to generate additional income or return to the reporting entity. They include covered options, caps, and floors (e.g., a reporting entity writes an equity call option on stock that it already owns).

Recognition and Measurement of Derivatives Used in Replication (Synthetic Asset) Transactions

53-54. Replication (Synthetic Asset) transaction means a derivative transaction entered into in conjunction with other investments in order to reproduce the investment characteristics of otherwise permissible investments. A derivative transaction entered into by an insurer as a hedging or income generation transaction shall not be considered a replication (synthetic asset) transaction.

Staff Review Completed by: Julie Gann – April 2019

Status:
On May 29, 2019, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 86—Derivatives, as shown above, to include
recognition and measurement guidance for derivatives that do not qualify as hedging, income generation or replication transactions.

On August 3, 2019, the Statutory Accounting Principles (E) Working Group re-exposed revisions to SSAP No. 86—Derivatives, as illustrated above, to clarify that “other” derivatives not used in hedging, income generation or replication shall be reported at fair value and do not qualify as admitted assets.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions to SSAP No. 86—Derivatives, as detailed under Proposed Revisions, to clarify the recognition and measurement guidance for derivatives that do not qualify as hedging, income generation or replication transactions.
Statutory Accounting Principles (E) Working Group

Maintenance Agenda Submission Form

Form A

Issue: Reinsurance Credit

Check (applicable entity):

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Description of Issue:
Regulators brought to the attention of the Working Group concerns regarding short-duration health reinsurance contracts which were termed quota share treaties but had features that limited the reinsurer’s risk. Concerns were noted that the reinsurance contracts were reported as meeting the “risk transfer” requirements under statutory accounting, but were not meeting “risk-transfer” requirements under U.S. GAAP. In addition, concerns were raised on whether similar reinsurance contracts that may meet risk transfer requirements for statutory accounting were taking a larger reinsurance accounting benefit than appropriate because the risk limiting features in the reinsurance contracts were limiting the actual amount of risks transferred. The Working Group directed NAIC staff to research and prepare an agenda item for subsequent discussion. Subsequent to this direction, the Working Group also received a referral from the Financial Analysis (E) Working Group noting additional concerns with short-duration contracts in particular and with a request that reinsurance disclosures designed to identify contracts with risk limiting features or noncompliant contracts that are required for SSAP No. 62R also be in SSAP No. 61R (See Activity to Date).

This agenda item addresses reinsurance risk transfer and accounting issues for clarification in statutory accounting primarily focused on reinsurance of short-duration products.

Overview of SSAP No. 61R (See Authoritative Literature in appendix for quotes of referenced material)

1. The scope of SSAP No. 61R is reinsurance of life deposit type and accident and health contracts.
2. While the majority of life contracts are long-duration, health has both long-duration (examples are long-term care and long-term disability) and short-duration products (example is group comprehensive health).
3. SSAP No. 61R explicitly quotes more of the FAS 113 long-duration contract risk transfer guidance.
4. Because SSAP No. 61R has more of a life contract (long-duration) focus it does not explicitly quote as much of short-duration risk transfer guidance from U.S. generally accepted accounting principles (GAAP) as SSAP No. 62R—Property and Casualty Reinsurance.
5. SSAP No. 61R adopts the following:
   a. GAAP guidance - FASB Statement No. 113, Accounting and Reporting for Reinsurance of Short-Duration and Long-Duration Contracts (FAS 113) with modifications; FAS 113 provides general risk transfer guidance but the majority of the guidance is different based on the classification categories of long-duration contracts and short-duration contracts. (FAS 113 requirements were incorporated into FASB codification primarily in ASC 944-20 and the key risk transfers aspects of FAS 113 are unchanged by FASB codification.)
   b. Appendix A-791—Life and Health Reinsurance Agreements (Appendix A-791) is based on NAIC Model Law 791—Life and Health Reinsurance Agreements (Model 791). It provides criteria for reinsurance accounting for proportional reinsurance contracts (see additional detail in following pages). Reinsurance contracts which receive reinsurance accounting under Appendix A-791 do not contain identified features.
which negate risk transfer. In addition, Appendix A-791 identifies significant risk categories by line of business that must be 100% ceded. The major risk categories are morbidity, mortality, lapse, credit quality, reinvestment and disintermediation. The current version of Model 791 was adopted by the NAIC in 1992.

c. Appendix A-785 is based on NAIC *Model Law 785- Credit for Reinsurance* (Model 785) which contains detailed information regarding when collateral is required and what types of collateral are acceptable in order to obtain credit for reinsurance. In general, collateral is required for unauthorized reinsurers and there is a sliding scale of collateral required for certified reinsurers. Model 785 is not the focus of this agenda item.

**SSAP No. 61R adopts FAS 113 with modifications** *(See Authoritative Literature in appendix for quotes of referenced material)*

SSAP No. 61R, paragraph 78, adopts FAS 113 with modifications noting that the statutory accounting principles established, reflect much more detailed guidance which differ substantially from GAAP. The documented list of statutory accounting modifications from FAS 113 includes 7 listed topics which are summarized below:

1. Reinsurance accounting reserve credits reduce reserves for policies, claims and unpaid claims (¶78.a.);
2. First year and renewal ceding commissions on indemnity reinsurance of new business are recognized as income and ceding commissions on ceded in-force business are included in the calculation of initial gain or loss (¶78b);
3. Initial gains on indemnity reinsurance of in-force blocks of business have unique accounting treatment which restricts the gains to the ceding entity until profits emerge (¶78d).
4. SSAP No. 61R prohibits recognition of a gain or loss in connection with the sale, transfer or reinsurance of an in-force block of business between affiliated entities in a non-economic transaction (¶78e).
5. SSAP No. 61R requires that a liability be established through a provision reducing surplus for unsecured reinsurance recoverables from unauthorized reinsurers (¶78f).
6. SSAP No. 61R prescribes offsetting certain reinsurance premiums (¶78g).
7. SSAP No. 61R, paragraph 78 explicitly notes the modifications to the FAS 113 risk transfer requirements regarding differences in GAAP and SAP classification of investment contracts, but does not note other modifications. The modification identifies contracts with insignificant mortality or morbidity risk. (¶78c).

78c. As discussed in SSAP No. 50, statutory accounting defines deposit-type contracts as those contracts which do not include any mortality or morbidity risk. GAAP defines investment contracts as those that do not subject the insurance enterprise to significant policyholder mortality or morbidity risk. (The distinction is any mortality or morbidity risk for statutory purposes vs. significant mortality or morbidity risk for GAAP purposes.) Therefore, a contract may be considered an investment contract for GAAP purposes, and that same contract may be considered other than deposit-type for statutory purposes. A **reinsurance treaty covering contracts that have insignificant mortality or morbidity risk** (i.e., contracts classified as other than deposit-type contracts for statutory purposes, but investment contracts for GAAP purposes) that does not transfer that mortality or morbidity risk, but does transfer all of the significant risk inherent in the business being reinsured (e.g., lapse, credit quality, reinvestment or disintermediation risk) qualifies for reinsurance accounting for statutory reporting purposes, but would not qualify for reinsurance accounting treatment for GAAP purposes;

**A-791** *(See Authoritative Literature in appendix for quotes of referenced material)*

The Model 791 proceedings citations (formerly known as the legislative history) notes that in 1985 the model was developed to prohibit reinsurance surplus aid abuses. Major revisions to Model 791 which are consistent with Appendix A-791, were adopted in 1992. The intent of the 1992 revisions was to provide more information to regulators on risk transfer, liability transfer and other considerations in regard to “surplus aid” reinsurance.
contracts in order to promote more uniformity in their treatment. Included as part of the revision was a name change from “Model Regulation—Life Reinsurance Agreements” to “Life and Health Reinsurance Agreements Model Regulation.” While a review of the minutes, proceedings citations and the model indicate that Model 791 includes accident and health within its scope; most of the guidance in Model 791 is focused on life and the small amount of health specific guidance provided is secondary.

Scope – Appendix A-791 excludes assumption reinsurance, yearly renewable term reinsurance and certain non-proportional reinsurance such as stop loss or catastrophe reinsurance. Appendix A-791 refers the reader to paragraphs 19 and 20 of SSAP No. 61R for yearly renewable term reinsurance and non-proportional reinsurance. Therefore, the primary focus of Appendix A-791 is proportional reinsurance agreements.

The preamble to Model 791 notes that there are legitimate forms of surplus relief and forms that are improper. This preamble is similar to paragraph 2.k. of Appendix A-791, but includes additional information regarding intent. This preamble paragraph was noted in the 1992 minutes as significant to enforcing the provisions of the model; however, this paragraph is not included in Appendix A-791.

Appendix A-791 includes reinsurance contract provisions or functions that require deposit accounting by prohibiting reinsurance reserve credit (loss reserve reductions) or establishment of assets related to the reinsurance contracts that contain specified clauses and or functions. Loss reserve reductions and establishment of admitted reinsurance assets is referred to as reinsurance accounting or reinsurance credit. Appendix A-791 also contains a chart which notes “significant risks” inherent in lines of business reinsured. It notes that 100% of the identified significant risks must be reinsured to allow any reinsurance accounting treatment. Appendix A-791, paragraphs 2, 4, and 5 seek to ensure that the reinsurer has taken on the risks that result in the reinsurer “standing in the shoes” meaning that the reinsurer is in the same economic position as the ceding entity. Appendix A-791 also provides guidance that contract features which result in “impermanent” risk transfer or surplus aid which result in deposit accounting.

Summary of Appendix A-791, by paragraph is below:

Appendix A-791, paragraph 2 provides a list of items that can prohibit reinsurance accounting (resulting in deposit accounting instead). If any of the noted conditions are present in substance or effect, then the ceding entity is prohibited from establishing assets or reducing liabilities based on that reinsurance contract.

a. Renewal expense allowances are not enough to cover future administrative expenses (unless a liability is established for the present value of the shortfall).

b. Ceding insurer can be deprived of surplus/assets at the reinsurer’s option or automatically on the occurrence of an event (termination for nonpayment of premium or other amounts due is an exception).

c. Ceding insurer is required to reimburse the reinsurer for negative experience under the contract. Exceptions: netting losses against gains for experience refunds and payments upon voluntary recapture. It notes that a reinsurer cannot force recapture by excessive premium increases.

d. The ceding insurer must, at scheduled points in time terminate or recapture the contract.

e. The reinsurance agreement has the possibility of payments from the ceding company that exceed the direct premiums charged to the insured.

f. The treaty does not transfer 100% of the identified significant risks inherent in the business being reinsured. A table of product types and significant risks are identified (morbidity, mortality, lapse, credit quality, reinvestment, disintermediation). Short-duration health is required to transfer all of the morbidity and lapse risks.

g. The assets are not transferred or are not put in a segregated account when credit quality, reinvestment, and disintermediation risk are required to be transferred.
h. Settlements are made less frequently than quarterly.
i. The ceding company must make warranties not reasonably related to the business being reinsured.
j. The ceding company must make warranties about the future performance of the business being reinsured.
k. The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect; the expected potential liability to the ceding insurer remains basically unchanged.

Paragraph 3 provides accounting guidance regarding reinsurance of in-force blocks of business, which requires restriction of surplus gains until profits emerge.

Paragraphs 4-5 are contract features that are required to be present to achieve reinsurance accounting.

Paragraph 4: Letter of intent (or signed treaty) must be in place before the as-of date of the financial statement in order to apply reinsurance accounting.

Paragraph 5: Treaty must be signed within 90 days after the execution of a letter of intent.

Appendix A-791 also contains questions and answers for certain paragraphs that were incorporated from actuarial guideline JJJ. The questions and answers provide practical implementation information and are helpful regarding intent of some items. The rest of Actuarial Guideline JJJ was incorporated in Actuarial Guideline 33 Determining CARVM Reserves for Annuity Contracts with Elective Benefits, to provide guidance on elective versus non-elective benefits and language which described integrated benefit streams. Therefore, Actuarial Guideline JJJ does not currently exist as a separate guideline.

Current Issues

FAS 113 and Appendix A-791

The FAS 113 risk transfer guidance is adopted by reference, and is also affected by the modifications to FAS 113 listed in SSAP No. 61R. Such modifications include the differences between GAAP and SAP classification of certain contracts, such as contracts that statutory accounting classifies as other than deposit type contracts and GAAP classifies as investment type contracts. Appendix A-791 plays a crucial role in the application of risk transfer guidance for proportional life and health reinsurance contracts. However, both the FAS 113 and Appendix A-791 have to be reviewed in conjunction with each other. The interaction of SSAP No. 61R guidance with Appendix A-791 needs to be more explicit in SSAP No. 61R.

Appendix A-791 creates differences between GAAP and SAP definitions of risk transfer for proportional life and health reinsurance contracts. The SAP risk transfer threshold for proportional life and health reinsurance contracts can be either higher or lower than GAAP depending on the facts and circumstances. The different standard in Appendix A-791 applies to products that both GAAP and SAP classify as insurance and to products in which there are differences in insurance or non-insurance classification between GAAP and SAP. The provisions of Appendix A-791 result in reinsurance accounting only for proportional reinsurance contracts that 1) do not result in “impermanent” surplus and 2) result in the reinsurer being in a relatively equivalent economic position as the direct writer. Below are some examples of the different results that can occur:

1. GAAP and SAP are different - For a proportional reinsurance on products that both GAAP and SAP classify as an insurance contract, Appendix A-791 creates a different standard for determining risk
transfer than GAAP. This standard can be either higher or lower than GAAP risk transfer requirements depending on the facts and circumstances.

a. Appendix A-791 requires 100% of identified significant risks to be transferred.

b. Appendix A-791 has several features that are prohibited in reinsurance contracts and also requires certain contractual features. These requirements and prohibitions are to ensure that the reinsurer is in a similar economic position as the ceding entity.

c. Appendix A-791 does not require reasonable possibility of significant loss to the reinsurer for proportional reinsurance contracts; however, as noted above, a reinsurance contract that complies with Appendix A-791 will result in a reinsurer that is in a similar economic position as the ceding entity.

To the extent a proportional reinsurance contract does not transfer 100% of the identified risks SAP has a higher threshold, because GAAP would allow reinsurance accounting for reinsurance contracts with less than 100% of the identified significant risks provided the reinsurer has reasonable possibility of loss. For these reinsurance contracts SAP (Appendix A-791) would require deposit accounting.

To the extent that a proportional contract transfers 100% of the identified risks and the reinsurer does not have a reasonable possibility of loss, SAP has a lower threshold because it would allow reinsurance accounting and GAAP would require deposit accounting.

To the extent that a proportional contract has reasonable possibility of loss to the reinsurer, but the reinsurance contract contains features prohibited by Appendix A-791, the SAP standard would require deposit accounting and be stricter than GAAP which would allow reinsurance accounting.

2. SAP allows reinsurance accounting in situations that GAAP prohibits - For a life or health product that GAAP classifies as an investment contract and SAP classifies as an insurance contract, SAP allows proportional reinsurance contracts which are compliant with Appendix A-791 to receive reinsurance accounting treatment. GAAP prohibits reinsurance accounting for these underling products because the products do not contain sufficient insurance risk. This is an intentional difference between SSAP No. 61R and FAS 113 and was necessary because some products are classified as life or other than deposit type insurance in statutory accounting based on the inclusion of any mortality or morbidity risk. The same products would likely be classified as an investment type contract for GAAP because the morbidity and mortality risk is not significant. SSAP No. 61R notes that a FAS 113 modification allows the transfer of risk for other than deposit type products if the reinsurance contract transfers 100% of the identified significant risks of the contract. Under FAS 113 such a reinsurance contract would not be classified as an investment contract, and not as insurance, due to the insignificant insurance risk. This is an intentional difference that can result in reinsurance accounting treatment for statutory accounting but not for GAAP.

Nonproportional Guidance in SSAP No. 61R

The rest of the text on risk transfer in SSAP No. 61R includes some of the FAS 113 long-duration guidance, and the rest of FAS 113 is adopted with the noted modifications by reference. SSAP No. 62R is more explicit on evaluation of non-proportional contracts and contains more of the FAS 113 short-duration risk transfer guidance. As a result, SSAP No. 62R is clearer than SSAP No. 61R regarding risk transfer for reinsurance contracts which transfer less than all of the insurance risks, such as non-proportional reinsurance contracts. SSAP No. 61R, paragraph 38, notes that reinsurance accounting for non-proportional reinsurance contracts is determined in a way that is similar to how property and casualty reinsurance accounting is determined. This agenda item recommends additional language on nonproportional contracts for SSAP No., 61R.
Amount of Reinsurance Accounting Credit

Additional language in SSAP No. 61R and SSAP No. 62R is recommended to clarify that reinsurance contracts which pass reinsurance risk transfer can and will result in different reinsurance accounting credit (financial benefits) based on the terms and circumstances of the reinsurance contracts. There appears to be a misunderstanding that passing risk transfer always results in full proportional reinsurance accounting credit. However, a reinsurance contract which passes risk transfer still has to have the amount of reinsurance accounting credit separately determined. An example of this concept is that a catastrophe reinsurance treaty can pass risk transfer and still result in no initial reinsurance accounting credit. Principles-based guidance on the separate calculation of the reinsurance accounting credit would be beneficial for SSAP No. 61R and SSAP No. 62R.

Provisions of Appendix A-791 that Prohibit Reinsurance Accounting

a. Expected potential liability remains unchanged

Some of the short-duration reinsurance contracts that were brought to the attention of the Working Group were noted as RBC relief treaties and had a primary purpose of providing capital relief (as opposed to surplus relief). These reinsurance contracts were noted as not having an impact to the ceding entity’s expected liabilities – (e.g., the total liabilities were basically unchanged). Reflected reinsurance accounting for a proportional reinsurance treaty when the surplus of the ceding entity remain basically unchanged in substance or effect would seem to be a violation of Appendix A-791, paragraph 2.k. Appendix A-791 Life and Health Reinsurance agreements prohibit reducing reinsurance liabilities of establishing reinsurance assets of a ceding entity if:

k. The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

b. All (100%) of the identified significant risks

Note that Appendix A-791, paragraph 2.f. requires all (100%) of the identified significant risks to be transferred. To the extent that the reinsuring clause or risk limiting features prevent all of the significant risk identified being transferred, the contract would not be eligible for reinsurance accounting treatment under Appendix A-791.

c. Proportional versus non-proportional reinsurance contracts

Appendix A-791 is for proportional reinsurance contracts and SSAP No. 61R includes additional guidance on risk transfer for non-proportional reinsurance contracts. SSAP No. 61R, paragraph 38 on non-proportional reinsurance, notes that reinsurance accounting credit is determined in a way that is similar to the way property and casualty reinsurance accounting credit is determined. This is because these modes of reinsurance more closely follow property and casualty indemnification principles than life insurance formula basis and these coverages are very similar to excess insurance on property and casualty products. In determining the appropriate reserve credit, the probability of a loss penetrating to the reinsurer's level of coverage (using reasonable assumptions) must be multiplied by the expected amount of recovery. That means that the determination of the amount of acceptable reinsurance accounting credit should take into account the amounts that the reinsurer is reasonably expected to pay.
Reinsurance contracts with large sliding scale commissions, loss corridors and other risk limiting features raise questions regarding whether a reinsurance contract that starts out as being labeled proportional, is proportionate in substance, or if the risk limiting features cause the contract to perform more like a non-proportional contract. Barron’s dictionary of Insurance Terms notes proportional reinsurance is:

A type of reinsurance whereby the reinsurer shares losses in the same proportion as it shares premium and policy amounts.

The FAWG referral, noted in the activity to date section, provides a similar concern and seems to describe a contract that would not be compliant with Appendix A-791 paragraphs 2.k. and 2.f.:

Some of the short-duration health reinsurance contracts that regulators have brought to the attention of the Working Group and noted by the Financial Analysis (E) Working Group utilize loss corridors, sliding scale commissions, or other risk-limiting features to significantly limit the risk transferred to the reinsurer. Often these limitations result in a quota share reinsurance agreement operating more like an excess of loss reinsurance agreement, but the ceding insurer is accounting for the contract as if full, proportional reinsurance were in place. In certain cases, the ceding insurers have lost millions of dollars on certain blocks of business and even reached insolvency, while the reinsurers have continued to recognize profits on the contracts.

Some treaties that were labeled as proportional do not operate proportionately when the risk limiting features in total are considered and some treaties seem to be taking a larger reinsurance accounting credit than the risk transferred under the contract indicates or are taking a reinsurance accounting credit when transfer is not indicated. **Note that classifying a contract as proportional when it is not, or taking a reinsurance accounting credit when a contract is not compliant with SSAP No. 61R and Appendix A-791, can result in either an inappropriate reinsurance accounting credit or result in a reinsurance accounting credit that is greater than allowed when the cash flows of the contract are evaluated for the possibility of loss.**

**Disclosure (See Authoritative Literature in appendix for quotes of referenced material)**

The short-duration health reinsurance contracts that were brought to the attention of the Working Group members have risk limiting features. SSAP No. 62R—Property and Casualty Reinsurance, paragraphs 93-98, began requiring audited disclosures in the statutory annual statement interrogatories and supplements related to reinsurance contracts with risk limiting features in 2006. The purpose of the disclosures is to identify certain reinsurance contracts with risk limiting features with provisions that limit losses below the stated quota share percentage or delay timely reimbursement for further regulatory review. The disclosures also require reporting entities to affirm that they have verified risk transfer in the reinsurance contracts which received prospective reinsurance accounting credit.

The FAWG referral noted health disclosure concerns noting:

While P&C insurers are required to disclose some of these features in the interrogatories, health insurers are not, and FAWG continues to be surprised by the fact that GAAP seems to prevent some of these contracts from being recorded as meeting risk transfer requirements while SAP may not. Although the number of P&C companies reporting these features and differences in GAAP/SAP reporting may be limited, they appear to be more prevalent in troubled company situations and are being offered by otherwise well-regarded reinsurers.

This agenda item recommends additional disclosures for SSAP No. 61R.
Existing Authoritative Literature:
- **SSAP No. 61R—Life, Deposit-Type, and Accident and Health Reinsurance**
- **SSAP No. 62R—Property and Casualty Reinsurance**
- **Statement of Financial Accounting Standards No. 113, Accounting and Reporting for Reinsurance of Short-Duration and Long-Duration Contracts**
- **Appendix A-791 Life and Health Reinsurance Agreements**

In researching reinsurance risk transfer in SSAP No. 61R, staff notes the following key points:
- SSAP No. 61R, paragraph 78 adopts the FAS 113 with modifications.
- FAS 113 requirements were incorporated into FASB codification primarily in ASC 944-20 and the key risk transfers aspects of FAS 113 are unchanged by FASB codification.
- SSAP No. 61R includes a risk transfer discussion that is similar to the long-duration risk transfer discussion in FAS 113, however slightly more GAAP text on risk transfer was explicitly incorporated into SSAP No. 62R.
- In addition to the FAS 113 risk transfer requirements, SSAP No. 61R, paragraph 79 incorporates requirements from the Credit for Reinsurance (Model 785) and the Life and Health Reinsurance (Model 791).
- Model 785 contains detailed information regarding when collateral is required and what types of collateral are acceptable in order to obtain credit for reinsurance. In general, collateral is required for unauthorized reinsurers and there is a sliding scale of collateral required for certified reinsurers.
- Model 791 contains examples of contract clauses that negate risk transfer and identifies significant insurance risk that must be ceded in full. (summarized above)
- Model 791 excludes yearly renewable term (YRT) which is a type of life reinsurance under which the risks, but not the permanent plan reserves, are transferred to the reinsurer for a premium that varies each year with the amount at risk and the ages of the insured. Although the model excludes YRT, most of the requirements from paragraph 2 and 3 of A-791 are required to be followed in SSAP No. 61R. This agenda item is not focused on Yearly Renewable Term reinsurance contracts.

Activity to Date (issues previously addressed by the SAPWG, Emerging Accounting Issues WG, SEC, FASB, other State Departments of Insurance or other NAIC groups):

At the 2016 Fall National Meeting the chair of the Working Group, Mr. Bruggeman stated that he had been contacted by a regulator regarding the application of reinsurance risk transfer under **SSAP No. 61R—Life, Deposit-Type, and Accident and Health Reinsurance**. The Working Group directed NAIC staff to research this issue and, if necessary, prepare an interpretation or draft changes to SSAP No. 61R for future discussion. In providing more detail on the issue, Mr. Bruggeman stated that reporting entities may be concluding that risk-transfer requirements under U.S. GAAP are higher than the risk-transfer requirements under SSAP No. 61R. As both requirements are based on the same standard in **Statement of Financial Accounting Standards No. 113, Accounting and Reporting for Reinsurance of Short-Duration and Long-Duration Contracts**, he stated that this reporting entity interpretation is difficult to substantiate. NAIC staff was directed to provide subsequent information on their research.

Risk Limiting Features (E) Working Group was inactive in 2016, but it is charged with reviewing risk transfer guidance for property and casualty reinsurance. This group will re-activate this year and work on clarifying aspects of Financial Condition Examiner’s Handbook and Financial Analysis Handbook guidance.

The Financial Analysis (E) Working Group (FAWG) provided a referral to the Statutory Accounting Principles (E) Working Group in April 2017, which also noted and risk limiting features concerns and including for property and casualty entities and concerns regarding health disclosures. The following provides a summary of this referral:
The referral notes that the FAWG has recently discussed a number of troubled and potentially troubled insurers that have participated in quota share/proportional reinsurance contracts with significant risk-limiting features. In many of these situations, the motivation for the contracts appears to be surplus relief, without a significant amount of insurance risk being transferred to the reinsurer. The contracts often utilize loss corridors, sliding scale commissions, or other risk-limiting features to significantly limit the risk transferred to the reinsurer. Often these limitations result in a quota share reinsurance agreement operating more like an excess of loss reinsurance agreement, but the ceding insurer is accounting for the contract as if full, proportional reinsurance were in place. In certain cases, the ceding insurers have lost millions of dollars on certain blocks of business and even reached insolvency, while the reinsurers have continued to recognize profits on the contracts. While P&C insurers are required to disclose some of these features in the interrogatories, health insurers are not, and FAWG continues to be surprised by the fact that GAAP seems to prevent some of these contracts from being recorded as meeting risk transfer requirements while SAP may not. Although the number of P&C companies reporting these features and differences in GAAP/SAP reporting may be limited, they appear to be more prevalent in troubled company situations and are being offered by otherwise well-regarded reinsurers. Therefore, FAWG suggests further changes to SAP to prevent these situations.

Information or issues (included in Description of Issue) not previously contemplated by the SAPWG:
None


Staff Review Completed by:
Robin Marcotte, NAIC Staff - July 2017

Staff Recommendation:
NAIC staff recommends that the Working Group receive the referral from the Financial Analysis (E) Working Group, move this item to the active listing, categorized as nonsubstantive, and expose revisions to SSAP No. 61R, SSAP No. 62R, Appendix A-791 and the Master Glossary as illustrated in Exhibit A (omitted from the 2019 Summer National Meeting Materials for brevity). The recommended course of action is summarized below, and the related revisions are illustrated on the following pages. The draft revisions and the noted exposure questions are recommended for exposure.

1. **Risk transfer clarifications SSAP No. 61R—Life and Health Reinsurance** – Expose clarifications to the guidance in SSAP No. 61R that emphasize categorizing reinsurance contracts correctly as either being proportional or non-proportional and make more explicit the interaction between Appendix A-791 which identifies the significant risks that must be 100% transferred for proportional reinsurance contracts and the remaining SSAP No. 61R risk transfer guidance. The proposed revisions also emphasize that the reinsurance accounting credit taken for reinsurance contracts that meet risk transfer criteria in SSAP No. 61R/ Appendix A-791 is only for the portion of risks actually transferred. Reinsurance credit should take into account all features of a contract including deductibles, loss ratio corridors, a loss caps, aggregate limits or any similar provisions.

2. **Risk transfer clarifications SSAP No. 62R—Property and Casualty Reinsurance** – Expose clarifications to the risk transfer guidance in SSAP No. 62R to make the existing guidance more clear reinsurance accounting credit taken for reinsurance contracts that meet risk transfer criteria only for the portion of risks actually transferred. These clarifications are intended to be consistent with the existing concepts highlighted in the SSAP No. 62R, paragraph 93 disclosure. This guidance notes that reinsurance contracts,
which contain features that limit the reinsurer’s losses below the stated quota share percentage (e.g. a deductible, a loss ratio corridor, a loss cap, an aggregate limit or any similar provisions), should reduce the amount of reinsurance accounting credit taken by the effects of any applicable limiting provision(s).

3. **Disclosures** – Expose disclosures, for 2018 reporting year in SSAP No. 61R based on the existing reinsurance disclosures in SSAP No. 62R in paragraphs 93-98 (adapted as needed using concepts from A-791). The disclosures would be to assist regulators in identifying reinsurance contracts that may require from additional regulatory scrutiny regarding risk transfer and or compliance with A-791.

   Exposure questions- Request comments regarding the scoping of the disclosures in SSAP No. 61R.

4. **Updates to terminology** –

   a. Expose updates to the glossary in SSAP No. 61R for specific terms including the definition of proportional and non-proportional.
   
   b. Expose clarifications to the existing descriptions of proportional and nonproportional in SSAP No. 62R, paragraph 5 which are consistent with the proposed revisions to SSAP No. 61R (along with edits to subparagraph numbering).
   
   c. Expose updates to the Master Glossary to define how to classify short-duration and long-duration for statutory accounting. These are GAAP terms (quoted in Authoritative literature) which have historically not been adopted in statutory accounting, however, recent updates to SSAP No. 35R also referenced this terminology.

   **Exposure questions** – Request comments on the current SSAP No. 61R glossary definitions, which are currently defined in a life specific context: coinsurance, modified coinsurance and retention. Request comments on if adding short-duration and long-duration terms (modified for statutory accounting differences in classification) to the Master Glossary would be useful especially in the context of adopted GAAP guidance.

5. **Appendix A-791 updates to include the Model 791 preamble** – Expose updates to Appendix A-791 to incorporate language from the preamble of Model Law 791. This language from the model is indicative of the intent behind the Model, which was to prevent reinsurance accounting for reinsurance contracts that provide temporary surplus aid without transferring all of the significant risks so that the expected potential liability of the ceding insurer remains “basically unchanged.” This includes much of the existing language in paragraph 2.k. of Appendix A-791, but also provides additional detail regarding intent.

   Exposure questions – Request comments on whether additional clarifications are needed on the interaction of Appendix A-791 and the risk transfer guidance or if the proposed changes to SSAP No. 61R are sufficient. Would adding to the questions and answers in A-791 regarding application be useful? If so, what questions should be addressed?

**Status:**

On August 6, 2017, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance, SSAP No. 62R—Property and Casualty Reinsurance and Appendix A-791—Life and Health Reinsurance, as illustrated in Exhibit A (omitted from the 2019 Summer National Meeting Materials for brevity), to clarify reinsurance contracts risk transfer requirements and to provide clarifications that reinsurance accounting credit for contracts that pass risk transfer is only for the amount of risk ceded. The agenda item also
updates terminology and incorporates new SSAP No. 61R disclosures to assist in reviewing contracts, similar to existing disclosures in SSAP No. 62R.

On November 6, 2017, the Statutory Accounting Principles (E) Working Group received comments. The Working Group provided the following direction for the next phase of work on this project:

1. NAIC staff was directed to work with Working Group and industry representatives to hold informal drafting calls to refine the exposure drafts for future Working Group consideration. The bi-weekly calls will generally be separate (P/C and Life) as feasible, with some combined calls for consistency issues.

2. The previously exposed revisions to add the GAAP definitions of short duration and long duration contracts to the master glossary would be removed going forward, as the comments from the Interested Parties and the ACLI responded that the proposed additional definitions were not helpful.

3. The suggested revisions to SSAP No. 62R, paragraph 29 on non-proportional reinsurance credit proposed by the interested parties provide a better starting point to redraft this paragraph. NAIC staff was directed to use this language and work with the informal drafting groups to add some non-proportional examples in the next phase of discussion. The proposed starting point language for SSAP No. 62R, paragraph 29 is as follows:

   29. Reporting entities shall not record reinsurance credit for non-proportional reinsurance until such time as losses have been incurred on the underlying business, which exceed the attachment point of the applicable reinsurance contract(s).

Recommendation for 2018 Summer National Meeting Discussion

The Informal Property and Casualty Drafting Group and an Informal Life and Health Drafting Group both of which include regulators and industry representatives have held several calls and recommend exposing the revisions described below:

1. **Informal Property and Casualty Drafting Group** - The drafting group recommends updates to SSAP No. 62R—Property and Casualty Reinsurance to incorporate GAAP guidance to be more consistent with ASC topic 994-20. The proposed revisions specifically incorporate more guidance from FASB Emerging Issues Task Force No. 93-6, Accounting for Multiple-Year Retrospectively Rated Contracts by Ceding and Assuming Enterprises (EITF 93-6) and its related interpretation EITF D-035, FASB Staff Views on Issue No. 93-6, "Accounting for Multiple-Year Retrospectively Rated Contracts by Ceding and Assuming Enterprises." SSAP No. 62R already, adopts EITF 93-6 with modification; however, it is incorporated by reference rather than explicitly quoted. As the informal drafting groups agrees that SSAP No. 62R intends to match GAAP to the extent feasible, the drafting group has recommended revisions to SSAP No. 62R text, and the existing Appendix to assist with addressing the concerns noted in the agenda item. These concerns include ensuring that credit for reinsurance reported by the cedant is not greater than the amount of risk ceded.

   Although the subgroup views the revisions as consistent updates, because of the extent of revisions, NAIC staff recommends categorizing these revisions to SSAP No. 62R as substantive and exposing the revisions to SSAP No. 62R as reflected in agenda item 2017-28 - Attachment Q1. (The attachment has several drafting notes to assist with review. These drafting notes are not planned to be in the final document.) During the exposure period, input on the effective date is also requested.

2. **Informal Life and Health Drafting Group** – The primary issue under discussion is how to provide clear pointers from SSAP No. 61R—Life and Health Reinsurance to the Appendix A-791 guidance so that users understand which contracts are subject to the guidance in the appendix, and to identify the contracts which not
subject to the appendix. The challenge is providing clear guidance that does not conflict with the existing appendix A-791, which is an accreditation standard model law. The Informal Life and Health Drafting Group recommends a partial exposure to obtain wider feedback on the scope of Appendix A-791 and proposed disclosures. The Informal Life and Health Drafting Group has prepared updates to the Appendix A-791 Q&A to assist with further defining the applicability of the Appendix. The drafting group will continue to work on revisions to the body of the statement, but believes feedback on the exposed QA revisions will assist with drafting further revisions. In addition, the drafting group has prepared disclosures for exposure also.

NAIC staff recommends exposing revisions to the SSAP No. 61R disclosure and the A-791 Q&A as reflected in agenda item 2017-28 - Attachment Q2. The Informal Life and Health Drafting Group is not recommending adoption of these revisions until the other revisions to the guidance in SSAP No. 61R are developed.

On August 4, 2018, the Statutory Accounting Principles (E) Working Group:

1. Exposed substantive revisions to SSAP No. 62R—Property and Casualty Reinsurance to incorporate guidance from EITF 93-6, Accounting for Multiple-Year Retrospectively Rated Contracts by Ceding and Assuming Enterprises and from EITF D-035, FASB Staff Views on Issue No. 93-6. (Drafting notes are not planned to be in the final document.) The Working Group also requested, input on the effective date. See separate document.

2. Exposed nonsubstantive revisions to SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance to incorporate disclosures. The proposed revisions also update the question-and-answer guidance in Appendix A-791—Life and Health Reinsurance Agreements to clarify the applicability of A-791. Note that the exposure includes a request for comments on whether the proposed disclosures adequately address the Financial Analysis (E) Working Group referral with a notation, that the feedback will assist with ongoing drafting group work. See Exhibit B (omitted from the 2019 Summer National Meeting Materials for brevity).

Comments are requested on the following items related to the exposed SSAP No. 61R disclosures:

1. The drafting group discussion determined that the prior exposure for SSAP No. 61R, paragraph 83, which was based on SSAP No. 62, paragraph 94 with modifications to be consistent with A-791 was repetitive on compliance with A-791. The subgroup reviewed existing paragraph 94 a-d, in SSAP No. 62R and determined it was not useful in the context of SSAP No. 61R. Regulator and industry input is requested on any additional contract features that should be identified for disclosure.

2. The FAWG, requested disclosures similar to existing disclosures in SSAP No. 62R—Property and Casualty Reinsurance for SSAP No. 61R. However, the existing SSAP No. 62R disclosures could not copied into SSAP No. 61R exactly because of variations between product types and the Appendix A-791. Regulator input is requested regarding whether proposed disclosures would be sufficient to address regulatory concerns and or the FAWG request

3. Comments are requested regarding contracts identified for disclosure in paragraph 85 should be identified in the annual statement reinsurance schedule S with a signifier to avoid repeating details in the annual statement note, which may be in the statement schedule.

On November 15, 2018, the Statutory Accounting Principles (E) Working Group adopted, as final, substantive revisions to SSAP No. 62R that clarify the determination of reinsurance credit and incorporate language from
EITF 93-6, Accounting for Multi-Year Retrospectively Rated Contracts by Ceding and Assuming Enterprises and EITF D-035, FASB Staff Views on Issue No. 93-6, with a January 1, 2019 effective date. The Working Group directed NAIC staff to draft an issue paper documenting the substantive revisions. The Working Group directed that comments received from Connecticut and New Jersey regarding SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance and Appendix A-791 be forwarded to the informal Life and Health Reinsurance Drafting Group for subsequent consideration.

On April 6, 2019, the Statutory Accounting Principles (E) Working Group exposed revisions to an issue paper to document for historical purposes the adopted revisions to SSAP No. 62R—Property and Casualty Reinsurance. Also, on April 6, 2019, the Working Group received an update from the Informal Life and Health Reinsurance Drafting Group, noting the following:

**Prior Actions** - At the 2018 Fall National Meeting, the Working Group heard comments on the exposure recommended by the informal life and health reinsurance drafting group. The revisions proposed updates to the A-791 Life and Health Reinsurance QA to clarify the applicability of A-791 and expand questions and answers to address business that has a statutorily required medical loss ratio or similar refund / rebate. In addition, the exposure proposed revised disclosures as requested by the Financial Analysis (E) Working Group. The Working Group directed the subgroup to expand their work to address group term life yearly renewable term (YRT) comments raised in comment letters from two states.

**Interim Activity** - The informal drafting group updated the membership to address the YRT issues raised and has held four calls. The YRT issues related to group term life risk that were raised are complex. While the informal drafting group does not have a recommendation for exposure at this time, they are making steady progress and appreciate the active engagement from regulators and industry. The primary areas that are being considered for updating are to the A-791 QA guidance and to the YRT guidance in SSAP No. 61R—Life and Health Reinsurance, paragraph 19. The drafting group will continue to hold calls on this topic in the interim and intends to have something to recommend for exposure by the 2019 Summer National Meeting.

**Recommendation for 2019 Summer National Meeting Discussion**

Receive Report of Interim Activity

The YRT issues related to group term life risk that were raised are complex. The informal drafting group is making steady progress and appreciates the active engagement from regulators and industry. The primary areas that were discussed in the interim were on updating the A-791 QA guidance and to the YRT guidance in SSAP No. 61R—Life and Health Reinsurance, paragraph 19.

The Informal Drafting Life and Health Reinsurance Drafting Group met 4 times during the interim year primarily focused on YRT issues. Additional meeting will continue as the Drafting Group works to address YRT issues also works on other topics such as non proportional reinsurance.

The informal drafting group reviewed prior exposures and their comments and recommends exposure of the following:

1. **SSAP No. 61R Disclosures** - These disclosures were previously exposed and the comments on the prior exposure have been reviewed by the drafting group. The disclosures are to address the request from the Financial Analysis (E) Working Group for life and health reinsurance contracts to have disclosure, which identify contracts with certain features including, risk limiting features. similar to existing disclosures in SSAP No. 62R—Property and Casualty Reinsurance for SSAP No. 61R. However, the existing SSAP No. 62R disclosures could not copied into SSAP No. 61R exactly because of variations between product types.
and the Appendix A-791. The drafting group also recommends notifying the Financial Analysis (E) Working Group of the exposure.

2. Two updates to the Appendix A-791 question and answers (QA)

   a. The informal life and health reinsurance-drafting group identified that the existing phrase “certain non-proportional reinsurance arrangements” in the current A-791 could benefit from additional guidance to promote consistent application. The proposed revisions to the answer below are to help identify non-proportional contracts, which are not subject to the Appendix A-791. The drafting group also reviewed the comments from Connecticut received from the August 2018 exposure and determined not to incorporate the YRT/RBC comments at this time as the YRT discussion is ongoing.

   b. The proposed Appendix A-791 question and answer regarding business that has a statutorily required medical loss ratio or similar refund / rebate. This item was previously exposed, and no questions were received. The drafting group did not recommend any additional revisions.

3. Add A-791 QA under paragraph 2c on YRT

   Regarding the YRT issues, industry drafted a Q&A in relation to paragraph 2c of A-791 for consideration. The regulator members agreed to the suggested approach to add the Q&A but eliminated the second part of the Answer that would continue to allow the reinsurer to charge premiums in excess of the underlying direct proportionate premium if the ceding entity established a liability for the excess amount. After further discussion, the regulator and industry members of the subgroup could not come to agreement.

   The industry members prefer to seek ways to explicitly allow the group term life YRT reinsurance contracts to exceed the amount of the underlying direct proportionate premium. The most recent industry proposal was to allow this, provided the ceding entity establishes a liability for the amount of reinsurance premium in excess of the direct premium. Industry discussed the commercial reasoning and argued that risk would still be transferred.

   The regulator members continued to question whether such group term life YRT contracts appropriately transferred risk if a reinsurer could charge premiums in excess of the underlying direct proportionate premium. It was noted that these contracts generally included other risk limiting features such as loss carry forward provisions and would typically not pass risk transfer requirements under GAAP. They also noted concerns that codifying the industry proposed exception in statutory accounting could result in unintended consequences and appeared to be designed address a commercial concern. Therefore, the regulator members proposed to accept the Q&A drafted by the industry but without wording that would allow reinsurers to charge premiums in excess of the underlying direct proportionate premium. The regulator members of the drafting group have requested exposure of the guidance to allow for specific concerns to be raised and addressed. This guidance provides that group term life YRT contracts which exceed the underlying direct premium are unreasonable and violate the provisions of paragraph 2c of A-791, and therefore, would not be subject to reinsurance accounting.
August 2019 Recommendation:
NAIC Staff recommends that the Working Group receive the drafting group recommendation on interim activity and expose for comment the following items which are illustrated below:

1. Disclosures, (previously exposed) Concurrent with the exposure, NAIC staff recommends that the Working Group also notify the Financial Analysis (E) Working Group of the exposure as the disclosures were originally developed at their request.

2. The two A-791 QA items one the topic of certain nonproportional reinsurance contracts covered under the A-791 and medical loss ratios (previously exposed – the drafting group reviewed the comments).

3. Regulator proposed revisions to add A-791 QA under paragraph 2c regarding group term life YRT reinsurance contracts. (which are not supported by industry members).

On August 3, 2019, the Statutory Accounting Principles (E) Working Group adopted, as final, Issue Paper No. 162—Property and Casualty to document for historical purposes the revisions related to SSAP No. 62R—Property and Casualty Reinsurance, which was adopted at the 2018 Fall National Meeting.

In addition to the issue paper adoption, on August 3, 2019, the Working Group also exposed for comment the following items which are illustrated below:

1. Disclosures, (previously exposed) and, directed notification to the Financial Analysis (E) Working Group of the exposure as the disclosures were originally developed at their request.

2. The two A-791 QA items related to certain nonproportional reinsurance contracts” covered under the A-791 and medical loss ratios (previously exposed – the drafting group reviewed the comments).

3. Regulator proposed revisions to add A-791 QA under paragraph 2c regarding group term life YRT reinsurance contracts.

Illustration of proposed revisions to SSAP No. 61R and A-791 exposed on August 3, 2019:

1. The revisions to SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance to incorporate disclosures proposed for exposure are as follows:

   Drafting Note: These disclosures were previously exposed, the shading is for minor edits recommended by the drafting group on June 11, 2019

   December 2019 Drafting Note: The disclosure paragraph numbering was updated from 81 – 87 as exposed to be 78 to 84 to reflect that the following disclosures will be inserted before existing paragraph 78. In addition, recommendations for Fall National meeting is illustrated language for Fall 2019 discussion illustrating the proposed December 31, 2020 effective date for the new disclosures.

   78. Disclosures for paragraphs 82-87, which are required to be included with the annual audit report financial statements beginning with the period ended December 31, 201X regarding reinsurance contracts. The disclosures required within paragraphs 82-87 shall be included in accompanying supplemental schedules of the annual audit report beginning in year-end 201X. These disclosures shall be limited to reinsurance contracts entered into, renewed or amended on or after January 1, 1996. This limitation applies to the annual audit report only and does not apply to the statutory annual statement
interrogatories and the property and casualty reinsurance summary supplemental filing. *(Drafting Note: From SSAP No. 62R, paragraph 92)*

79. Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) subject to A-791 that includes a provision, which limits the reinsurer's assumption of significant risks identified as in A-791. Examples of risk limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. For contracts subject to A-791, indicate if deposit accounting was applied for all contracts, which limit significant risks. *(Drafting Note: Similar to SSAP No. 62R, paragraph 93, and is also relevant to A-791 evaluations.)*

80. Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) not subject to A-791, for which reinsurance accounting was applied and includes a provision that limits the reinsurer's assumption of risk. Examples of risk limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. If affirmative, indicate if the reinsurance credit was reduced for the risk limiting features. *(Drafting Note: Similar to SSAP No. 62R, paragraph 93.)*

81. Disclose if any reinsurance contracts which contain features (except reinsurance contracts with a federal or state facility) described below which result in delays in payment in form or in fact:

   a. Provisions which permit the reporting of losses, or settlements are made, less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date (unless there is no activity during the period). *(Drafting Note: From SSAP No. 62R, paragraph 94.e and Appendix A-791, paragraph 2.e.)*

   b. Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity. *(Drafting Note: From SSAP No. 62R, paragraph 94.f, also relevant to risk transfer guidance in SSAP No. 61R)*

82. Disclose if the reporting entity has reflected reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R and identify the type of contracts and the reinsurance contracts.

   a. Assumption Reinsurance – new for the reporting period.

   b. Non-proportional reinsurance, which does not result in significant surplus relief. If yes, indicate if the insured event(s) triggering contract coverage has been recognized.

83. Disclose if the reporting entity ceded any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement, and either: *(Drafting Note: From SSAP No. 62R, paragraph 97)*

   a. Accounted for that contract as reinsurance under statutory accounting principles (“SAP”) and as a deposit under generally accepted accounting principles (“GAAP”); or

   b. Accounted for that contract as reinsurance under GAAP and as a deposit under SAP.

84. If affirmative disclosure is required for paragraph 86, explain why the contract(s) is treated differently for GAAP and SAP. *(Drafting Note: From SSAP No. 62R, paragraph 98)*
Drafting Note - These disclosures are expected to begin at existing paragraph 77 in SSAP No. 61R. The paragraph numbering will be updated in the final draft.

2. Proposed updates to A-791 QA (previously exposed)

   a. Update to A-791 QA under paragraph 1 to address the phrase “certain non-proportional”

      1. This Appendix shall not apply to assumption reinsurance, yearly renewable term reinsurance or certain non-proportional reinsurance such as stop loss or catastrophe reinsurance.

      Q – Aside from assumption reinsurance, what other types of reinsurance are exempt from the accounting requirements?

      A – Yearly renewable term (YRT) and certain nonproportional reinsurance arrangements, such as stop loss and catastrophe reinsurance are exempt because these do not normally provide significant surplus relief and therefore are outside the scope of this Appendix. If a catastrophe arrangement takes a reserve credit for actual losses beyond the attachment point or the unearned premium reserve (UPR) of the current year's premium, there will most likely be no regulatory concern.

      Similarly, if a YRT treaty provides incidental reserve credits for the ceding insurer's net amount at risk for the year with no other allowance to enhance surplus, there will most likely be no regulatory concern. For purposes of this exemption, a treaty labeled as YRT does not meet the intended definition of YRT if the surplus relief in the first year is greater than that provided by a YRT treaty with zero first year reinsurance premium and no additional allowance from the reinsurer.

      Additional pertinent information applicable to all YRT treaties and to non-proportional reinsurance arrangements is contained in paragraphs 19 and 20 of SSAP No. 61R.

      To further elaborate on the phrase "certain non-proportional reinsurance" in paragraph 1, the beginning of the answer notes that contracts such as stop-loss and catastrophe do not normally provide significant surplus relief, and are therefore not subject to the accounting guidance in Appendix A-791. Non-proportional reinsurance agreements are considered not to provide significant surplus relief if they possess all of the following features. For the purposes of defining these features, the term "triggering event" means the event or sequence of events that would lead to a loss being reimbursable by the reinsurer pursuant to the terms of the reinsurance agreement.

      1. The triggering event has not occurred at the time of the inception of the reinsurance agreement.

      2. The triggering event is materially less likely than not to occur during each settlement period of the reinsurance agreement.

      3. There is no initial reinsurance credit for ceded policy reserves and any reinsurance expense allowance or commission is reported so that surplus is not impacted until the related premium is reported as earned.

      These criteria shall be evaluated separately for each measurement period under the reinsurance agreement, where the measurement period is that period of time for which the direct writer’s experience is used to determine the amounts owed to and from the reinsurer. If there are carry-forwards of experience debits or credits from one calendar year to the next, then those multiple years will be considered one settlement period.
The fact that the triggering event does eventually occur, is not itself evidence that the second criterion above has not been met. The criterion should be evaluated based on reasonable expectations rather than posteriori results.

b. New Appendix A-791 question and answer regarding business that has a statutorily required medical loss ratio or similar refund / rebate.

Q: If a company cedes health insurance business that is subject to a Medical Loss Ratio (MLR), or similar statutorily required refunds / rebates, must the reinsurer participate in the payment of any refunds / rebates?

A: The reinsurer needs to participate in the payment of its share of any statutorily required MLR or similar refund or rebate based on loss ratio calculations to the extent that the experience of the health business reinsured, during the period that it is reinsured, contributes to the calculation of the refund. Although the payment of such a refund based on the experience of business that is currently reinsured could result in a reduction of surplus on the part of the ceding insurer, if the reduction in surplus of the ceding insurer is entirely attributable to the experience prior to the effective date of the reinsurance, then it is outside of the contract requirements. Accordingly, such a provision should not cause a reinsurance agreement to be out of compliance with Appendix A-791 of the Accounting Practices and Procedure Manual. It is recognized that some refund calculations may involve multiple years.

Furthermore, just as an experience refund is not considered in the determination as to whether a reinsurance agreement is proportional, the requirement for the payment of a refund to policyholders based on a Medical Loss Ratio requirement should also not be considered.

Note: This Q&A only applies to refunds related to a statutory MLR or similar refund or rebate requirement for health insurance and should not be applied to any other situation.

3. Regulator Proposed Revisions Regarding YRT

Suggested new Q&A on group term life YRT for placement under paragraph 2c of A-791

2c. The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty;

Q: If group term life business is reinsured under a YRT reinsurance agreement (which includes risk limiting features such as with an experience refund provision which offsets refunds against current and/or prior years' losses (i.e., a "loss carryforward" provision), under what circumstances would any provisions of the reinsurance agreement be considered "unreasonable provisions which allow the reinsurer to reduce its risk under the agreement" thereby violating subsection 2.c.?

A: Unlike individual life insurance where reserves held by the ceding insurer reflect a statutorily prescribed valuation premium above which reinsurance premium rates would be considered unreasonable, group term life has no such guide. So long as the reinsurer cannot charge premiums in
excess of the premium received by the ceding insurer under the provisions of the YRT reinsurance agreement, such provisions would not be considered unreasonable. Any provision in the YRT reinsurance agreement which allows the reinsurer to charge reinsurance premiums in excess of the proportionate premium received by the ceding insurer would be considered unreasonable.

For Fall 2019 Discussion

NAIC Staff recommends that the Working Group take the following actions regarding the exposed items:

1. **Adopt the exposed SSAP No. 61R disclosures (with paragraph number updates)** reflected below and with an initial effective date of year end 2020 reporting. Proposed effective date language for the disclosures is illustrated below.

   **Fall 2019 Drafting Note:** The disclosure paragraph numbering was updated from 81 – 87 as exposed to be 78 to 84 to reflect that the following disclosures will be inserted before existing paragraph 78. In addition, recommendations for Fall National meeting is illustrated language for Fall 2019 discussion illustrating the proposed December 31, 2020 effective date for the new disclosures:

   78. Disclosures for paragraphs 82-87, which are required to be included with the annual audit report financial statements beginning with the period ended December 31, 201X regarding reinsurance contracts. The disclosures required within paragraphs 82-87 shall be included in accompanying supplemental schedules of the annual audit report beginning in year-end 201X. These disclosures shall be limited to reinsurance contracts entered into, renewed or amended on or after January 1, 1996. This limitation applies to the annual audit report only and does not apply to the statutory annual statement interrogatories and the property and casualty reinsurance summary supplemental filing. *(Drafting Note: From SSAP No. 62R, paragraph 92)*

   79. Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) subject to A-791 that includes a provision, which limits the reinsurer’s assumption of significant risks identified as in A-791. Examples of risk limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. For contracts subject to A-791, indicate if deposit accounting was applied for all contracts, which limit significant risks. *(Drafting Note: Similar to SSAP No. 62R, paragraph 93, and is also relevant to A-791 evaluations.)*

   80. Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) not subject to A-791, for which reinsurance accounting was applied and includes a provision that limits the reinsurer’s assumption of risk. Examples of risk limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. If affirmative, indicate if the reinsurance credit was reduced for the risk limiting features. *(Drafting Note: Similar to SSAP No. 62R, paragraph 93.)*

   81. Disclose if any reinsurance contracts which contain features (except reinsurance contracts with a federal or state facility) described below which result in delays in payment in form or in fact:

   c. Provisions which permit the reporting of losses, or settlements are made, less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date (unless there is no activity during the period). *(Drafting Note: From SSAP No. 62R, paragraph 94.e. and Appendix A-791, paragraph 2.e.)*

   d. Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity. *(Drafting Note:)*
82. Disclose if the reporting entity has reflected reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R and identify the type of contracts and the reinsurance contracts.
   a. Assumption Reinsurance – new for the reporting period.
   b. Non-proportional reinsurance, which does not result in significant surplus relief. If yes, indicate if the insured event(s) triggering contract coverage has been recognized.

83. Disclose if the reporting entity ceded any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement, and either: (Drafting Note: From SSAP No. 62R, paragraph 97)
   a. Accounted for that contract as reinsurance under statutory accounting principles (“SAP”) and as a deposit under generally accepted accounting principles (“GAAP”); or
   b. Accounted for that contract as reinsurance under GAAP and as a deposit under SAP.

84. If affirmative disclosure is required for paragraph 86, explain why the contract(s) is treated differently for GAAP and SAP. (Drafting Note: From SSAP No. 62R, paragraph 98)

Effective Date (not previously exposed)
86. The disclosure for compliance with Model #787 or AG 48 shall be effective for reporting periods ending on or after December 31, 2015. The revisions adopted in November 2018 to expand liquidity disclosures are effective year-end 2019, concurrent with the inclusion of data-captured financial statement disclosures. The disclosures captured in paragraphs 78-84 which help to identify certain reinsurance contract features are effective for reporting periods ending on or after December 31, 2020.

2. Adopt the exposed revisions to A-791 question and answer regarding contracts with medical loss ratios.

3. Refer to the informal life and health reinsurance drafting group the exposed revisions to the A-791 question and answer update to clarify the phrase “certain non-proportional contracts” with informal questions received by NAIC staff regarding: 1) the application of the exposed language regarding measurement period and settlement period and, 2) the application of substantially less likely than not. During the interim the informal questions were distributed to the drafting group. Based on informal input from with various drafting group members, more discussion is needed regarding this question and answer item and this is an issue that the drafting group can lend some useful expertise.

4. Provide direction on the A-791 question and answer, regarding the paragraph 2c exposed regulator language. As noted in the summary section above, regulator and industry members of the drafting group could not come to agreement. Industry comments received still indicate opposition on the topic of limiting group term life YRT reinsurance contracts to being not greater than the amount of the underlying direct proportionate premium reinsurance premium for the contract to receive reinsurance accounting. If preferred, the Working Group could have further discussion and provide direction at a subsequent meeting as the drafting group has noted that the regulators and the industry members are not in agreement on this topic. In addition, request assistance and input from LATF on evaluation of YRT risk transfer.
On December 7, 2019, the Statutory Accounting Principles (E) Working Group adopted, as final:

1. Disclosure revisions to SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance, with an effective date of Dec. 31, 2020,
2. A-791—Life and Health Reinsurance Agreements Q&A updates regarding contracts with medical loss ratios
3. A-791—Life and Health Reinsurance Agreements Q&A for paragraph 2c. regarding risk transfer and group term life yearly renewable term reinsurance, with an effective date of Jan. 1, 2021.

The adopted revisions are illustrated below. The Working Group also directed staff to notify the Life Actuarial (A) Task Force of the adoptions.

The proposed revisions to A-791 Q&A regarding the scope of nonproportional contracts subject to Appendix A-791 was referred to the informal life and health reinsurance drafting group to address informal application questions.

1. **Adopted - SSAP No. 61R Disclosures**

78. Disclosures for paragraphs 79-84, are required to be included with the annual audit report financial statements beginning with the period ended December 31, 2020 regarding reinsurance contracts. The disclosures required within paragraphs 79-84 shall be included in accompanying supplemental schedules of the annual audit report beginning in year-end 2020. These disclosures shall be limited to reinsurance contracts entered into, renewed or amended on or after January 1, 1996. This limitation applies to the annual audit report only and does not apply to the statutory annual statement interrogatories and the property and casualty reinsurance summary supplemental filing.

79. Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) subject to A-791 that includes a provision, which limits the reinsurer’s assumption of significant risks identified as in A-791. Examples of risk limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. For contracts subject to A-791, indicate if deposit accounting was applied for all contracts, which limit significant risks.

80. Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) not subject to A-791, for which reinsurance accounting was applied and includes a provision that limits the reinsurer’s assumption of risk. Examples of risk limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. If affirmative, indicate if the reinsurance credit was reduced for the risk limiting features.

81. Disclose if any reinsurance contracts contain features (except reinsurance contracts with a federal or state facility) described below which result in delays in payment in form or in fact:

   a. Provisions which permit the reporting of losses, or settlements are made, less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date (unless there is no activity during the period).
   
   b. Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity.
82. Disclose if the reporting entity has reflected reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R and identify the type of contracts and the reinsurance contracts.

   a. Assumption Reinsurance – new for the reporting period.

   b. Non-proportional reinsurance, which does not result in significant surplus relief. If yes, indicate if the insured event(s) triggering contract coverage has been recognized.

83. Disclose if the reporting entity ceded any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement, and either:

   a. Accounted for that contract as reinsurance under statutory accounting principles (“SAP”) and as a deposit under generally accepted accounting principles (“GAAP”); or

   b. Accounted for that contract as reinsurance under GAAP and as a deposit under SAP.

84. If affirmative disclosure is required for paragraph 86, explain why the contract(s) is treated differently for GAAP and SAP.

86. The disclosure for compliance with Model #787 or AG 48 shall be effective for reporting periods ending on or after December 31, 2015. The revisions adopted in November 2018 to expand liquidity disclosures are effective year-end 2019, concurrent with the inclusion of data-captured financial statement disclosures. The disclosures captured in paragraphs 78-84 which help to identify certain reinsurance contract features are effective for reporting periods ending on or after December 31, 2020.

2. Adopted new Appendix A-791 question and answer regarding business that has a statutorily required medical loss ratio or similar refund / rebate. This question relates to more than one topic, but will be placed under paragraph 2f. as a new QA item.

Q: If a company cedes health insurance business that is subject to a Medical Loss Ratio (MLR), or similar statutorily required refunds / rebates, must the reinsurer participate in the payment of any refunds / rebates?

A: The reinsurer needs to participate in the payment of its share of any statutorily required MLR or similar refund or rebate based on loss ratio calculations to the extent that the experience of the health business reinsured, during the period that it is reinsured, contributes to the calculation of the refund. Although the payment of such a refund based on the experience of business that is currently reinsured could result in a reduction of surplus on the part of the ceding insurer, if the reduction in surplus of the ceding insurer is entirely attributable to the experience prior to the effective date of the reinsurance, then it is outside of the contract requirements. Accordingly, such a provision should not cause a reinsurance agreement to be out of compliance with Appendix A-791 of the Accounting Practices and Procedure Manual. It is recognized that some refund calculations may involve multiple years.

Furthermore, just as an experience refund is not considered in the determination as to whether a reinsurance agreement is proportional, the requirement for the payment of a refund to policyholders based on a Medical Loss Ratio requirement should also not be considered.

Note: This Q&A only applies to refunds related to a statutory MLR or similar refund or rebate requirement for health insurance and should not be applied to any other situation.
3. **Adopted A-791—Life and Health Reinsurance Agreements Q&A for paragraph 2c. regarding risk transfer and group term life yearly renewable term reinsurance, with an effective date of Jan. 1, 2021, as detailed below. Placement would be at the end of the current paragraph 2c. QA items.**

   2c. The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty;

   Q: If group term life business is reinsured under a YRT reinsurance agreement (which includes risk limiting features such as with an experience refund provision which offsets refunds against current and/or prior years' losses i.e., a “loss carryforward” provision), under what circumstances would any provisions of the reinsurance agreement be considered “unreasonable provisions which allow the reinsurer to reduce its risk under the agreement” thereby violating subsection 2.c.?

   A: Unlike individual life insurance where reserves held by the ceding insurer reflect a statutorily prescribed valuation premium above which reinsurance premium rates would be considered unreasonable, group term life has no such guide. So long as the reinsurer cannot charge premiums in excess of the premium received by the ceding insurer under the provisions of the YRT reinsurance agreement, such provisions would not be considered unreasonable. Any provision in the YRT reinsurance agreement which allows the reinsurer to charge reinsurance premiums in excess of the proportionate premium received by the ceding insurer would be considered unreasonable. The revisions to this QA regarding group term life yearly renewable term agreements is effective for contracts in effect as of January 1, 2021.

4. **Referred** the A-791 QA under paragraph 1 to address the phrase “certain non-proportional contracts” to the informal life and health reinsurance drafting group to address informal application questions received. The application questions received include: 1) the application of the exposed language regarding measurement period and settlement period and, 2) the application of substantially less likely than not.

   1. This Appendix shall not apply to assumption reinsurance, yearly renewable term reinsurance or certain non-proportional reinsurance such as stop loss or catastrophe reinsurance.

   Q – Aside from assumption reinsurance, what other types of reinsurance are exempt from the accounting requirements?

   A – Yearly renewable term (YRT) and certain nonproportional reinsurance arrangements, such as stop loss and catastrophe reinsurance are exempt because these do not normally provide significant surplus relief and therefore are outside the scope of this Appendix. If a catastrophe arrangement takes a reserve credit for actual losses beyond the attachment point or the unearned premium reserve (UPR) of the current year's premium, there will most likely be no regulatory concern. Similarly, if a YRT treaty provides incidental reserve credits for the ceding insurer's net amount at risk for the year with no other allowance to enhance surplus, there will most likely be no regulatory concern. For purposes of this exemption, a treaty labeled as YRT does not meet the intended definition of YRT if the surplus relief in the first year is greater than that provided by a YRT treaty with zero first year reinsurance premium and no additional allowance from the reinsurer.
Additional pertinent information applicable to all YRT treaties and to non-proportional reinsurance arrangements is contained in paragraphs 19 and 20 of SSAP No. 61R.

To further elaborate on the phrase "certain non-proportional reinsurance" in paragraph 1, the beginning of the answer notes that contracts such as stop-loss and catastrophe do not normally provide significant surplus relief, and are therefore not subject to the accounting guidance in Appendix A-791. Non-proportional reinsurance agreements are considered not to provide significant surplus relief if they possess all of the following features. For the purposes of defining these features, the term "triggering event" means the event or sequence of events that would lead to a loss being reimbursable by the reinsurer pursuant to the terms of the reinsurance agreement.

1. The triggering event has not occurred at the time of the inception of the reinsurance agreement.

2. The triggering event is materially less likely than not to occur during each settlement period of the reinsurance agreement.

3. There is no initial reinsurance credit for ceded policy reserves and any reinsurance expense allowance or commission is reported so that surplus is not impacted until the related premium is reported as earned.

These criteria shall be evaluated separately for each measurement period under the reinsurance agreement, where the measurement period is that period of time for which the direct writer’s experience is used to determine the amounts owed to and from the reinsurer. If there are carry-forwards of experience debits or credits from one calendar year to the next, then those multiple years will be considered one settlement period.

The fact that the triggering event does eventually occur, is not itself evidence that the second criterion above has not been met. The criterion should be evaluated based on reasonable expectations rather than posteriori results.
**Issue: ASU 2014-17, Business Combinations – Pushdown Accounting, a Consensus of the FASB Emerging Issues Task Force**

**Check (applicable entity):**

- Modification of existing SSAP
- New Issue or SSAP
- Interpretation

**Description of Issue:**

*ASU 2014-17, Business Combinations – Pushdown Accounting, a Consensus of the FASB Emerging Issues Task Force* (ASU 2014-17) was issued to provide guidance on whether and at what threshold an acquired entity that is a business or nonprofit activity can apply pushdown accounting in its separate financial statements. Prior to the issuance of this ASU, pushdown accounting was only required under U.S. GAAP for SEC registrants. Pursuant to the provisions in the ASU, acquirees now have the option to apply pushdown accounting. Pushdown accounting is a convention of accounting for the purchase of a subsidiary at the purchase cost rather than its historical basis. In effect, the acquiree’s assets and liabilities are written up (or down) to reflect the purchase price and, to the extent that the purchase price exceeds fair value, to recognize the excess as goodwill. In short, the total amount that is paid to purchase the subsidiary becomes the subsidiary’s new book value on its financial statements.

To illustrate the difference in applying pushdown accounting:

- Acquiree’s Book Value of Assets = $100 and Liabilities = $50.
- Acquiree’s Fair Value of Assets = $120 and Liabilities = $30.

If the purchase price was $90:

- “Normal” Purchase Accounting = Recognize SCA at $50 with the parent recognizing goodwill of $40.
- “Pushdown” Purchase Accounting = Recognize SCA at $90 with no goodwill recognized by the parent.

Under U.S. GAAP, goodwill is calculated as the purchase price of the acquiree less the market value of the acquiree. Any gains and losses associated with the new book value are “pushed down” from the acquirer’s income statement and balance sheet to the acquired company’s income statement and balance sheet. ASU 2014-17 states that an acquired entity may elect the option to apply pushdown accounting in the reporting period in which the change-in-control event occurs, but it also has the option to apply pushdown accounting in a reporting period subsequent to its most recent change-in-control event. If pushdown accounting is applied in a subsequent reporting period, it will be considered a change in accounting principle.

Under statutory accounting, a business combination is accounted for as either a statutory purchase or a statutory merger. A business combination in which one entity is acquired by another, and a parent-subsidiary relationship is created, is accounted for as a statutory purchase. The acquirer reports its investment at cost, which is defined as the sum of (a) any cash payment, (b) the fair value of other assets distributed, (c) the fair value of any liabilities assumed, and (d) any direct costs of the acquisition. For acquired subsidiary, controlled and affiliated (SCA) entities valued...
under an equity method of accounting, goodwill is defined as the difference between the cost of acquiring the SCA and the reporting entity’s share of the book value of the SCA. For U.S. insurance SCAs, the historical basis of the SCA will continue to be used in preparing its statutory financial statements. As such, pushdown accounting is not permitted for this equity method of accounting.

While statutory accounting utilizes the framework that was established by U.S. GAAP, statutory accounting focuses on the balance sheet, as opposed to the income statement, and places additional emphasis on the concepts of consistency and conservatism due to this difference in reporting objectives. The use of pushdown accounting as an accounting method under statutory accounting is problematic for the reasons listed below.

- A change in the ownership of an entity should not result in a new basis of accounting for that entity in its separate financial statements as transactions affecting an entity’s stock should not affect the entity’s accounting.

- If the acquiree has entered into third-party agreements with terms related to financial statements presented on the existing basis of accounting, restatement under pushdown accounting could pose problems in determining or maintaining compliance with those requirements.

- In the event there are still minority ownership interests in the acquired entity, utilization of pushdown accounting would result in a different set of financial statements and these owners would not have a meaningful set of comparative financial statements.

- There isn’t a reasonable way to determine which owner’s transactions should qualify for pushdown accounting, in a scenario in which there are multiple owners who are deemed to control the acquiree (10%+ ownership of outstanding stock measured at the holding company level).

- Goodwill restrictions under statutory accounting, such as the admissibility of goodwill limited to 10% of the reporting entity’s surplus and amortization over a ten-year span, would essentially be eluded.

**Example of U.S. GAAP with and without Pushdown Accounting versus Statutory Accounting**

Entity A purchases 100% of Entity Z (which has a fair value of 200 and is on the books for $100, Assets = $200 and Liabilities = $100) for $500.

**Entity Z’s Accounting on Standalone Financials:**

<table>
<thead>
<tr>
<th></th>
<th>U.S. GAAP without Pushdown</th>
<th>U.S. GAAP with Pushdown</th>
<th>Statutory Accounting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assets</td>
<td>300</td>
<td>500</td>
<td>200</td>
</tr>
<tr>
<td>Liabilities</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Equity</td>
<td>200</td>
<td>400</td>
<td>100</td>
</tr>
<tr>
<td>Goodwill</td>
<td>300</td>
<td>0</td>
<td>400</td>
</tr>
</tbody>
</table>

**Result:** Pushdown accounting increases the basis of the acquired entity from $100 under statutory accounting to $400 under U.S. GAAP. It also circumvents the goodwill restrictions under statutory accounting by increasing the basis of the acquired entity on its standalone financial statements.

**Actual SCA Filing**

NAIC Staff also refer to an actual SCA Sub 2 filing that was submitted during 2018 under the 8.b.iii valuation method (Non-Insurance SCA Entity under GAAP Basis). This acquisition was completed.
under the pushdown accounting method for U.S. GAAP. Since the existing guidance in SSAP No. 97 values 8.b.iii entities on the audited “U.S. GAAP equity of the investee,” the existing guidance does not allow for modifications/adjustments to remove the “pushdown accounting” impact. This allowed the parent reporting entity to avoid reporting goodwill for the acquired SCA. (*Entity names and values have been changed.*)

ABC purchased 50% of G for $500. G’s book value was $105 (Assets = $205 and Liabilities = $100) and fair value was $290.

**Entity G’s Accounting on Standalone Financials:**

<table>
<thead>
<tr>
<th></th>
<th>U.S. GAAP without Pushdown</th>
<th>U.S. GAAP with Pushdown</th>
<th>Statutory Accounting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assets</td>
<td>390</td>
<td>600</td>
<td>205</td>
</tr>
<tr>
<td>Liabilities</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Equity</td>
<td>290</td>
<td>500</td>
<td>105</td>
</tr>
<tr>
<td>Goodwill</td>
<td>210</td>
<td>0</td>
<td>395</td>
</tr>
</tbody>
</table>

The insurance reporting entity’s investment in G was increased due to the goodwill that was paid as part of the acquisition of G. This results in a value of G that vastly differs between U.S. GAAP where pushdown accounting is used and statutory accounting, which is much more conservative.

**Existing Authoritative Literature:**

**SSAP No. 68—Business Combinations and Goodwill**

**Statutory Purchases of SCA Investments**

3. The statutory purchase method of accounting is defined as accounting for a business combination as the acquisition of one entity by another. It shall be used for all purchases of SCA entities including partnerships, joint ventures, and limited liability companies. The acquiring reporting entity shall record its investment at cost. Cost is defined as the sum of: (a) any cash payment, (b) the fair value of other assets distributed, (c) the fair value of any liabilities assumed, and (d) any direct costs of the acquisition. Contingent consideration issued in a purchase business combination that is embedded in a security or that is in the form of a separate financial instrument shall be recorded by the issuer at fair value at the acquisition date.

4. For those acquired SCA entities accounted for in accordance with paragraphs 8.b.i., 8.b.ii., 8.b.iii. or 8.b.iv. of SSAP No. 97, and joint venture, partnership or limited liability company entities accounted for in accordance with paragraph 8 of SSAP No. 48, goodwill is defined as the difference between the cost of acquiring the entity and the reporting entity’s share of the book value of the acquired entity. When the cost of the acquired entity is greater than the reporting entity’s share of the book value, positive goodwill exists. When the cost of the acquired entity is less than the reporting entity’s share of the book value, negative goodwill exists. Goodwill resulting from assumption reinsurance shall be recorded as a separate write-in for other-than-invested assets. All other goodwill shall be reported in the carrying value of the investment.

5. A business combination accounted for under the statutory purchase method and in which the acquired entity is valued in accordance with paragraphs 8.b.ii., 8.b.iii. or, 8.b.iv. of SSAP No. 97 shall determine the amount of positive goodwill or negative goodwill created by the combination using the reporting entity’s share of the GAAP net book value of the acquired entity, adjusted to a statutory basis of accounting in accordance with paragraph 9 of SSAP No. 97 in the case of acquired entities valued in accordance paragraphs 8.b.ii. or 8.b.iv. of SSAP No. 97. Business combinations accounted for under the
statutory purchase method and in which the acquired entity is valued in accordance with, paragraph 8.b.i. of SSAP No. 97 shall determine the amount of positive or negative goodwill created by the business combination using the insurer’s share of the statutory book value of the acquired entity.

6. For those acquired SCA entities accounted for in accordance with paragraph 8.b.i. of SSAP No. 97 under the statutory purchase method, the historical bases of the acquired entity shall continue to be used in preparing its statutory financial statements. Therefore, pushdown accounting is not permitted.

7. Positive goodwill recorded under the statutory purchase method of accounting shall be admitted subject to the following limitation: Positive goodwill from all sources, including life, accident and health, and deposit-type assumption reinsurance, is limited in the aggregate to 10% of the acquiring entity’s capital and surplus as required to be shown on the statutory balance sheet of the reporting entity for its most recently filed statement with the domiciliary state commissioner adjusted to exclude any net positive goodwill, EDP equipment and operating system software, and net deferred tax assets. Additionally, all positive goodwill shall be nonadmitted when the underlying investment in the SCA or partnership, joint venture and limited liability company is nonadmitted. When negative goodwill exists, it shall be recorded as a contra-asset. Positive or negative goodwill resulting from the purchase of an SCA, joint venture, partnership or limited liability company shall be amortized to unrealized capital gains and losses on investments over the period in which the acquiring entity benefits economically, not to exceed 10 years. Positive or negative goodwill resulting from life, accident and health, and deposit-type assumption reinsurance shall be amortized to operations as a component of general insurance expenses over the period in which the assuming entity benefits economically, not to exceed 10 years. Goodwill shall be evaluated separately for each transaction.

SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities

Valuation of Investments in Downstream Holding Companies

22. SSAP No. 48 requires the financial statements of joint ventures, partnerships, and/or limited liability companies in which the downstream noninsurance holding company has a minor ownership interest or otherwise lacks control, i.e., ownership interest is less than 10% (hereinafter referred to as “non SCA SSAP No. 48 entities”), to be valued using U.S. GAAP basis financial statements. Valuation of a downstream holding company, including its investments in SCA entities, depends upon the nature of the SCA entities and non SCA SSAP No. 48 entities it holds in accordance with paragraph 8 of this statement. All liabilities, commitments, contingencies, guarantees or obligations of the downstream noninsurance holding company, which are required to be recorded under applicable statutory accounting guidance, shall be reflected in the parent insurance reporting entity’s determination of the carrying value of the investment in the downstream noninsurance holding company, if not already recorded in the financial statements of the downstream noninsurance holding company. If an SCA investment of the downstream holding company does not meet the provisions of paragraph 8.a. or if it elects not to use the guidance in paragraph 8.a., and instead uses the guidance in paragraph 8.b., the downstream holding company would be valued as the sum of the following (if applicable):

a. Investments by a downstream holding company in U.S. insurance SCA entities are recorded based upon the guidance in paragraph 8.b.i.;

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1 The “acquiring” entity is intended to reflect the insurance reporting entity that reports the investment resulting in goodwill. The goodwill limitation test shall be completed at the individual reporting company level.

2 This includes, but is not limited to, situations in which the investment is nonadmitted as the audited financial statements for the SCA, joint venture, partnership or limited liability company includes substantial doubt on the entity’s ability to continue as a going concern, or on the basis/contents of the audit opinion pursuant to paragraph 21 of SSAP No. 97.
b. Investments by a downstream holding company in noninsurance SCA entities that are engaged in transactions or activities described in paragraph 8.b.ii., are recorded based upon the guidance in paragraph 8.b.ii.;

c. Investments by a downstream holding company in noninsurance SCA entities that do not qualify under paragraph 21.b. shall be recorded based upon the guidance in paragraph 8.b.iii.;

d. Investments by a downstream holding company in foreign insurance SCA entities shall be recorded based upon the guidance in paragraph 8.b.iv.; and

e. Any other assets and/or liabilities of the downstream holding company (not addressed in paragraphs 21.a. through 21.d.) shall be valued in accordance with the applicable SSAP.

For purposes of applying paragraphs 21-26 of this statement, a downstream holding company shall be considered to be the parent reporting entity’s investment in a SCA entity. See paragraphs 25 and 26 for a limited exception to the audited financial statements requirement for downstream noninsurance holding companies which meet specified conditions.

Admissibility Requirements of Investments in Downstream Holding Companies

23. To meet the admissibility requirements of this statement, unless the limited exception to the audited financial statements requirement discussed in paragraphs 25 and 26 applies, an annual audit of the financial statements of SCA entities, including the downstream holding company valued under paragraphs 8.b.i through 8.b.iv. must be obtained. The requirement for audited financial statements may be met by utilizing any one of the following methods:

a. Audited US GAAP financial statements of the downstream SCA holding company. (Consolidated or combined financial statements are allowed encompassing one or more downstream holding companies, including such holding companies that directly own U.S. insurance entities, provided that the statutory financial statements of such U.S. insurance entities are audited. Annual consolidated or combined audits are allowed for insurance entities if completed in accordance with the Model Regulation Requiring Annual Audited Reports as adopted by the SCA’s domiciliary state.) The audited financial statements of the downstream holding company shall include as other financial information, consolidating or combining balance sheet schedule(s) showing the equity of all relevant SCA entities and non-SCA SSAP No. 48 entities, and any required intercompany eliminations. The consolidating or combining balance sheet schedule shall separately present those entities owned directly by the downstream holding company. The consolidating or combining balance sheet schedule shall then be adjusted for GAAP to SAP differences for paragraph 8.b.i., 8.b.ii. and 8.b.iv. entities owned directly or indirectly by the downstream holding company. The adjusted amount would then be the reported value of the investment in the downstream holding company at the higher-level reporting entity; or

b. Audited foreign GAAP-basis financial statements of the downstream SCA holding company. (Consolidated or combined financial statements are allowed encompassing one or more downstream holding companies, including such holding companies that directly own U.S. insurance entities, provided that the statutory financial statements of such U.S. insurance entities are audited. Annual consolidated or combined audits are allowed for insurance entities if completed in accordance with the Model Regulation Requiring Annual Audited Reports as adopted by the SCA’s domiciliary state.) The audited foreign GAAP basis financial statements shall include an audited footnote disclosure within the financial statements that reconciles each consolidated entity’s net income and equity on a foreign
basis of accounting to a U.S. GAAP basis. The audited financial statements of the
downstream holding company shall include as other financial information, consolidating or
combining balance sheet schedule(s) showing the equity of all relevant SCA entities non
SCA SSAP No. 48 entities, and any required intercompany eliminations. The consolidating
or combining balance sheet schedule shall separately present those entities owned directly
by the downstream holding company. The consolidating or combining balance sheet shall
then be adjusted for GAAP to SAP differences of the insurance entities and paragraph
8.b.ii., and 8.b.iv. entities owned directly or indirectly by the downstream holding company.
The adjusted amount would then be the reported value of the investment in the
downstream holding company at the higher-level reporting entity; or

c. Individual audits of the downstream holding company and the downstream holding
company’s investments in individual SCA entities.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E)
Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): During the 2019
Summer National Meeting, the Working Group received information on the history of pushdown and information
from discussions with AICPA and interested party representatives. This information has been captured in the agenda
item for future reference:

Comparison of SAP / GAAP Goodwill Guidance, including GAAP Pushdown:

<table>
<thead>
<tr>
<th>SCA Acquisition</th>
<th>Purchase Price: $300</th>
<th>Asset Book Value: $90</th>
<th>Asset Fair Value: $150</th>
</tr>
</thead>
</table>
| Standard SAP Accounting: | Investment in SCA: $90  
  Goodwill: $210 | The combined $300 is reported as the investment in SCA, but the goodwill is separately reported and is subject to the SSAP No. 68 admittance restrictions and the 10-year amortization. |
| U.S. GAAP Standard: | Investment in SCA: $150  
  Goodwill: $150 | When pushdown is not elected, under U.S. GAAP, goodwill is calculated on the difference between fair value and the purchase price. This is different than SAP where goodwill is calculated based on the difference between book value and the purchase price. |
| U.S. GAAP Pushdown: | Parent Reporting:  
  Investment in SCA: $300 | With pushdown, the reported value at the reporting entity level simply reflects the purchase price. |
| | SCA Reporting:  
  Assets: $150  
  Goodwill: $150 | With pushdown, the acquired SCA increases the book value of their assets to fair value, and reports goodwill on their F/S for any remaining difference. |

Preliminary information from discussions with AICPA and Industry representations

- Insurance reporting entities that were SEC filers have historically used pushdown when acquiring SCAs. This is because pushdown accounting was required for SEC filers and US GAAP allowed pushdown to prevent differences between the SEC and US GAAP.
With ASU 2014-17, the US GAAP guidance became an election for all reporting entities. As such, more entities may have elected to use pushdown, but no information is known as to the extent pushdown accounting has been applied.

**For the SEC registrants that used pushdown, the U.S. GAAP guidance was followed.** As such, at acquisition the assets and liabilities of the SCA were adjusted to fair value, and the goodwill calculated was the difference between the purchase price and the fair value of the SCA. (This is different from the goodwill calculation required under SSAP No. 68.) The goodwill was then recognized as an asset on the SCA books (and not at the insurance reporting entity level). This goodwill was subject to the U.S. GAAP impairment calculation, which requires annual testing of impairment, but was not subject to the admittance or amortization requirements of SSAP No. 68.

**For non-SEC registrants that have elected pushdown under the new GAAP provisions, it is uncertain how goodwill was calculated prior to the pushdown.** (Whether it was calculated under the guidance in SSAP No. 68 or under U.S. GAAP.)

Although U.S. GAAP now permits pushdown beyond SEC filers, pushdown is prohibited under IFRS.

Per the discussion with interested parties’ representatives, the acquisition of a new SCA from a non-related party is considered to be an economic transaction under SSAP No. 25. However, if the acquisition of an SCA was from a related party, it would not be considered an economic transaction. With classification as an economic transaction, the interested parties noted that increase of the SCA to represent fair value is consistent under SSAP No. 25.

**Historical SAP Guidance:**

The original Issue Paper No. 68 noted that pushdown should be prohibited in all SCA acquisitions. Issue Papers are not authoritative, and this guidance was not what was adopted in the original SSAP No. 68. There is no discussion in the original Issue Paper on the expansion that permitted pushdown for the “7.b.iii” entities in the issued SSAP No. 46. The expansion on the use of pushdown to all SCA entities except insurance SCA entities “8.b.i” was then reflected as a modification to SSAP No. 68 from the 2004 adoption of SSAP No. 88—Investments in Subsidiary, Controlled and Affiliated Entities, A Replacement of SSAP No. 46. (This revision expanded the ability to use pushdown accounting to noninsurance entities that engage in insurance “activities” and meet the revenue test under 8.b.ii.) There was no discussion in the corresponding Issue Paper (No. 118) regarding the expansion to all entities except insurance SCAs. NAIC staff suspects that as pushdown was limited to only SEC registrants under U.S. GAAP, the expansion to all entities that could use audited U.S. GAAP was not concerning as it would be applied only in the SEC-qualifying situations. This aspect of SSAP No. 68 has not been modified since the adoption of SSAP No. 88.

Original Codification of AP&P Manual – Effective Jan. 1, 2001:

**Issue Paper No. 68—Business Combinations and Goodwill:**

8. Under the statutory purchase method the historical bases of the acquired entity shall continue to be used in preparing its statutory financial statements except in those instances provided for in paragraph 8.b. of Issue Paper No. 46. Therefore, pushdown accounting is not permitted.
Issue Paper No. 46—Accounting for Investments in Subsidiary, Controlled or Affiliated Entities:

8b. If a SCA investment does not meet the requirements for the market valuation approach in paragraph 7.a. or, if the requirements are met, but a reporting entity elects not to use that approach, investments in SCAs shall be recorded as follows:

i. Investments in insurance SCA entities shall be recorded based on the underlying statutory equity of the respective entity's financial statements, adjusted for unamortized goodwill as provided for in Issue Paper No. 68—Business Combinations and Goodwill (Issue Paper No. 68);

ii. Investments in noninsurance SCA entities that have no significant ongoing operations other than to hold assets that are primarily for the direct or indirect benefit or use of the reporting entity or its affiliates, shall be recorded based on the underlying equity of the respective entity's financial statements adjusted to a statutory basis of accounting and the resultant proportionate share of the subsidiary's adjusted surplus, adjusted for unamortized goodwill as provided for in Issue Paper No. 68. Examples include but are not limited to: 1) an insurer and a SCA entity that leases autos, furniture, office equipment, or computer equipment to the insurer, 2) an insurer and a SCA entity that owns real estate property that is leased to the insurer for office space, and 3) an insurer and an SCA entity which holds investments which an insurer could acquire directly (i.e., "look through" investment subsidiary);

iii. Investments in noninsurance SCA entities that have significant ongoing operations beyond the holding of assets that are primarily for the direct or indirect benefit or use of the reporting entity or its affiliates, shall be recorded based on the audited GAAP equity of the investee. Examples include but are not limited to: 1) a property-casualty or life insurer and a SCA entity that is an oil and gas venture, and 2) a property-casualty or life insurer and a SCA manufacturer.

SSAP No. 68—Business Combinations and Goodwill

8. Under the statutory purchase method the historical bases of the acquired entity shall continue to be used in preparing its statutory financial statements except in those instances provided for in paragraph 7.b.iii of SSAP No. 46. Therefore, pushdown accounting is not permitted.

SSAP No. 46—Investments in Subsidiary, Controlled and Affiliated Entities:

7.b.iii. Investments in noninsurance SCA entities that have significant ongoing operations beyond the holding of assets that are primarily for the direct or indirect benefit or use of the reporting entity or its affiliates, shall be recorded based on the audited GAAP equity of the investee. Examples include but are not limited to: (i) a property-casualty or life insurer and a SCA entity that is an oil and gas venture, and (ii) a property-casualty or life insurer and a SCA manufacturer.

AP&P Manual – As of March 2005:

SSAP No. 88—Investments in Subsidiary, Controlled and Affiliated Entities, A Replacement of SSAP No. 46 detailed the amendments adopted to SSAP No. 68:

26. This statement supersedes paragraphs 4-6 of SSAP No. 68—Business Combinations and Goodwill as follows:

4. For those acquired SCA entities accounted for in accordance with paragraphs 8.b.i., 8.b.ii., 8.b.iii. or 8.b.iv. of SSAP No. 88, goodwill is defined as the difference between the cost of acquiring the entity and the reporting entity’s share of the book value of the acquired entity. When the cost of the acquired entity is greater than the reporting entity’s share of the book
value, positive goodwill exists. When the cost of the acquired entity is less than the reporting entity’s share of the book value, negative goodwill exists. Goodwill resulting from assumption reinsurance shall be recorded as a separate write-in for other-than-invested assets. All other goodwill shall be reported in the carrying value of the investment.

5. A business combination accounted for under the statutory purchase method and in which the acquired entity is valued in accordance with paragraphs 8.b.ii., 8.b.iii. or, 8.b.iv. of SSAP No. 88 shall determine the amount of positive goodwill or negative goodwill created by the combination using the reporting entity’s share of the GAAP net book value of the acquired entity. Business combinations accounted for under the statutory purchase method and in which the acquired entity is valued in accordance with, 8 b. i. SSAP No. 88 shall determine the amount of positive or negative goodwill created by the business combination using the insurer’s share of the statutory book value of the acquired entity.

6. For those acquired SCA entities accounted for in accordance with paragraph 8.b.i. under the statutory purchase method the historical bases of the acquired entity shall continue to be used in preparing its statutory financial statements. Therefore, pushdown accounting is not permitted.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group:
None

Convergence with International Financial Reporting Standards (IFRS):
Currently, there is no guidance in IFRS on pushdown accounting as this is not a method of accounting that is accepted under IFRS.

Staff Recommendation:
Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose the proposed revisions to SSAP No. 68—Business Combinations and Goodwill and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities to reject ASU 2014-17, Business Combinations – Pushdown Accounting for statutory accounting. This agenda item also explicitly prohibits use of pushdown accounting under the statutory accounting basis, which includes all entities accounting for under SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies and SSAP No. 97. These revisions will explicitly prohibit insurance reporting entities that hold SCAs valued on the basis of U.S. GAAP (8.b.ii or 8.b.iii) to utilize a value for the SCA that reflects the impact of pushdown accounting. Insurance reporting entities that hold SCAs that utilized pushdown accounting for U.S. GAAP will be required to adjust their U.S. GAAP financial statements to remove the effect of pushdown accounting, and provide audited support of their modification. The insurance reporting entity shall recognize the difference between the purchase price and the net book value of the entity (prior to pushdown accounting) as goodwill in accordance with SSAP No. 68. This goodwill shall be admitted and amortized in accordance with the limitations and provisions of SSAP No. 68. The effective date of these revisions shall be Jan. 1, 2020.

Staff Note: Staff has considered that it will be more difficult to maintain separate sets of accounting records if multiple entities are acquired, especially with the complex nature of insurance company reporting structures. Staff also notes that the election to apply pushdown accounting under U.S. GAAP is irrevocable; as such, a grandfather provision will allow any SCAs acquired prior to December 31, 2019 to continue to use pushdown accounting in its financial statements.

Staff Review Completed by:
Fatima Sediqzad - NAIC Staff
March 2019
Proposed Revisions:

SSAP No. 68—Business Combinations and Goodwill

Business Combinations
2. A business combination shall be accounted for as either a statutory purchase or a statutory merger. Business combinations that create a parent-subsidiary relationship shall be accounted for as a statutory purchase. Business combinations where equity of one entity is issued in exchange for the equity of another entity, which is then canceled, and prospectively only one entity exists, shall be accounted for as a statutory merger.

Statutory Purchases of SCA Investments
3. The statutory purchase method of accounting is defined as accounting for a business combination as the acquisition of one entity by another. It shall be used for all purchases of SCA entities including partnerships, joint ventures, and limited liability companies. The acquiring reporting entity shall record its investment at cost. Cost is defined as the sum of: (a) any cash payment, (b) the fair value of other assets distributed, (c) the fair value of any liabilities assumed, and (d) any direct costs of the acquisition. Contingent consideration issued in a purchase business combination that is embedded in a security or that is in the form of a separate financial instrument shall be recorded by the issuer at fair value at the acquisition date. Pushdown accounting is not a permitted convention of accounting under statutory accounting, including the acquisition of an entity that follows U.S. GAAP as its basis of accounting.

6. For those acquired SCA entities accounted for using the equity method in accordance with paragraph 8.b.+ of SSAP No. 97 under the statutory purchase method, the historical bases of the acquired entity shall continue to be used in preparing its statutory financial statements. Therefore, pushdown accounting is not permitted, as noted in paragraph 20.

20. This statement rejects ASU 2017-04, Simplifying the Test for Goodwill Impairment, ASU 2016-03, Intangibles—Goodwill and Other, Business Combinations, Consolidation, Derivatives and Hedging; ASU 2014-17, Business Combinations – Pushdown Accounting, a Consensus of the FASB Emerging Issues Task Force; ASU 2014-02, Accounting for Goodwill (a consensus of the Private Company Council), ASU 2012-02, Testing Indefinite-Lived Intangible Assets for Impairment, ASU 2011-08, Testing Goodwill for Impairment and ASU 2010-28, When to Perform Step 2 of the Goodwill Impairment Test for Reporting Units with Zero or Negative Carrying Amounts; Accounting Principles Board Opinion No. 16, Business Combinations; FASB Statement No. 38, Accounting for Preacquisition Contingencies of Purchased Enterprises, an amendment of APB Opinion No. 16; Accounting Principles Board Opinion No. 17, Intangible Assets; FASB Statement No. 79, Elimination of Certain Disclosures for Business Combinations by Nonpublic Enterprises; FASB Statement No. 141, Business Combinations; and FASB Statement No. 142, Goodwill and Other Intangible Assets. The following related interpretative pronouncements are also rejected:

SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities

Applying the Market Valuation, Audited Statutory Equity and Audited GAAP Equity Methods
8. The admitted investments in SCA entities shall be valued using either the market valuation approach (as described in paragraph 8.a.), or one of the equity methods (as described in paragraph 8.b.) adjusted as appropriate in accordance with the guidance in SSAP No. 25—Affiliates and Other Related Parties (SSAP No. 25), paragraph 16.d.

a. In order to use the market valuation approach for SCA entities, the following requirements apply:
b. If a SCA investment does not meet the requirements for the market valuation approach in paragraph 8.a. or, if the requirements are met, but a reporting entity elects not to use that approach, the reporting entity’s proportionate share of its investments in SCAs shall be recorded as follows:

i. Investments in U.S. insurance SCA entities shall be recorded based on either 1) the underlying audited statutory equity of the respective entity’s financial statements, adjusted for any unamortized goodwill as provided for in SSAP No. 68—*Business Combinations and Goodwill* (SSAP No. 68)\(^3\) or 2) the underlying audited statutory equity of the respective entity’s financial statements, adjusted for any unamortized goodwill, modified to remove the impact of any permitted or prescribed accounting practices that depart from the NAIC *Accounting Practices and Procedures Manual*. Reporting entities shall record investments in U.S. insurance SCA entities on at least a quarterly basis, and shall base the investment value on the most recent quarterly information available from the SCA. Entities may recognize their investment in U.S. insurance SCA entities based on the unaudited statutory equity in the SCAs year-end Annual Statement if the annual SCA audited financial statements are not complete as of the filing deadline. The recorded statutory equity shall be adjusted for audit adjustments, if any, as soon as the annual audited financial statements have been completed. Annual consolidated or combined audits are allowed if completed in accordance with the Model Regulation Requiring Annual Audited Financial Reports as adopted by the SCA’s domiciliary state;

ii. Investments in both U.S. and foreign noninsurance SCA entities that are engaged in the following transactions or activities:

(a) Collection of balances as described in SSAP No. 6—*Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers*

(b) Sale/lease or rental of EDP Equipment and Software as described in SSAP No. 16R—*Electronic Data Processing Equipment and Software*

(c) Sale/lease or rental of furniture, fixtures, equipment or leasehold improvements as described in SSAP No. 19—*Furniture, Fixtures, Equipment and Leasehold Improvements*

(d) Loans to employees, agents, brokers, representatives of the reporting entity or SCA as described in SSAP No. 20—*Nonadmitted Assets*

(e) Sale/lease or rental of automobiles, airplanes and other vehicles as described in SSAP No. 20—*Nonadmitted Assets*

(f) Providing insurance services on behalf of the reporting entity including but not limited to accounting, actuarial, auditing, data processing,

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\(^3\) If the insurance SCA employs accounting practices that depart from the NAIC accounting practices and procedures, and the reporting insurance entity has not adjusted the valuation of the insurance SCA to be consistent with the NAIC accounting practices and procedures, (i.e., retains the effect of the permitted or prescribed practice in its valuation), disclosure about those accounting practices that affect the insurance SCA’s net income and surplus shall be made pursuant to paragraph 36. If the reporting entity has adjusted the investment in the insurance SCA with the resulting valuation being consistent with the accounting principles of the AP&P Manual, the disclosures in paragraph 36 are not required.
underwriting, collection of premiums, payment of claims and benefits, policyowner services

(g) Acting as an insurance or administrative agent or an agent for a government instrumentality performing an insurance function (e.g. processing of state workers compensations plans, managing assigned risk plans, Medicaid processing etc).

(h) Purchase or securitization of acquisition costs

and if 20% or more of the SCA’s revenue is generated from the reporting entity and its affiliates, then the underlying equity of the respective entity’s audited U.S. Generally Accepted Accounting Principles (GAAP) financial statements shall be adjusted to a limited statutory basis of accounting in accordance with paragraphs 9 and 20FN. For purposes of this section, revenue means GAAP revenue reported in the audited U.S. GAAP financial statements excluding realized and unrealized capital gains/losses. Foreign SCA entities are defined as those entities incorporated or otherwise legally formed under the laws of a foreign country. Paragraphs 232-287 provide guidance for investments in holding companies;

New Footnote – If the audited U.S. GAAP financial statements reflect the pushdown method of accounting, the financial statements must first be modified to eliminate the effects of the pushdown accounting before applying the statutory basis adjustments.

iii. Investments in both U.S. and foreign noninsurance SCA entities that do not qualify under paragraph 8.b.ii., shall be recorded based on the audited U.S. GAAP equity of the investee, adjusted in accordance with paragraph 20. Foreign SCA entities are defined as those entities incorporated or otherwise legally formed under the laws of a foreign country. Additional guidance on investments in downstream holding companies is included in paragraphs 232-287. Additional guidance on the use of audited foreign GAAP basis financial statements for the U.S. GAAP equity valuation amount is included in paragraph 243.b.

iv. Investments in foreign insurance SCA entities shall be recorded based on the underlying U.S. GAAP equity from the audited U.S. GAAP basis financial statements, adjusted to a limited statutory basis of accounting in accordance with paragraphs 9 and 20, if available. If the audited U.S. GAAP basis financial statements are not available, the investment can be recorded on the audited foreign statutory basis financial statements of the respective entity adjusted to a limited statutory basis of accounting in accordance with paragraph 9 and adjusted for reserves of the foreign insurance SCA with respect to the business it assumes directly and indirectly from a U.S. insurer using the statutory accounting principles promulgated by the NAIC in the Accounting Practices and Procedures Manual. The audited foreign statutory basis financial statements must include an audited footnote that reconciles net income and equity on the foreign statutory basis of accounting to the U.S. GAAP basis. Foreign insurance SCA entities are defined as alien insurers formed according to the legal requirements of a foreign country.

**Pushdown Accounting**

20. Pushdown accounting is a convention of accounting for the purchase of a subsidiary at the purchase cost rather than its historical cost. Under pushdown accounting, the acquiree’s assets and liabilities are written up (or down) to reflect the purchase price and, to the extent that the purchase price exceeds fair value, to recognize the excess as goodwill. As such, the total amount that is paid to purchase
the subsidiary becomes the subsidiary's new book value on its financial statements. Pushdown accounting is not permitted under statutory accounting, therefore all SCAs that utilize audited U.S. GAAP financial statements to determine the valuation method under this statement (SCAs valued in accordance with paragraphs 8.b.ii and 8.b.iii) that reflect pushdown accounting must be adjusted, in accordance with an audited reconciliation, to eliminate the effects of pushdown accounting. In addition to adjusting the equity basis of the SCA to eliminate pushdown accounting, the insurance reporting entity shall separately recognize goodwill, as appropriate based on the purchase price and net book value of the entity at acquisition (without pushdown accounting) and report the goodwill in accordance with the provisions of SSAP No. 68. Reporting entities that do not have audited support to eliminate the impact of pushdown accounting shall consider the SCA nonadmitted for statutory reporting purposes. Historical acquisitions of SCAs that have involved pushdown accounting shall continue admittance of the SCA with approval of the domiciliary commissioner. On a prospective basis for newly acquired SCAs, and for historical SCA acquisitions in which domiciliary commissioner approval is not received, reporting entities that do not have audited support to eliminate the impact of pushdown accounting shall report the SCA as a nonadmitted asset for statutory reporting purposes.

Valuation of Investments in Downstream Holding Companies

22. SSAP No. 48 requires the financial statements of joint ventures, partnerships, and/or limited liability companies in which the downstream noninsurance holding company has a minor ownership interest or otherwise lacks control, i.e., ownership interest is less than 10% (hereinafter referred to as “non SCA SSAP No. 48 entities”), to be valued using U.S. GAAP basis financial statements. Valuation of a downstream holding company, including its investments in SCA entities, depends upon the nature of the SCA entities and non SCA SSAP No. 48 entities it holds in accordance with paragraph 8 of this statement. All liabilities, commitments, contingencies, guarantees or obligations of the downstream noninsurance holding company, which are required to be recorded under applicable statutory accounting guidance, shall be reflected in the parent insurance reporting entity’s determination of the carrying value of the investment in the downstream noninsurance holding company, if not already recorded in the financial statements of the downstream noninsurance holding company. The historical basis of the acquired entity shall continue to be used in preparing its financial statements. If an SCA investment of the downstream holding company does not meet the provisions of paragraph 8.a. or if it elects not to use the guidance in paragraph 8.a., and instead uses the guidance in paragraph 8.b., the downstream holding company would be valued as the sum of the following (if applicable):

Admissibility Requirements of Investments in Downstream Holding Companies

23. To meet the admissibility requirements of this statement, unless the limited exception to the audited financial statements requirement discussed in paragraphs 26 and 27 applies, an annual audit of the financial statements of SCA entities, including the downstream holding company valued under paragraphs 8.b.i through 8.b.iv. must be obtained. The requirement for audited financial statements may be met by utilizing any one of the following methods:

a. Audited US GAAP financial statements of the downstream SCA holding company, where the historical basis of the SCA has been used to prepare its financial statements. (Consolidated or combined financial statements are allowed encompassing one or more downstream holding companies, including such holding companies that directly own U.S. insurance entities, provided that the statutory financial statements of such U.S. insurance entities are audited. Annual consolidated or combined audits are allowed for insurance entities if completed in accordance with the Model Regulation Requiring Annual Audited Reports as adopted by the SCA’s domiciliary state.) The audited financial statements of the downstream holding company shall include as other financial information, consolidating or combining balance sheet schedule(s) showing the equity of all relevant SCA entities and non-SCA SSAP No. 48 entities, and any required intercompany eliminations. The consolidating or combining balance sheet schedule shall separately present those entities owned directly by the downstream holding company. The consolidating or combining balance sheet shall then be adjusted for GAAP to SAP differences for paragraph 8.b.i.,
8.b.ii. and 8.b.iv. entities owned directly or indirectly by the downstream holding company. The adjusted amount would then be the reported value of the investment in the downstream holding company at the higher-level reporting entity; or

b. Audited foreign GAAP-basis financial statements of the downstream SCA holding company. (Consolidated or combined financial statements are allowed encompassing one or more downstream holding companies, including such holding companies that directly own U.S. insurance entities, provided that the statutory financial statements of such U.S. insurance entities are audited. Annual consolidated or combined audits are allowed for insurance entities if completed in accordance with the Model Regulation Requiring Annual Audited Reports as adopted by the SCA’s domiciliary state.) The audited foreign GAAP basis financial statements shall include an audited footnote disclosure within the financial statements that reconciles each consolidated entity’s net income and equity on a foreign basis of accounting to a U.S. GAAP basis. The audited financial statements of the downstream holding company shall include as other financial information, consolidating or combining balance sheet schedule(s) showing the equity of all relevant SCA entities non SCA SSAP No. 48 entities, and any required intercompany eliminations. The consolidating or combining balance sheet schedule shall separately present those entities owned directly by the downstream holding company. The consolidating or combining balance sheet shall then be adjusted for GAAP to SAP differences of the insurance entities and paragraph 8.b.ii., and 8.b.iv. entities owned directly or indirectly by the downstream holding company. The adjusted amount would then be the reported value of the investment in the downstream holding company at the higher-level reporting entity; or

c. Individual audits of the downstream holding company and the downstream holding company’s investments in individual SCA entities.

48. This statement rejects ASU 2014-17, Business Combinations – Pushdown Accounting, a Consensus of the FASB Emerging Issues Task Force, ASU 2011-10, Derecognition of in Substance Real Estate, APB Opinion No. 18, The Equity Method of Accounting for Investments in Common Stock, AICPA Accounting Interpretations APB 18, The Equity Method of Accounting for Investments in Common Stock: Accounting Interpretations of APB Opinion No. 18, FASB Technical Bulletin No. 79-19, Investor’s Accounting for Unrealized Losses on Marketable Securities Owned by an Equity Method Investee, FASB Emerging Issues Task Force No. 87-21, Change of Accounting Basis in Master Limited Partnership Transactions, FASB Emerging Issues Task Force No. 96-16, Investor’s Accounting for an Investee When the Investor Has a Majority of the Voting Interest but the Minority Shareholder or Shareholders Have Certain Approval or Veto Rights, FASB Emerging Issues Task Force No. 98-2: Accounting by a Subsidiary or Joint Venture for an Investment in the stock of Its Parent Company or Joint Venture Partner and FASB Staff Position No. APB 18-1, Accounting by an Investor for Its Proportionate Share of Accumulated Other Comprehensive Income of an Investee Accounted for under the Equity Method in Accordance with APB Opinion No. 18 upon a Loss of Significant Influence.

Status:
On April 6, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No 68—Business Combinations and Goodwill and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities to reject ASU 2014-17, Business Combinations – Pushdown Accounting for statutory accounting as well as explicitly prohibit the use of pushdown accounting under statutory accounting, which includes all entities accounted for under SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies and SSAP No. 97.

On August 3, 2019, the Statutory Accounting Principles (E) Working Group exposed this agenda item with a request for comments on the three options listed below. Additionally, to ensure that goodwill resulting from an insurance reporting entity’s acquisition of an SCA when pushdown is applied is captured within the goodwill admittance
The options for Working Group consideration include:

1) **Complete rejection of pushdown accounting.** As pushdown is now an election for SEC / U.S. GAAP filers, reporting entities can avoid use of pushdown if prohibited for statutory accounting. (NAIC staff would propose a prospective effective date if electing this option to avoid restatement of those entities that have previously elected pushdown.)

2) **Permission to use pushdown for all non-insurance entities.** This option would increase optionality into the statutory financial statements. If permitted, this approach would result in different SCA values and goodwill calculations for those that follow the guidance in SSAP No. 68 and those that utilize pushdown. Under SSAP No. 68, acquired SCAs do not write-up their assets or liabilities to fair value and goodwill is calculated as the difference between purchase price and book value. Under U.S. GAAP pushdown, acquired SCAs write-up their assets and liabilities to fair value, and goodwill is calculated as the difference between the purchase price and the fair value of the acquired entity. With pushdown, the goodwill is reported at the SCA level. As such, goodwill will be an indefinite asset unless it is identified as impaired. (Under U.S. GAAP, private entities and not-for-profit entities can elect to amortize goodwill over a 10-year period, but this is not an election for public entities.) **If this option is supported, NAIC staff would recommend that the goodwill admittance limitation capture goodwill from an insurance entity’s acquisition of an SCA that is reported on the SCA financial statements.** (This option would not permit pushdown for insurance SCAs (8.b.i entities).

   (If this option is considered, NAIC staff would propose restrictions on the use of pushdown that differ from U.S. GAAP. For example, under U.S. GAAP, a reporting entity could subsequent elect pushdown accounting in any reporting period after original acquisition. If pushdown was permitted, NAIC staff would propose to require the election at original acquisition and not allow subsequent elections.)

3) **Permit pushdown if elected by SEC Registrants, excluding non-insurance entities.** Although this option would introduce different accounting by type of reporting entity, it is consistent with when pushdown would have been applied under prior statutory accounting guidance. (Under the old SEC provisions, pushdown was only permitted when meeting certain SEC requirements.) This would seemingly allow the companies that have historically utilized pushdown under the SEC rules to continue acquisitions under that prior approach. **If this option is supported, NAIC staff would recommend that the goodwill admittance limitation capture goodwill from the acquisition of an SCA that is reported on the SCA financial statements.** (Also, NAIC staff would propose restrictions to the provisions to ensure the election is made at the time of original acquisition.) (This option would not permit pushdown for insurance SCAs (8.b.i entities).

Exposed Edits to SSAP No. 68—Business Combinations and Goodwill:

8. For those acquired SCA entities accounted for in accordance with paragraph 8.b.i. of SSAP No. 97 under the statutory purchase method, the historical bases of the acquired entity shall continue to be used in preparing its statutory financial statements. Therefore, pushdown accounting is not permitted.

9. Positive goodwill recorded under the statutory purchase method of accounting shall be admitted subject to the following limitation: Positive goodwill from all sources, including life, accident and health, and deposit-type assumption reinsurance and goodwill resulting from the acquisition of an SCA by the insurance reporting entity that is reported on the SCA’s financial statements (resulting from the application of
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pushdown accounting), is limited in the aggregate to 10% of the acquiring\(^4\) entity’s capital and surplus as required to be shown on the statutory balance sheet of the reporting entity for its most recently filed statement with the domiciliary state commissioner adjusted to exclude any net positive goodwill, EDP equipment and operating system software, and net deferred tax assets. Additionally, all positive goodwill shall be nonadmitted when the underlying investment in the SCA or partnership, joint venture and limited liability company is nonadmitted\(^5\). When negative goodwill exists, it shall be recorded as a contra-asset. Positive or negative goodwill resulting from the purchase of an SCA, joint venture, partnership or limited liability company shall be amortized to unrealized capital gains and losses on investments over the period in which the acquiring entity benefits economically, not to exceed 10 years. Positive or negative goodwill resulting from life, accident and health, and deposit-type assumption reinsurance shall be amortized to operations as a component of general insurance expenses over the period in which the assuming entity benefits economically, not to exceed 10 years. Goodwill shall be evaluated separately for each transaction.\(^{1\text{INT 01-18}}\)

On December 7, 2019, the Statutory Accounting Principles (E) Working Group adopted, as final, a clarification edit to SSAP No. 68—Business Combinations and Goodwill to clarify that all goodwill from an insurance entity’s acquisition of SCAs, regardless of whether pushdown accounting is applied, is subject to the existing 10% admittance limitation. (With adoption of this edit, paragraph 9 was split into two separate paragraphs.) The remainder of this agenda item was re-exposed to allow additional time for specific examples of pushdown accounting to be provided by interested parties, as well as consider comments received on pushdown.

**Dec. 7 - Adopted SSAP No. 68 Revisions:**

9. Positive goodwill recorded under the statutory purchase method of accounting shall be admitted subject to the following limitation: Positive goodwill from all sources, including life, accident and health, and deposit-type assumption reinsurance and goodwill resulting from the acquisition of an SCA by the insurance reporting entity that is reported on the SCA’s financial statements (resulting from the application of pushdown accounting), is limited in the aggregate to 10% of the acquiring\(^6\) entity’s capital and surplus as required to be shown on the statutory balance sheet of the reporting entity for its most recently filed statement with the domiciliary state commissioner adjusted to exclude any net positive goodwill, EDP equipment and operating system software, and net deferred tax assets. Additionally, all positive goodwill shall be nonadmitted when the underlying investment in the SCA or partnership, joint venture and limited liability company is nonadmitted\(^7\). When negative goodwill exists, it shall be recorded as a contra-asset.

10. Positive or negative goodwill resulting from the purchase of an SCA, joint venture, partnership or limited liability company shall be amortized to unrealized capital gains and losses on investments over the period in which the acquiring entity benefits economically, not to exceed 10 years. Positive or negative goodwill resulting from life, accident and health, and deposit-type assumption reinsurance shall be amortized to operations as a component of general insurance expenses over the period in which the

\(^4\) The “acquiring” entity is intended to reflect the insurance reporting entity that reports the investment resulting in goodwill. The goodwill limitation test shall be completed at the individual reporting company level.

\(^5\) This includes, but is not limited to, situations in which the investment is nonadmitted as the audited financial statements for the SCA, joint venture, partnership or limited liability company includes substantial doubt on the entity’s ability to continue as a going concern, or on the basis/contents of the audit opinion pursuant to paragraph 20 of SSAP No. 97.

\(^6\) The “acquiring” entity is intended to reflect the insurance reporting entity that reports the investment resulting in goodwill. The goodwill limitation test shall be completed at the individual reporting company level.

\(^7\) This includes, but is not limited to, situations in which the investment is nonadmitted as the audited financial statements for the SCA, joint venture, partnership or limited liability company includes substantial doubt on the entity’s ability to continue as a going concern, or on the basis/contents of the audit opinion pursuant to paragraph 20 of SSAP No. 97.
assuming entity benefits economically, not to exceed 10 years. Goodwill shall be evaluated separately for each transaction.\((\text{INT \ 01-18})\)

(Remaining paragraphs will be renumbered accordingly.)

**Dec. 7 - Re-Exposure of the Agenda Item Requests Comments and Examples on the Following Options:**

1) **Complete rejection of pushdown accounting.** As pushdown is now an election for SEC / U.S. GAAP filers, reporting entities can avoid use of pushdown if prohibited for statutory accounting. (NAIC staff would propose a prospective effective date if electing this option to avoid restatement of those entities that have previously elected pushdown.)

2) **Permission to use pushdown for all non-insurance entities.** This option would increase optionality into the statutory financial statements. If permitted, this approach would result in different SCA values and goodwill calculations for those that follow the guidance in SSAP No. 68 and those that utilize pushdown. Under SSAP No. 68, acquired SCAs do not write-up their assets or liabilities to fair value and goodwill is calculated as the difference between purchase price and book value. Under U.S. GAAP pushdown, acquired SCAs write-up their assets and liabilities to fair value, and goodwill is calculated as the difference between the purchase price and the fair value of the acquired entity. With pushdown, the goodwill is reported at the SCA level. As such, goodwill will be an indefinite asset unless it is identified as impaired. (Under U.S. GAAP, private entities and not-for-profit entities can elect to amortize goodwill over a 10-year period, but this is not an election for public entities.) (This option would not permit pushdown for insurance SCAs (8.b.i entities).

   (If this option is considered, NAIC staff would propose restrictions on the use of pushdown that differ from U.S. GAAP. For example, under U.S. GAAP, a reporting entity could subsequent elect pushdown accounting in any reporting period after original acquisition. If pushdown was permitted, NAIC staff would propose to require the election at original acquisition and not allow subsequent elections.)

3) **Permit pushdown if elected by SEC Registrants, excluding non-insurance entities.** Although this option would introduce different accounting by type of reporting entity, it is consistent with when pushdown would have been applied under prior statutory accounting guidance. (Under the old SEC provisions, pushdown was only permitted when meeting certain SEC requirements.) This would seemingly allow the companies that have historically utilized pushdown under the SEC rules to continue acquisitions under that prior approach. (Also, NAIC staff would propose restrictions to the provisions to ensure the election is made at the time of original acquisition.) (This option would not permit pushdown for insurance SCAs (8.b.i entities).
The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force met via conference call Oct. 22, 2019. The following Working Group members participated: Jake Garn, Chair (UT); Kim Hudson, Vice Chair (CA); Michael Estabrook (CT); N. Kevin Brown (DC); Adrienne Lupo (DE); Carolyn Morgan, Jason Reynolds and Robert Ridenour (FL); Daniel Mathis (IA); Roy Eft (IN); Dan Schaefer (MI); Debbie Doggett (MO); Lindsay Crawford (NE); Patricia Gosselin (NH); Amal Mechaiel (NJ); Dale Bruggeman and Tracy Snow (OH); Joel Sander (OK); Greg Lathrop (OR); Joe DiMemmo (PA); Hui Wattanaskolpant (TN); Shawn Frederick (TX); Steve Drutz and Patrick McNaughton (WA); Randy Milquet (WI); and Justin Parr (WV).

1. **Adopted its Sept. 5 and Aug. 20 Minutes**

The Working Group conducted an e-vote that concluded Sept. 5 to expose proposal 2019-24BWG, which requests the addition of a life experience data conduct to the electronic Jurat page for life/fraternal company filers only with an effective date for first quarter 2020. During its Aug. 20 meeting, the Working Group took the following action: 1) adopted its July 2 and June 24 minutes; 2) adopted items previously exposed; 3) discussed its procedures; 4) exposed three new items for public comment; and 5) adopted the editorial listing.

Mr. Hudson made a motion, seconded by Mr. Drutz, to adopt the Working Group’s Sept. 5 (Attachment Two-A) and Aug. 20 (Attachment Two-B) minutes. The motion passed unanimously.

2. **Adopted Items Previously Exposed**

   a. **For Note 33, Modify the Illustrations to Disclosure Individually Separate Account with Guarantees Products and Separate Account Nonguaranteed Products (2019-21BWG) Effective 12/31/2020**

   Mr. Garn stated that this proposal breaks out the separate accounts disclosure and related illustration in Note 33 to show the Separate Account with Guarantees products and Separate Account Nonguaranteed products separately. He indicated that there were no interested party comments on this proposal.

   Ms. Crawford made a motion, seconded by Mr. Drutz, to adopt the proposal (Attachment Two-C). The motion passed unanimously.

   b. **Add a Question Regarding the Executive Summary of the PBR Actuarial Opinion to the Supplemental Exhibits and Schedules Interrogatories (2019-22BWG) Effective 12/31/2020**

   Jennifer Frasier (NAIC) stated that this proposal is sponsored by the Life Actuarial (A) Task Force, with an annual 2020 effective date. It adds a question to the Supplemental Exhibits and Schedules Interrogatories asking if the Executive Summary of the PBR Actuarial Report would be filed with the state of domicile by April 1.

   Mr. Hudson made a motion, seconded by Ms. Gosselin, to adopt the proposal (Attachment Two-D). The motion passed unanimously.

   c. **Modify the Instructions and Illustration for Note 8 – Derivatives for Disclosures Adopted by SSAP No. 108. Add Instructions and a Blanks Page for Schedule DB, Part E, to the Quarterly Statement (2019-23BWG) Effective 1/1/2020**

   Mr. Bruggeman stated that this proposal pertains to *Statement of Statutory Accounting Principles (SSAP) No. 108—Derivatives Hedging Variable Annuity Guarantees*. When the annual proposal was adopted in June with proposal 2019-14BWG, the quarterly disclosure was not included. At the Summer National Meeting, it was noted, and the interested parties agreed, that the intent of the Statutory Accounting Principles (E) Working Group change was to capture a quarterly disclosure as well. This agenda item, which was exposed in August, adds that quarterly 2020 disclosure. There was a minor column reference modification, which should be included as a friendly amendment.
Mr. Bruggeman made a motion, seconded by Ms. Gosselin, to adopt the proposal, including the column reference modification as a friendly amendment (Attachment Two-E). The motion passed unanimously.

d. Add a Life Experience Data Contact to the Electronic Jurat Page for Life/Fraternal Companies Only. Health, Property and Title are Included in the Proposal Due to the Jurat Instructions Being Uniform for all Statement Types (2019-24BWG) Effective 1/1/2020

Ms. Frasier stated that the purpose of this proposal is that under the Standard Valuation Law (#820) and supporting Valuation Manual included in each state’s laws, the NAIC serves as the data collection agent for various studies of data (e.g., mortality experience data). NAIC staff need a contact person from each legal entity life insurance company to facilitate communication regarding these data studies and submission of the data to the NAIC. This company contact should be filed in the electronic-only Jurat and will not be included on the hard copy/portable document format (PDF) Jurat. Interested parties had no comments other than the timing of the request.

Mr. Hudson made a motion, seconded by Mr. Milquet, to adopt the proposal (Attachment Two-F). The motion passed unanimously.

3. Exposed its Procedures

Mr. Garn stated the there are several pending issues with regards to the Blanks (E) Working Group procedures. He stated that there has been discussion with the software vendors regarding the changes within the Blanks (E) Working Group procedures document. He stated that during the discussions, for the most part, the vendor software representatives were in favor of the changes. John Bauer (Prudential Financial) stated that while interested parties are in favor of the need for the procedure changes, they would like additional time to review the time frames. He indicated that interested parties would prefer to hold one in-person meeting at one of the NAIC national meetings and to incorporate that language within the procedures document. Connie Woodroof (Sapiens) indicated that while she agrees with the proposed time frames, she wants to encourage state insurance regulators and interested parties to have proposals and comments in early. This way, the proposals should be able to be processed within the given time frames and not have so many last-minute issues. She encouraged everyone to follow related working group and task force projects to be informed of possible impacts to the blanks and instructions. These issues could then be discussed during a Blanks (E) Working Group meeting to get a head start on the issues where possible.

Ms. Caswell confirmed that approval had been obtained to allow the Blanks (E) Working Group time on the 2020 NAIC Spring National Meeting agenda. She also suggested a minor revision to the current edited version of the procedures. The “parent groups” should be defined to include groups above the Blanks (E) Working Group in the statutory hierarchy. This would include the Statutory Accounting Principles (E) Working Group. With the significant amount of changes from the previous exposure, Mr. Garn indicated that there should be another 30-day exposure period to receive comments.

Mr. Drutz made a motion, seconded by Mr. Lathrop, to expose the procedures for a public comment period ending Nov. 22. The motion passed unanimously.

4. Exposed New Items


Mr. Snow stated that this proposal modifies the instructions for column 10 in the Property Schedule F, Part 3, Ceded Reinsurance, and Schedule F Part 2 in the Life/Fraternal statement removing the “exclude” instructions for adjusting other reserves from that column. The proposal adds instructions to include the defense and cost containment reserves in column 10. It adds a new instruction for column 12 for each of those schedules for the “IBNR LAE Reserves” column to include defense and cost containment and adjusting and other expenses consistent with that reported in Schedule P, Part 1.

Mr. Hudson made a motion, seconded by Ms. Crawford, to expose the proposal for a public comment period ending Nov. 22. The motion passed unanimously.

Mr. Garn stated that this proposal adds instructions and crosschecks for line 34 on the Analysis of Operations by Lines of Business – Summary. It adds instructions for column 5, Indexed Life on the Analysis of Operations by Lines of Business for individual life. It adds clarifying instructions to the Analysis of Operations by Lines of Business for individual life and group life indicating that the reporting should be consistent with policy-type language in the contract and reporting of policies issued with secondary guarantees that have expired. He stated that this proposal is to be effective with the annual 2020 filing. There is a guidance document with this language being presented at this meeting, for posting to the NAIC web page to assist companies in reporting the annual 2019 filing.

Ms. Crawford made a motion, seconded by Ms. Gosselin, to expose the proposal for a public comment period ending Nov. 22. The motion passed unanimously.

c. **Remove the Alphabetic Index from Inclusion at the Back of the Annual Statement Blank, Instructions and Blanks (E) Working Group Web page (2019-27BWG)**

Mr. Hudson stated that this proposal requests the removal of the alphabetic index from inclusion at the back of the annual statement blank, instructions and the Blanks (E) Working Group web page. Most people now either use the bookmarks in the PDF, the search features in the PDFs, or the table of contents in the front of the blank. Therefore, the alphabetical index is no longer needed.

Mr. Hudson made a motion, seconded by Mr. Drutz, to expose the proposal for a public comment period ending Nov. 22. The motion passed unanimously.

5. **Adopted the Editorial Listing**

Mr. Hudson made a motion, seconded by Mr. Milquet, to adopt the editorial listing (Attachment Two-G). The motion passed unanimously.

6. **Reviewed the State Filing Checklists**

Mr. Garn asked the Working Group members and interested parties if there were any issues detected upon review of the State Filing Checklists. Receiving no comments, the members approved the checklists and directed NAIC staff to proceed with posting to the appropriate NAIC web page.

7. **Approved Guidance**

Mr. Garn asked the Working Group members and interested parties if there were any issues identified with the Analysis of Operations by Lines of Business 2019 instructional clarification guidance document. Receiving no comments, the members approved the guidance document for posting to the Blanks (E) Working Group web page.

8. **Discussed Life/Fraternal Blank Statement Cover**

Bill Tank (Tank Consulting) asked for clarification as to whether the brown cover would still be used for the fraternal companies filing on the life blank or if they would instead use the blue cover. Ms. Caswell indicated that if both colors cannot appear on the cover, the blue cover should be used by the licensed life filers, and the brown cover should still be used by the licensed fraternal filers that are using the life blank. The reason for retaining the color system is for situations where a state law or regulation might refer to a particular blank color in place of the statement title. The NAIC uses both colors on its blanks and instructions publications.
9. **Discussed Other Matters**

Mr. Garn asked the Working Group members and industry to be mindful of other groups’ work that might affect the annual or quarterly statement blank. As the members or interested parties become aware of potential impacts, those could be reviewed or discussed during future meetings. This could help members and industry prepare for expansive changes, participate in the process and allow more time for vetting of the issue.

Having no further business, the Blanks (E) Working Group adjourned.

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The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force concluded an e-vote on Sept. 5, 2019. The following Working Group members participated: Jake Garn, Chair (UT); Kim Hudson, Vice Chair (CA); Jeffery Bethel (AK); William Arfanis (CT); N. Kevin Brown (DC); Dave Lonchar (DE); Daniel Mathis (IA); Roy Eft (IN); Dan Schaefer (MI); Debbie Doggett (MO); Lindsay Crawford (NE); Steve Kerner (NJ); Tracy Snow (OH); Joel Sander (OK); Ryan Keeling, (OR); Joe DiMemmo (PA); Trey Hancock (TN); Shawn Frederick (TX); Steve Drutz (WA); Jamie Taylor (WV); and Randy Milquet (WI).

1. Exposed Proposal 2019-24BWG

The Working Group conducted an e-vote to consider exposure of proposal 2019-24BWG sponsored by Mike Boerner (TX) as Chair of the Life Actuarial (A) Task Force with an effective date of first quarter 2020. The proposal proposes the addition of a life experience data contact to the electronic Jurat page for life/fraternal company filers only. Health, Property and Title are included in the proposal due to the Jurat instructions being uniform for all statement types. Under the Standard Valuation Law (SVL) and supporting Valuation Manual (VM) included in each state’s laws, NAIC serves as the data collection agent for various studies of data (e.g., mortality experience data). The purpose of this proposal is to allow NAIC staff and regulators to more easily locate a contact person from each legal entity life insurance company to facilitate communication regarding these data studies and submission of the data to the NAIC.

Mr. DiMemmo made a motion, seconded by Mr. Eft, to expose proposal 2019-24BWG for a public comment period ending Oct. 8. The motion passed unanimously by two-thirds of the members present in accordance with the Working Group procedures.

Having no further business, the Blanks (E) Working Group adjourned.
The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force met via conference call Aug. 20, 2019. The following Working Group members participated: Jake Garn, Chair (UT); Kim Hudson, Vice Chair, and Susan Bernard (CA); William Arfanis and Wanchin Chou (CT); N. Kevin Brown (DC); Ryllyn Brown and Tom Hudson (DE); Virginia Christy and Carolyn Morgan (FL); Daniel Mathis (IA); Roy Eft (IN); Dan Schaefer (MI); Julie Lederer (MO); Lindsay Crawford and Justin Schrader (NE); Doug Bartlett and Patricia Gosselin (NH); John Sirovetz (NJ); Dale Bruggeman and Tracy Snow (OH); Joel Sander (OK); Greg Lathrop (OR); Joe DiMemmo (PA); Trey Hancock (TN); Mike Boerner and Shawn Frederick (TX); Steve Drutz (WA); Jerry DeArmond and Randy Milquet (WI); and Jamie Taylor (WV). Also participating were: Rich Piazza (LA); and Stacey Alden and Karen Ducharme (VT).

1. **Adopted its July 2 and June 24 Minutes**

The Working Group conducted an e-vote that concluded July 2 to expose proposal 2019-20BWG sponsored by the Executive (EX) Committee and Casualty Actuarial and Statistical (E) Task Force. The proposal requests changes to the Property and Casualty Actuarial Opinion that the Committee adopted on June 25. The Working Group also met June 24 to: 1) adopt 17 proposals exposed during the Spring National Meeting; expose two new proposals; and 3) adopt the editorial listing. The exposed proposals include requested disclosure changes or reporting clarifications sponsored by the Statutory Accounting Principles (E) Working Group; changes to the investment schedules reporting on behalf of the Valuation of Securities (E) Task Force; and reporting clarifications within the VM-20 Supplement and the life blank Analysis of Operations by Lines of Business.

Mr. Sirovetz made a motion, seconded by Ms. Gosselin, to adopt the Working Group’s July 2 and June 24 minutes (see NAIC Proceedings – Summer 2019, Accounting Practices and Procedures (E) Task Force, Attachment Two and Attachment Three). The motion passed unanimously.

2. **Adopted Items Previously Exposed**

   a. **Add an NAIC Designation Modifier to the NAIC Designation Column for Schedule D, DL and BA to Accommodate the NAIC Designation Category Granularity Framework Adopted by the Valuation of Securities (E) Task Force (2019-18BWG) Effective 12/31/2020**

Mr. Garn stated that this proposal is sponsored by the Valuations of Securities (E) Task Force. It adds an NAIC designation modifier to the NAIC Designation Column for Schedule D, Schedule DL, and Schedule BA to accommodate the NAIC designation category granularity framework. He stated that there have been several modifications to the proposal received during the comment period. One additional comment received was to change the effective date from first quarter 2020 to annual 2020. A contingency may be with regards to the elimination of the residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS) price points to allow the Structured Securities Group (SSG) to produce the designation.

John Bauer (Prudential Financial) stated that interested parties agree with the change to the effective date to annual 2020. He stated that there is a lot of work for vendors in setting up their systems for these new designation modifiers. He stated that there is ongoing work for annual 2019 related to specific designations including the “YE” and “IF” and the removal of the preferred stock prefixes, as well as removal of the market indicators. He stated that interested parties will need to work with the Securities Valuation Office (SVO) staff to be sure that the specifications for the RMBS and CMBS price points are completed by mid-year 2020.

Mr. Hudson made a motion, seconded by Mr. Sirovetz, to adopt the modifications to the proposal, including the effective date of annual 2020. The motion passed unanimously. Mr. Hudson made a motion, seconded by Mr. Arfanis to adopt the modified proposal (Attachment Two-B1). The motion passed unanimously.

   b. **Add a New Category Line for Unaffiliated Certificates of Deposit to Schedules D, DL and E. Add a Line to the Summary Investment Schedule for Unaffiliated Certificates of Deposit. Modify the List of Bonds for Lines 8 Through**
Mary Caswell (NAIC) stated that this proposed change requested by NAIC staff was intended to eliminate validation failures as it relates to unaffiliated certificates of deposit. The proposal adds a new line category for the unaffiliated certificates of deposit to the investment schedules, as well as to the Summary Investment Schedule. The proposal modifies the list of bonds for the respective lines of the Summary by Country to include unaffiliated certificates of deposit. She stated that this additional breakout would help state insurance regulators better identify the unaffiliated certificates of deposit. She stated that instructions would also need to be added to zero fill the Committee on Uniform Security Identification Procedures (CUSIP) and Identification Securities Identification Numbers (ISIN) columns for unaffiliated certificates of deposit.

Mr. Garn stated that based on comments received from interested parties, the Working Group may want to consider the withdrawal of this proposal and a resubmission of a more expansive proposal to include the bigger issue of line number changes. Mr. Bauer stated that this change would require extensive revisions to create the separate recording for unaffiliated certificates of deposit. He stated that interested parties are not sure that there are a lot of these holdings to justify the breakout. He suggested adding a new code to the code column to identify these investments. Mr. Garn stated that the expansion of the line numbering will need to be addressed in the future, similar to the changes for the Schedule DBs, to accommodate the growing number of securities.

Mr. Hudson stated that he is supportive of the withdrawal to give interested parties and NAIC staff additional time to address this issue as, well as the line numbering issue, and resubmit as a new proposal.

Mr. Hudson made a motion, seconded by Mr. Milquet to withdraw the proposal. The motion passed unanimously.

c. Add “Qualification Documentation” to Require the Appointed Actuary to Maintain Workpapers Explaining How the Actuary Meets the Definition of a “Qualified Actuary.” Add a New Objective Definition of “Qualified Actuary” and the Results of an Assessment of Actuarial Educational Syllabi in an “NAIC-Accepted Actuarial Designation” Section (2019-20BWG) Effective 12/31/2019

Mr. Piazza stated that he has served as chair of the Casualty Actuarial and Statistical (C) Task Force for the past seven years and as the vice chair for three years. The role of the appointed actuary is one of the most important roles actuaries serve, in the eyes of state insurance regulators. State insurance regulators review reserve accuracy and company solvency to protect the interest of their states’ consumers and rely heavily on the information contained in the Actuarial Opinion. He stated that this proposal is intended to change the Property and Casualty Actuarial Opinion instructions specifically in the qualification area to include the Society of Actuaries (SOA) general insurance track, as well as the Casualty Actuarial Society (CAS) designations as being qualified for the role of appointed actuary.

Mr. Piazza stated that this proposal has a long history, starting more than seven years ago with the Casualty Actuarial and Statistical (C) Task Force. The Task Force has worked non-stop on the underlying project to include the SOA designation, as well as CAS, since 2012/2013. In the last two years, the Executive (EX) Committee has taken a role in reviewing this proposal. The Task Force was asked to evaluate the SOA educational track to determine if it is acceptable by state insurance regulators for the appointed actuaries, just like the American Academy of Actuaries (Academy) membership is acceptable. Both organizations (SOA and CAS) have been educating, testing and credentialing actuaries for decades, if not a century each. Mr. Piazza stated that both are good at what they do for the education of the actuary profession. When the Task Force was asked if the SOA met the minimum requirements, there was some reluctance from the actuarial organizations to take a direct role in this project. The Academy was asked and refused to take on this project. It did say it would cooperate in changing its qualification requirements to comply with any revised instructions inserted into the NAIC Property and Casualty Actuarial Opinion instructions. The Executive (EX) Committee asked the Task Force to look at this issue and decide whether the SOA should be included in the acceptable designation.

Mr. Piazza stated that the Casualty Actuarial and Statistical (C) Task Force was divided in how to approach this charge. There were at least three different options: 1) do nothing; 2) reevaluate the situation in five or more years; and 3) accept the SOA general insurance definition. He stated that the Task Force sought help to review this and approached the Property and Casualty Insurance (C) Committee, which agreed with getting an independent company to help pursue this review in an independent, unbiased manner. The Executive (EX) Committee funded a project to obtain an independent consultant to create an objective way to evaluate the new actuarial tract—the SOA education track. This was intended to be used by state insurance regulators
Mr. Piazza stated that there were more than 30 subject matter experts (SMEs) involved in the project, nominated by the three major actuarial organizations, to provide information to the consultants and work with them throughout the entire process. The consultant group conducted a job analysis and performed analysis of the examination syllabi of the actual organization. It did a comparison of the knowledge and educational materials for the actuary to see if it was in the syllabi of the other actuarial originsations. This proposal defines the qualified actuary for both the SOA and the CAS and establishes basic educational requirements for the appointed actuary to be qualified per the instructions. The instructions have been vetted many times since the start of this project, and in the last 18 months, there were four separate exposures and one hearing on this issue. The proposal was discussed by the state insurance department commissioners at various levels in the last 18 months. Mr. Piazza stated that this was a large, multi-faceted and open effort to get to this proposal. This proposal follows the charge given to the Casualty Actuarial and Statistical (C) Task Force to define the qualified actuary objectively and to include the SOA if he or she met basic education expectations of the NAIC.

Mr. Garn stated that based on the passed precedents of the Blanks (E) Working Group, it does not appear as though this is the appropriate level to decide policy issues. When the Working Group has received proposals from the Statutory Accounting Principles (E) Working Group, the Valuation of Securities (E) Task Force, the Capital Adequacy (E) Task Force or similar groups, the Working Group will defer on the policy matter that has already been vetted to the groups presenting the proposal. He stated that he would be uncomfortable making any substantive changes to the language in the proposal. He recommended that for those who feel there is still some needed policy language change, that should be taken up with the policy-making group as a new requirement. He stated that any outstanding policy issue could also be taken up by the Accounting Practices and Procedures (E) Task Force or the Financial Condition (E) Committee as the proposal moves through the process.

Ralph Blanchard (Travelers) stated that the Casualty Actuarial and Statistical (C) Task Force was in agreement that the “exception” language within the instructions should revert back to the old language where the exception was available to a member of the Academy only, rather than to any person submitting a request to the Academy. Mr. Blanchard stated that he is a dues-paying member of the Academy and has seen court cases in the past where people sue the Academy. In these cases, frequently one of the actual protections for the professional organizations is whether the person suing is a member of the organization or not. By being a voluntary member of that organization, the member will have to agree to some of the criteria and rules of that organization. As it is currently stated, the actuary could apply through the Academy as a non-member, in which case, if the Academy refuses to hear or evaluate him or her, the Academy could be sued for anti-trust. If the actuary is a member, the Academy would have that protection. He stated that it does not make sense to remove the Academy membership in the wording.

Craig Hanna (Academy) stated that the Academy would not consider any application from a non-member. He stated that reverting the language back to what Mr. Blanchard suggested would be appropriate. Mr. Chou stated that since 2012, the Blanks (E) Working Group has been trying to merge the SOA and CAS, which has caused a lot of the dispute even up to 2019. One of the issues is the Academy membership and how that is treated in the life and health blanks.

Connie Woodroof (Sapiens) stated that there is an electronic data capture element to be added within this proposal that has an effective date of annual 2019, and vendor testing begins in September.

Mr. Garn stated that the Blanks (E) Working Group is not the appropriate entity to make policy decision changes. Mr. Chou stated that he would recommend the motion be withdrawn until there is further discussion. Mr. Frederick seconded the motion. Kay Noonan (NAIC) questioned whether a motion to withdraw would substitute for the original motion. The motion to adopt was considered first to account for any opposition to warrant consideration of a withdrawal motion. Ms. Noonan stated that the Academy membership issue does not affect the overall proposal. She suggested considering the proposal for adoption to include the SOA and taking the Academy membership issue back up with the Casualty Actuarial and Statistical (C) Task Force as a separate issue.

Mr. Piazza stated that the Casualty Actuarial and Statistical (C) Task Force reviews the instructions every year for any needed changes. He stated that the Task Force can review and amend Academy membership issues in the future if so desired. He stated that the framework being discussed with this proposal to add the SOA is recognized as being qualified, well done and objective principles-based and should be adopted as written. Mr. Garn stated that a “no” vote on the primary motion would effectively be a vote to withdraw. Therefore, he called for a vote on the primary motion.
Ann Weber (SOA) stated that there has been a lot of work performed by the 30 volunteers, the Casualty Actuarial and Statistical (C) Task Force, the state insurance department commissioner oversee group, the Executive (EX) Committee, and the Property and Casualty Insurance (C) Committee. She stated that this has been a long and arduous process. There is a subjective, analytical process to review the knowledge basis and educational programs of the CAS and SOA, which has been approved by the Executive (EX) Committee.

Mr. Hudson made a motion, seconded by Mr. Sander, to adopt the proposal (see NAIC Proceedings – Fall 2019, Accounting Practices and Procedures (E) Task Force, Attachment Three-A). The motion passed by roll call vote, with Connecticut, Missouri, Nebraska and Texas dissenting and Ohio abstaining.

3. Discussed the Blanks (E) Working Group Procedures

Mr. Garn stated that there are several pending issues with regards to the Blanks (E) Working Group procedures. He suggested that this issue be deferred to create additional time to address those issues and then discuss the changes during the next Working Group conference call.

Mr. Hudson made a motion, seconded by Mr. Drutz, to defer discussion on the procedures. The motion passed unanimously.

4. Exposed New Items for Public Comment

a. For Note 33, Modify the Illustration to Disclosure Individually Separate Account with Guarantees Products and Separate Account Nonguaranteed Products (2019-21BWG)

Mr. Schrader stated that this proposal is a data-capture item for Note 33 to modify the illustration to disclosure individually the Separate Account with Guarantees products and Separate Account Nonguaranteed products.

Mr. Hudson made a motion, seconded by Mr. Sirovetz, to expose the proposal for a 45-day public comment period ending Oct. 8. The motion passed unanimously.

b. Add a Question Regarding the Executive Summary of the PBR Actuarial Opinion to the Supplemental Exhibits and Schedules Interrogatories (2019-22BWG)

Jennifer Frasier (NAIC) stated that this is a proposal sponsored by the Life Actuarial (A) Task Force to add a question regarding the Executive Summary of the PBR Actuarial Opinion to the Supplemental Exhibits and Schedules Interrogatories.

Mr. Arfanis made a motion, seconded by Mr. Eft, to expose the proposal for a 45-day public comment period ending Oct. 8. The motion passed unanimously.

c. Modify the Instructions and Illustration for Note 8 – Derivatives for Disclosures Adopted by SSAP No. 108. Add Instruction and Blank Page for Schedule DB, Part E, to the Quarterly Statement (2019-23BWG)

Mr. Bruggeman stated that this proposal pertains to Statement of Statutory Accounting Principles (SSAP) No. 108—Derivative Hedging Variable Annuity Guarantees. He stated that when the annual proposal was adopted in June with proposal 2019-14BWG, the quarterly disclosure was not included. He stated that interested parties agreed that the intent of the Statutory Accounting Principles (E) Working Group change was to capture a quarterly disclosure as well. This agenda item adds that quarterly 2020 disclosure.

Mr. Bruggeman made a motion, seconded by Ms. Gosselin, to expose the proposal for a 45-day public comment period ending Oct. 8. The motion passed unanimously.

5. Adopted the Editorial Listing

Mr. Hudson made a motion, seconded by Mr. Sirovetz, to adopt the editorial listing (Attachment Two-B2). The motion passed unanimously.

Having no further business, the Blanks (E) Working Group adjourned.
## NAIC BLANKS (E) WORKING GROUP

### Blanks Agenda Item Submission Form

| DATE: | 05/20/2019 |
| CONTACT PERSON: | Charles Therriault |
| TELEPHONE: | 212 386-1920 |
| EMAIL ADDRESS: | CTheriault@naic.org |
| ON BEHALF OF: | Kevin Fry, Chair, VOS Task Force |
| NAME: | Kevin Fry |
| TITLE: | Chair, VOS Task Force |
| AFFILIATION: | |
| ADDRESS: | |

### FOR NAIC USE ONLY

| Agenda Item # | 2019-18BWG MOD |
| Year | 2020 |
| Changes to Existing Reporting | [ X ] |
| New Reporting Requirement | [ ] |

### REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

| No Impact | [ X ] |
| Modifies Required Disclosure | [ ] |

### DISPOSITION

| Rejected For Public Comment | [ ] |
| Referred To Another NAIC Group | [ ] |
| Received For Public Comment | [ ] |
| Adopted | Date 08/20/2019 |
| Rejected | Date |
| Deferred | Date |
| Other (Specify) | |

### BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ X ] QUARTERLY STATEMENT
- [ X ] LIFE, ACCIDENT & HEALTH/Fraternal
- [ X ] PROPERTY/CASUALTY
- [ X ] HEALTH
- [ X ] SEPARATE ACCOUNTS
- [ X ] PROTECTED CELL
- [ X ] HEALTH (LIFE SUPPLEMENT)
- [ ] Instructions
- [ X ] Blank
- [ ] Crosschecks

Anticipated Effective Date: 1st Quarter Annual 2020

### IDENTIFICATION OF ITEM(S) TO CHANGE

See next page for details of changes.

### REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

See next page for details of changes.

### NAIC STAFF COMMENTS

Comment on Effective Reporting Date: ________________________________

Other Comments:

This proposal assumes the adoption of 2019-03BWG adding NAIC Designation Column to Schedule D, Part 2, Section 2. It does not assume adoption of 2019-04BWG as a result some of the language for Schedule BA will need to be adjusted to reflect those changes if adopted.

** This section must be completed on all forms. Revised 7/18/2018
REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The Valuation of Securities (E) Task Force (“VOS TF”) adopted on June 11, 2018 a more granular NAIC Designation Category framework. The new NAIC Designation Category applies wherever an NAIC Designation is reported and produced by the SVO, independently or based on CRP credit ratings for filing exempt and PL securities as well as those assigned to RMBS and CMBS based on financial modelling by the SSG. Upon the determination of an NAIC Designation, the SVO or SSG will produce NAIC Designation Categories which are a subset of each NAIC Designation.

NAIC Designation Category means and refers to 20 more granular delineations of credit risk in the NAIC 1 through NAIC 6 credit risk scale used by the VOS/TF to relate credit risk in insurer owned securities. This granular level of credit risk can be used by the NAIC Capital Adequacy (E) Task Force to assign granular risk-based capital factors when they are adopted. In the meantime, this additional level of credit risk provides NAIC members additional insight into the risk of insurer investments. Each delineation of credit risk is represented by a letter, an NAIC Designation Modifier, which modifies the NAIC Designation grade to indicate a more granular measure of credit risk within the NAIC Designation grade. The more granular delineations of credit risk are called an NAIC Designation Category, a combination of the NAIC Designation and NAIC Designation Modifier, and are distributed as follows: 7 for the NAIC 1 Designation grade indicated by the letters A through G; 3 delineations each for each of the NAIC Designation grades NAIC 2, NAIC 3, NAIC 4 and NAIC 5 indicated by the letters A, B and C and 1 delineation for NAIC Designation grade NAIC 6 with no NAIC Designation Modifier. All NAIC Designation Modifiers roll up into the respective NAIC Designation grade as they are a subset of them.

IDENTIFICATION OF ITEM(S) TO CHANGE

2020 Quarterly Statement:

Instructions:

Schedule D, Part 3  
Add reference to NAIC Designation Modifier in Description of Column 10  
Add instruction for NAIC Designation Modifier for the column  
Add clarification indicating that the column will be three sub-columns in data table  
Provide list of valid NAIC Designation and NAIC Designation Modifier Combinations.

Schedule D, Part 4  
Add reference to NAIC Designation Modifier in Description of Column 22  
Add instruction for NAIC Designation Modifier for the column  
Add clarification indicating that the column will be three sub-columns in data table  
Provide list of valid NAIC Designation and NAIC Designation Modifier Combinations.

Schedule DL, Part 1  
Add reference to NAIC Designation Modifier in Description of Column 4  
Add reference as to where to find instructions for determining NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol for Schedule DA, Part 1 and Schedule E, Part 2 investments  
Add clarification column will be three sub-columns in data table

Schedule DL, Part 2  
Add reference to NAIC Designation Modifier in Description of Column 4  
Add reference as to where to find instructions for determining NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol for Schedule DA, Part 1 and Schedule E, Part 2 investments  
Add clarification indicating that the column will be three sub-columns in data table
| Schedule BA, Part 2 | Add reference to NAIC Designation Modifier in Description of Column 6  
|                     | Add instruction for NAIC Designation Modifier for the column  
|                     | Add clarification indicating that the column will be three sub-columns in data table  
|                     | Provide list of valid NAIC Designation and NAIC Designation Modifier Combinations.  

**Blank:**

| Schedule D, Part 3 | Add reference to NAIC Designation Modifier in Description of Column 10  
| Schedule D, Part 4 | Add reference to NAIC Designation Modifier in Description of Column 22  
| Schedule DL, Part 1 | Add reference to NAIC Designation Modifier in Description of Column 4  
| Schedule DL, Part 2 | Add reference to NAIC Designation Modifier in Description of Column 4  
| Schedule BA, Part 2 | Add reference to NAIC Designation Modifier in Description of Column 6  

**2020 Annual Statement:**

**Instructions:**

| Schedule D, Part 1 | Add reference to NAIC Designation Modifier in Description of Column 6  
| Add instruction for NAIC Designation Modifier for the column  
| Add clarification indicating that the column will be three sub-columns in data table  
| Provide list of valid NAIC Designation and NAIC Designation Modifier Combinations.  
| Add instruction for the NAIC Designation Category footnote.  

| Schedule D, Part 2, Section 1 | Add reference to NAIC Designation Modifier in Description of Column 20  
| Add instruction for NAIC Designation Modifier for the column  
| Add clarification indicating that the column will be three sub-columns in data table  
| Provide list of valid NAIC Designation and NAIC Designation Modifier Combinations.  
| Add instruction for the NAIC Designation Category footnote.  

| Schedule D, Part 2, Section 2 | Add reference to NAIC Designation Modifier in Description of Column 18  
| Add instruction for NAIC Designation Modifier for the column  
| Add clarification indicating that the column will be three sub-columns in data table  
| Provide list of valid NAIC Designation and NAIC Designation Modifier Combinations.  
| Add instruction for the NAIC Designation Category footnote.  

| Schedule DL, Part 1 | Add reference to NAIC Designation Modifier in Description of Column 4  
| Add reference as to where to find instructions for determining NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol for Schedule DA, Part 1 and Schedule E, Part 2 investments  
| Add clarification indicating that the column will be three sub-columns in data table  

Schedule DL, Part 2  Add reference to NAIC Designation Modifier in Description of Column 4
Add reference as to where to find instructions for determining NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol for Schedule DA, Part 1 and Schedule E, Part 2 investments
Add clarification indicating that the column will be three sub-columns in data table

Schedule E, Part 2  Add electronic only Column 11 for Designation Category
Add instruction for NAIC Designation Equivalent for the column
Add instruction for NAIC Designation Modifier Equivalent for the column
Add clarification indicating that the column will be two sub-columns in data table
Provide list of valid NAIC Designation Equivalent and NAIC Designation Modifier Equivalent Combinations.
Add instruction for the NAIC Designation Category footnote.

Schedule DA, Part 1  Add electronic only Column 22 for Designation Category
Add instruction for NAIC Designation Equivalent for the column
Add instruction for NAIC Designation Modifier Equivalent for the column
Add clarification indicating that the column will be two sub-columns in data table
Provide list of valid NAIC Designation Equivalent and NAIC Designation Modifier Equivalent Combinations.
Add instruction for the NAIC Designation Category footnote.

Schedule BA, Part 2  Add reference to NAIC Designation Modifier in Description of Column 7
Add instruction for NAIC Designation Modifier for the column
Add clarification indicating that the column will be three sub-columns in data table
Provide list of valid NAIC Designation and NAIC Designation Modifier Combinations.
Add instruction for the NAIC Designation Category footnote.

Blank:

Schedule D, Part 1  Add reference to NAIC Designation Modifier in Description of Column 6
Add footnote to capture subtotal of B/ACV by NAIC Designation Category

Schedule D, Part 2, Section 1  Add reference to NAIC Designation Modifier in Description of Column 20
Add footnote to capture subtotal of B/ACV by NAIC Designation Category

Schedule D, Part 2, Section 2  Add reference to NAIC Designation Modifier in Description of Column 18
Add footnote to capture subtotal of B/ACV by NAIC Designation Category

Schedule DL, Part 1  Add reference to NAIC Designation Modifier in Description of Column 4
Add footnote to capture subtotal of B/ACV by NAIC Designation Category
<table>
<thead>
<tr>
<th>Schedule</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>DL, Part 2</td>
<td>Add reference to NAIC Designation Modifier in Description of Column 4</td>
</tr>
<tr>
<td>BA, Part 2</td>
<td>Add reference to NAIC Designation Modifier in Description of Column 7</td>
</tr>
<tr>
<td></td>
<td>Add footnote to capture subtotal of B/ACV by NAIC Designation Category</td>
</tr>
<tr>
<td>DA, Part 1</td>
<td>Add footnote to capture subtotal of B/ACV by NAIC Designation Category</td>
</tr>
<tr>
<td>E, Part 2</td>
<td>Add footnote to capture subtotal of B/ACV by NAIC Designation Category</td>
</tr>
</tbody>
</table>
QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE D – PART 3

LONG-TERM BONDS AND STOCKS ACQUIRED DURING THE CURRENT QUARTER

Detail Eliminated to Conserve Space

Column 10 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

Provide the appropriate combination of NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol (see below) at the end of the quarter for each security shown. The list of valid SVO Administrative Symbols is shown below.

The listing of valid NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol combinations can be found on the NAIC’s website for the Securities Valuation Office (www.naic.org/svo.htm).

For Bond Mutual Funds – as Identified by the SVO, enter 1.

Exchange Traded Funds – as Identified by the SVO should be reported as perpetual securities.

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed schedule but will be three sub-columns in the data table.

- NAIC Designation Column 10A
- NAIC Designation Modifier Column 10B
- SVO Administrative Symbol Column 10C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

NAIC Designation Modifier:

The NAIC Designation Modifier should only be used for securities reported on the lines below if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), otherwise, the field should be left blank.

- Bonds Lines 0199999 through 658299999
- Preferred Stocks Line 8499999 and 8599999
- Common Stocks Line 9499999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments using reporting an NAIC Designation 6, therefore, and the NAIC Designation Modifier field should be left blank.

Refer to the P&P Manual for the application of these modifiers.
**SVO Administrative Symbol:**

**Long Term Bond:**

Following are valid SVO Administrative Symbols for bonds. Refer to the P&P Manual for the application of these symbols.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Additional or other non-payment risk</td>
</tr>
<tr>
<td>FE</td>
<td>Filing Exempt</td>
</tr>
<tr>
<td>FM</td>
<td>Financially Modeled RMBS/CMBS subject to SSAP 43R</td>
</tr>
<tr>
<td>AM</td>
<td>Analytically Modeled subject to SSAP 43R</td>
</tr>
<tr>
<td>YE</td>
<td>Year-end carry over</td>
</tr>
<tr>
<td>IF</td>
<td>Initial filing</td>
</tr>
<tr>
<td>PL</td>
<td>Private Letter Rating</td>
</tr>
<tr>
<td>PLGI</td>
<td>Private Letter Rating – General Interrogatory</td>
</tr>
<tr>
<td>Z</td>
<td>Insurer self-designated</td>
</tr>
<tr>
<td>GI</td>
<td>General Interrogatory</td>
</tr>
<tr>
<td>F</td>
<td>Sub-paragraph D Company – insurer self-designated</td>
</tr>
<tr>
<td>*</td>
<td>Limited to NAIC Designations 6</td>
</tr>
</tbody>
</table>

**Preferred Stock:**

Following are valid SVO Administrative Symbols for preferred stock. Refer to the P&P Manual of the NAIC Investment Analysis Office for the application of these symbols.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Additional or other non-payment risk</td>
</tr>
<tr>
<td>FE</td>
<td>Filing Exempt</td>
</tr>
<tr>
<td>YE</td>
<td>Year-end carry over</td>
</tr>
<tr>
<td>IF</td>
<td>Initial filing</td>
</tr>
<tr>
<td>PL</td>
<td>Private Letter Rating</td>
</tr>
<tr>
<td>PLGI</td>
<td>Private Letter Rating – General Interrogatory</td>
</tr>
<tr>
<td>Z</td>
<td>Insurer self-designated</td>
</tr>
<tr>
<td>GI</td>
<td>General Interrogatory</td>
</tr>
<tr>
<td>F</td>
<td>Sub-paragraph D Company – insurer self-designated</td>
</tr>
<tr>
<td>*</td>
<td>Limited to NAIC Designations 6</td>
</tr>
</tbody>
</table>

**Common Stock:**

For securities reported on Line 9499999 (Mutual Funds) provide the appropriate NAIC Designation (1 through 6) and NAIC Modifier as assigned by the Securities Valuation Office. For all other common stock the NAIC designation, NAIC Modifier and SVO Administrative Symbol field should be left blank.

Following are valid SVO Administrative Symbols for common stock. Refer to the P&P Manual for the application of these symbols.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>YE</td>
<td>Year-end carry over</td>
</tr>
</tbody>
</table>

For common stock the NAIC Designation and Administrative symbol field should be zero-filled.
The NAIC Designation Category is the combination of NAIC Designation and NAIC Designation Modifier. Valid combinations of NAIC Designation and NAIC Designation Modifier for NAIC Designation Category are shown below:

<table>
<thead>
<tr>
<th>NAIC Designation</th>
<th>NAIC Designation Modifier</th>
<th>NAIC Designation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
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<td>6</td>
</tr>
</tbody>
</table>

Detail Eliminated to Conserve Space
SCHEDULE D – PART 4

LONG-TERM BONDS AND STOCKS SOLD, REDEEMED OR OTHERWISE DISPOSED OF DURING THE CURRENT QUARTER

Detail Eliminated to Conserve Space

Column 22 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

Provide the appropriate combination of the NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol (see below) at date of disposal for each security shown. The list of valid SVO Administrative Symbols is shown below.

Where multiple disposal transactions occurred for the same CUSIP, and those transactions are summarized on one line, enter the appropriate combination of NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol for the last disposal using the last available designation.

The listing of valid NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol combinations can be found on the NAIC’s website for the Securities Valuation Office (www.naic.org/svo.htm).

For Bond Mutual Funds—as Identified by the SVO, enter 1.

Exchange Traded Funds—as Identified by the SVO should be reported as perpetual securities.

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed but will be three sub-columns in the data table:

- NAIC Designation Column 22A
- NAIC Designation Modifier Column 22B
- SVO Administrative Symbol Column 22C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

NAIC Designation Modifier:

The NAIC Designation Modifier should only be used for securities reported on the lines below if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), otherwise, the field should be left blank.

- Bonds Lines 0199999 through 658299999
- Preferred Stocks Line 8499999 and 8599999
- Common Stocks Line 9499999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments using reporting an NAIC Designation 6, therefore, and the NAIC Designation Modifier field should be left blank.

Refer to the P&P Manual for the application of these modifiers.
SVO Administrative Symbol:

Long Term Bond:

Following are valid SVO Administrative Symbols for bonds. Refer to the P&P Manual Purposes and Procedures Manual of the NAIC Investment Analysis Office for the application of these symbols.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Additional or other non-payment risk</td>
</tr>
<tr>
<td>FE</td>
<td>Filing Exempt</td>
</tr>
<tr>
<td>FM</td>
<td>Financially Modeled RMBS/CMBS subject to SSAP 43R</td>
</tr>
<tr>
<td>AM</td>
<td>Analytically Modeled subject to SSAP 43R</td>
</tr>
<tr>
<td>YE</td>
<td>Year-end carry over</td>
</tr>
<tr>
<td>IF</td>
<td>Initial filing</td>
</tr>
<tr>
<td>PL</td>
<td>Private Letter Rating</td>
</tr>
<tr>
<td>PLGI</td>
<td>Private Letter Rating – General Interrogatory</td>
</tr>
<tr>
<td>Z</td>
<td>Insurer self-designated</td>
</tr>
<tr>
<td>GI</td>
<td>General Interrogatory</td>
</tr>
<tr>
<td>F</td>
<td>Sub-paragraph D Company – insurer self-designated</td>
</tr>
<tr>
<td>*</td>
<td>Limited to NAIC Designations 6</td>
</tr>
</tbody>
</table>

Preferred Stock:

Following are valid SVO Administrative Symbols for preferred stock. Refer to the P&P Manual for the application of these symbols.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Additional or other non-payment risk</td>
</tr>
<tr>
<td>FE</td>
<td>Filing Exempt</td>
</tr>
<tr>
<td>YE</td>
<td>Year-end carry over</td>
</tr>
<tr>
<td>IF</td>
<td>Initial filing</td>
</tr>
<tr>
<td>PL</td>
<td>Private Letter Rating</td>
</tr>
<tr>
<td>PLGI</td>
<td>Private Letter Rating – General Interrogatory</td>
</tr>
<tr>
<td>Z</td>
<td>Insurer self-designated</td>
</tr>
<tr>
<td>GI</td>
<td>General Interrogatory</td>
</tr>
<tr>
<td>F</td>
<td>Sub-paragraph D Company – insurer self-designated</td>
</tr>
<tr>
<td>*</td>
<td>Limited to NAIC Designations 6</td>
</tr>
</tbody>
</table>

Common Stock:

For securities reported on Line 9499999 (Mutual Funds) provide the appropriate NAIC Designation (1 through 6) and NAIC Modifier as assigned by the Securities Valuation Office. For all other common stock the NAIC designation, NAIC Modifier and SVO Administrative Symbol field should be left blank.

Following are valid SVO Administrative Symbols for common stock. Refer to the P&P Manual for the application of these symbols.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>YE</td>
<td>Year-end carry over</td>
</tr>
</tbody>
</table>

For common stock the NAIC Designation and Administrative symbol field should be zero-filled.
The NAIC Designation Category is the combination of NAIC Designation and NAIC Designation Modifier. Valid combinations of NAIC Designation and NAIC Designation Modifier for NAIC Designation Category are shown below:

<table>
<thead>
<tr>
<th>NAIC Designation</th>
<th>NAIC Designation Modifier</th>
<th>NAIC Designation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
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<tr>
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<td>B</td>
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<td>6</td>
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</tr>
</tbody>
</table>

Detail Eliminated to Conserve Space
### SCHEDULE DL – PART 1

**SEcurities lending collateral assets**

Reinvested Collateral Assets Owned Current Statement Date

(Securities lending collateral assets reported in aggregate on Line 10 of the asset page and not included on Schedules A, B, BA, D, DB and E.)

---

#### Detail Eliminated to Conserve Space

<table>
<thead>
<tr>
<th>Column 4</th>
<th>NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol reported for this column should be determined in a manner consistent with the instructions of other schedules for the lines shown below:</td>
</tr>
<tr>
<td></td>
<td>Lines 0199999 through 7099999 .................................................................. Schedule D, Part 1, Column 6</td>
</tr>
<tr>
<td></td>
<td>Lines 7199999 through 7399999 .................................................................. Schedule D, Part 2, Section 1, Column 20</td>
</tr>
<tr>
<td></td>
<td>Lines 7499999 through 7999999 .................................................................. Schedule D, Part 2, Section 2, Column 17</td>
</tr>
<tr>
<td></td>
<td>Line 8899999 .......................................................................................... Schedule BA, Part 1, Column 7</td>
</tr>
<tr>
<td></td>
<td>Line 8999999 .......................................................................................... Schedule DA, Part 1, Column 22</td>
</tr>
<tr>
<td></td>
<td>Line 90999999 ......................................................................................... Schedule E, Part 2, Column 11</td>
</tr>
<tr>
<td></td>
<td>For Lines 8699999, 8799999, 8999999, 9099999, 9199999 and 9299999, the column should be left blank.</td>
</tr>
<tr>
<td></td>
<td>The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed schedule but will be three sub-columns in the data table.</td>
</tr>
<tr>
<td></td>
<td>• NAIC Designation ........................................................................ Column 4A</td>
</tr>
<tr>
<td></td>
<td>• NAIC Designation Modifier ......................................................... Column 4B</td>
</tr>
<tr>
<td></td>
<td>• SVO Administrative Symbol ......................................................... Column 4C</td>
</tr>
<tr>
<td></td>
<td>On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).</td>
</tr>
</tbody>
</table>

---

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SCHEDULE DL – PART 2

SECURITIES LENDING COLLATERAL ASSETS
Reinvested Collateral Assets Owned Current Statement Date
(Securities lending collateral assets included on Schedules A, B, BA, D, DB and E
and not reported in aggregate on Line 10 of the asset page.)

Detail Eliminated to Conserve Space

Column 4 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol reported for this column should be same for the security as reported in other schedules for the lines shown below:

Lines 0199999 through 7099999 .................. Schedule D, Part 1, Column 6
Lines 7199999 through 7399999 .................. Schedule D, Part 2, Section 1, Column 20
Lines 7499999 through 7999999 .................. Schedule D, Part 2, Section 2, Column 17
Line 8899999 ................................................ Schedule BA, Part 1, Column 7
Line 8899999 ................................................ Schedule BA, Part 1, Column 7
Line 8999999 ................................................ Schedule DA, Part 1, Column 22
Line 909199999 ............................................ Schedule E, Part 2, Column 11

For Lines 8699999, 8799999, 8999999, 9099999, 9199999 and 9299999, the column should be left blank.

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed schedule but will be three sub-columns in the data table.

- NAIC Designation Column 4A
- NAIC Designation Modifier Column 4B
- Administrative Symbol Column 4C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).
Column 6 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

This column must be completed for those investments included on Lines 0799999 and 1599999.

For Schedule BA investments with the underlying characteristics of a bond or a preferred stock instrument, insert the appropriate combination of the NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol. The list of valid SVO Administrative Symbols is shown below.

The listing of valid NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol combinations can be found on the NAIC’s website for the Securities Valuation Office (www.naic.org/svo.htm).

The NAIC Designation, NAIC Designation Modifier and Administrative Symbol will be shown as one column on the printed schedule but will be three sub-columns in the data table:

- NAIC Designation Column 6A
- NAIC Designation Modifier Column 6B
- SVO Administrative Symbol Column 6C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

**NAIC Designation Modifier:**

The NAIC Designation Modifier should only be used for securities reported on the lines below if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), otherwise, the field should be left blank.

- Underlying Characteristics of Bonds Lines 0799999 through 0899999
- Underlying Characteristics of Preferred Stocks Line 1399999 through 1499999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, and the NAIC Designation Modifier field should be left blank.

Refer to the P&P Manual for the application of these modifiers.
SVO Administrative Symbol:

Following are valid SVO Administrative Symbols for bonds and preferred stock. Refer to the P&P Manual – Purposes and Procedures Manual of the NAIC Investment Analysis Office for the application of these symbols.

- S: Additional or other non-payment risk
- YE: Year-end carry over
- FE: Filing Exempt
- F: Sub-paragraph D Company – insurer self-designated

The NAIC designation NAIC Designation Modifier and SVO Administrative Symbol field should be left blank for those Schedule BA investments which have not been assigned an NAIC designation by the Securities Valuation Office (SVO) pursuant to the policies in the Purposes and Procedures Manual of the NAIC Investment Analysis Office.

The NAIC Designation Category is the combination of NAIC Designation and NAIC Designation Modifier. Valid combinations of NAIC Designation and NAIC Designation Modifier for NAIC Designation Category are shown below:

<table>
<thead>
<tr>
<th>NAIC Designation</th>
<th>NAIC Designation Modifier</th>
<th>NAIC Designation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
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<td>C</td>
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<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Detail Eliminated to Conserve Space
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE D – PART 1

LONG-TERM BONDS OWNED DECEMBER 31 OF CURRENT YEAR

Detail Eliminated to Conserve Space

Column 6 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

Provide the appropriate NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol combination for each security. The list of valid SVO Administrative Symbols is shown below.

The listing of valid NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol combinations can be found on the NAIC’s website for the Securities Valuation Office (www.naic.org/svo.htm).

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed schedule but will be three sub-columns in the data table.

- NAIC Designation Column 6A
- NAIC Designation Modifier Column 6B
- SVO Administrative Symbol Column 6C

For Bond Mutual Funds – as Identified by the SVO, enter 1.

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

NAIC Designation Modifier:

The NAIC Designation Modifier should only be used for bonds eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), otherwise, the field should be left blank.

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments using reporting an NAIC Designation 6, therefore, and the NAIC Designation Modifier field should be left blank.

Refer to the P&P Manual for the application of these modifiers.
SVO Administrative Symbol:

Following are valid SVO Administrative Symbols for bonds. Refer to the Purposes and Procedures Manual of the NAIC Investment Analysis Office for the application of these symbols.

- S Additional or other non-payment risk
- FE Filing Exempt
- FM Financially Modeled RMBS/CMBS subject to SSAP 43R
- AM Analytically Modeled subject to SSAP 43R
- YE Year-end carry over
- IF Initial filing
- PL Private Letter Rating
- PLGI Private Letter Rating – reported on General Interrogatory
- Z Insurer self-designated
- GI General Interrogatory
- F Sub-paragraph D Company – insurer self-designated
- * Limited to NAIC Designations 6

The NAIC Designation Category is the combination of NAIC Designation and NAIC Designation Modifier. Valid combinations of NAIC Designation and NAIC Designation Modifier for NAIC Designation Category are shown below:

<table>
<thead>
<tr>
<th>NAIC Designation</th>
<th>NAIC Designation Modifier</th>
<th>NAIC Designation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>1A</td>
</tr>
<tr>
<td></td>
<td>B</td>
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</tr>
<tr>
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<td>C</td>
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<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NAIC Designation Category Footnote:

Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount reported in Column 11.

The sum of the amounts reported for each NAIC Designation Category in the footnote should equal Line 8399999.
Column 20  –  NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

Provide the appropriate combination of NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol for each security. The list of valid Administrative Symbols is shown below.

The listing of valid NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol combinations can be found on the NAIC’s website for the Securities Valuation Office (www.naic.org/svo.htm).

Exchange Traded Funds should be reported as perpetual securities.

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed schedule but will be three sub-columns in the data table.

- NAIC Designation Column 20A
- NAIC Designation Modifier Column 20B
- SVO Administrative Symbol Column 20C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

Designation Modifier:

The NAIC Designation Modifier should only be used for securities reported on lines below if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), otherwise, the field should be left blank.

- Industrial and Miscellaneous (Unaffiliated) Perpetual Preferred  Line 8499999
- Industrial and Miscellaneous (Unaffiliated) Redeemable Preferred  Line 8599999

The NAIC Designation Modifier should be left blank for securities reported on lines below.

- Parent, Subsidiaries and Affiliates  Line 8699999
- Parent, Subsidiaries and Affiliates  Line 8799999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments using reporting an NAIC Designation 6, therefore, and the NAIC Designation Modifier field should be left blank.

Refer to the P&P Manual for the application of these modifiers.
SVO Administrative Symbol:

Following are valid SVO Administrative Symbols for preferred stock. Refer to the P&P Manual Purposes and Procedures Manual of the NAIC Investment Analysis Office for the application of these symbols.

- S Additional or other non-payment risk assigned by the SVO or SSG
- FE Filing Exempt assigned by the SVO
- YE Year-end carry over assigned by the SVO
- IF Initial filing - insurer reported designation with Admin Symbol assigned by the SVO
- PL Private Letter Rating assigned by the SVO
- PLGI Private Letter Rating – insurer assigned and reported on General Interrogatory
- Z Insurer assigned and reported subject to limitation
- GI Insurer assigned and reported on General Interrogatory
- F Sub-paragraph D Company – insurer self-designated
* Limited to NAIC Designations 6 – insurer assigned

The NAIC Designation Category is the combination of NAIC Designation and NAIC Designation Modifier. Valid combinations of NAIC Designation and NAIC Designation Modifier for NAIC Designation Category are shown below:

<table>
<thead>
<tr>
<th>NAIC Designation</th>
<th>NAIC Designation Modifier</th>
<th>NAIC Designation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>1A</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>1B</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>1C</td>
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<tr>
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<td>D</td>
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<tr>
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<td>E</td>
<td>1E</td>
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<td>2</td>
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<td>B</td>
<td>2B</td>
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<td>C</td>
<td>2C</td>
</tr>
<tr>
<td>3</td>
<td>A</td>
<td>3A</td>
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<tr>
<td></td>
<td>B</td>
<td>3B</td>
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<td>C</td>
<td>3C</td>
</tr>
<tr>
<td>4</td>
<td>A</td>
<td>4A</td>
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<tr>
<td></td>
<td>B</td>
<td>4B</td>
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<td>C</td>
<td>4C</td>
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<tr>
<td>5</td>
<td>A</td>
<td>5A</td>
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<td>B</td>
<td>5B</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>5C</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Detail Eliminated to Conserve Space

NAIC Designation Category Footnote:

Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount reported in Column 8.

The sum of the amounts reported for each NAIC Designation Category in the footnote should equal the sum of Lines 8499999 and 8599999.
SCHEDULE D – PART 2 – SECTION 2

COMMON STOCKS OWNED DECEMBER 31 OF CURRENT YEAR

Detail Eliminated to Conserve Space

Column 18 – NAIC Designation, and NAIC Designation Modifier and SVO Administrative Symbol

For securities reported on Line 9499999 (Mutual Funds) provide the appropriate NAIC Designation (1 through 6), and NAIC Designation Modifier (A through G) and SVO Administrative Symbol combination as assigned by the Securities Valuation Office. For all other common stock the NAIC Designation and NAIC Designation Modifier administrative symbol field should be left blank.

The listing of valid NAIC Designations, NAIC Designation Modifier and SVO Administrative Symbol combinations can be found on the NAIC’s website for the Securities Valuation Office (www.naic.org/svo.htm).

The NAIC Designation and Designation Modifier will be shown as one column on the printed schedule but will be two sub-columns in the data table.

- NAIC Designation Column 18A
- NAIC Designation Modifier Column 18B
- SVO Administrative Symbol Column 18C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

NAIC Designation Modifier:

The NAIC Designation Modifier should only be used for securities reported on Line 9499999 (Mutual Funds) if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), otherwise, the field should be left blank.

The Designation Modifier should be left blank for securities reported on lines below.

- Industrial and Miscellaneous (Unaffiliated) Publicly Traded Line 9099999
- Industrial and Miscellaneous (Unaffiliated) Other Line 9199999
- Parent, Subsidiaries and Affiliates Publicly Traded Line 9299999
- Parent, Subsidiaries and Affiliates Other Line 9399999
- Unit Investment Trusts Line 9599999
- Closed-End Funds Line 9699999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments using reporting an NAIC Designation 6, therefore, the NAIC Designation Modifier field should be left blank.

Refer to the P&P Manual for the application of these modifiers.
SVO Administrative Symbol:

Following are valid SVO Administrative Symbols for common stock. Refer to the P&P Manual for the application of these symbols.

YE Year-end carry over

The NAIC Designation Category is the combination of NAIC Designation and NAIC Designation Modifier. Valid combinations of NAIC Designation and NAIC Designation Modifier for NAIC Designation Category are shown below:

<table>
<thead>
<tr>
<th>NAIC Designation</th>
<th>NAIC Designation Modifier</th>
<th>NAIC Designation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>1A</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>1B</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>1C</td>
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<td>D</td>
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<td>E</td>
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<td>F</td>
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<td>3</td>
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<td>B</td>
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<td>C</td>
<td>3C</td>
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<tr>
<td>4</td>
<td>A</td>
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<td>B</td>
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<td>C</td>
<td>4C</td>
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<tr>
<td>5</td>
<td>A</td>
<td>5A</td>
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<tr>
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<td>B</td>
<td>5B</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>5C</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Detail Eliminated to Conserve Space

NAIC Designation Category Footnote:

Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount reported in Column 6.

The sum of the amounts reported for each NAIC Designation Category in the footnote should equal Line 9499999.
SCHEDULE DL – PART 1

SECURITIES LENDING COLLATERAL ASSETS
Reinvested Collateral Assets Owned December 31 Current Year
(Securities lending collateral assets reported in aggregate on Line 10 of the asset page
and not included on Schedules A, B, BA, D, DB and E.)

Detail Eliminated to Conserve Space

Column 4 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol reported for
this column should be determined in a manner consistent with the instructions of other schedules for
the lines shown below:

- Lines 0199999 through 7099999 ................................ Schedule D, Part 1, Column 6
- Lines 7199999 through 7399999 ......................... Schedule D, Part 2, Section 1, Column 20
- Lines 7499999 through 7999999 ......................... Schedule D, Part 2, Section 2, Column 17
- Line 8899999 ............................................. Schedule BA, Part 1, Column 7
- Line 8999999 ............................................. Schedule DA, Part 1, Column 22
- Line 8999999 ............................................. Schedule E, Part 1, Column 11

For Lines 8699999, 8799999, 8899999, 8999999, 9099999, 9199999, 9299999, the column should be left
blank.

The NAIC Designation, Designation Modifier and SVO Administrative Symbol will be shown as one
column on the printed but will be three sub-columns in the data table.

- NAIC Designation Column 4A
- NAIC Designation Modifier Column 4B
- SVO Administrative Symbol Column 4C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation
and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the
SVO Administrative Symbol (e.g., “1.A YE”).

Detail Eliminated to Conserve Space

NAIC Designation Category Footnote:

Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount
reported in Column 6.
SCHEDULE DL – PART 2

SECURITIES LENDING COLLATERAL ASSETS
Reinvested Collateral Assets Owned December 31 Current Year
(Securities lending collateral assets included on Schedules A, B, BA, D, DB and E and not reported in aggregate on Line 10 of the asset page.)

<table>
<thead>
<tr>
<th>Column 4</th>
<th>NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol</th>
</tr>
</thead>
<tbody>
<tr>
<td>The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol reported for this column should be same for the security as reported in other schedules for the lines shown below:</td>
<td></td>
</tr>
<tr>
<td>Lines 0199999 through 7099999 ................................ Schedule D, Part 1, Column 6</td>
<td></td>
</tr>
<tr>
<td>Lines 7199999 through 7399999 ................................ Schedule D, Part 2, Section 1, Column 20</td>
<td></td>
</tr>
<tr>
<td>Lines 7499999 through 7999999 ................................ Schedule D, Part 2, Section 2, Column 17</td>
<td></td>
</tr>
<tr>
<td>Line 8899999 ................................................ Schedule BA, Part 1, Column 7</td>
<td></td>
</tr>
<tr>
<td>Line 8999999 ................................................ Schedule DA, Part 1, Column 22</td>
<td></td>
</tr>
<tr>
<td>Line 9099999 ................................................ Schedule E, Part 2, Column 11</td>
<td></td>
</tr>
</tbody>
</table>

For Lines 8699999, 8799999, 8999999, 9099999, 9199999 and 9299999, the column should be left blank.

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed but will be three sub-columns in the data table.

- **NAIC Designation** Column 4A
- **NAIC Designation Modifier** Column 4B
- **SVO Administrative Symbol** Column 4C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).
** SCHEDULE E – PART 2 – CASH EQUIVALENTS **

** Detail Eliminated to Conserve Space **

** Columns 10 and 11 will be electronic only. **

<table>
<thead>
<tr>
<th>Column 10</th>
<th>Legal Entity Identifier (LEI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provide the 20-character Legal Entity Identifier (LEI) for any issuer as assigned by a designated Local Operating Unit. If no LEI number has been assigned, leave blank.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 11</th>
<th>NAIC Designation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provide the appropriate combination of NAIC Designation Equivalent (1 through 6) and NAIC Designation Modifier Equivalent (A through G) (see table below) for each security shown.</td>
</tr>
</tbody>
</table>

** Exchange Traded Funds – as Identified by the SVO should be reported as perpetual securities. **

The NAIC Designation Category will be two sub-columns in the data table:

- **NAIC Designation Equivalent** Column 11A
- **NAIC Designation Modifier Equivalent** Column 11B

** NAIC Designation Equivalent:**

For the NAIC Designation Equivalent, use the NAIC Designation that would have been used for the investment had it been reported on Schedule D, Part 1 if available. If no NAIC Designation is available, the reporting entity should use a Designation Equivalent most closely resembles their credit risk the investment.

** NAIC Designation Modifier Equivalent:**

Bonds (Lines 0199999 through 6599999)

Use the NAIC Designation Modifier that would have been used for the investment had it been reported on Schedule D, Part 1 if available.

If no NAIC Designation Modifier is available, the reporting entity should use a Designation Modifier Equivalent most closely resembles their credit risk the investment.

The NAIC Designation Modifier Equivalent should be left blank for the following lines:

- **Sweep Accounts** Line 8499999
- **Exempt Money Market Mutual Funds – as Identified by the SVO** Line 8599999
- **All Other Money Market Mutual Funds** Line 8699999
- **Other Cash Equivalents** Line 8799999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments using reporting an NAIC Designation 6, therefore, and the NAIC Designation Modifier field should be left blank.
Refer to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for the application of these codes.

The NAIC Designation Category Equivalent is the combination of NAIC Designation Equivalent and NAIC Designation Modifier Equivalent. Valid combinations of NAIC Designation Equivalent and NAIC Designation Modifier Equivalent for NAIC Designation Category Equivalent are shown below:

<table>
<thead>
<tr>
<th>NAIC Designation Equivalent</th>
<th>NAIC Designation Modifier Equivalent</th>
<th>NAIC Designation Category Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>1A</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>1B</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>1C</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>1D</td>
</tr>
<tr>
<td></td>
<td>E</td>
<td>1E</td>
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<tr>
<td>4</td>
<td>A</td>
<td>4A</td>
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<tr>
<td></td>
<td>B</td>
<td>4B</td>
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<td></td>
<td>C</td>
<td>4C</td>
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<td>5</td>
<td>A</td>
<td>5A</td>
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<td>B</td>
<td>5B</td>
</tr>
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<td>C</td>
<td>5C</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

**DRAFTING NOTE:** Electronic columns used for data table:

<table>
<thead>
<tr>
<th>11 NAIC Designation Category Equivalent</th>
<th>11A</th>
<th>11B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td></td>
</tr>
</tbody>
</table>

**NAIC Designation Category Equivalent Footnote:**

Provide the total book/adjusted carrying value amount by NAIC Designation Category Equivalent that represents the amount reported in Column 7.

The sum of the amounts reported for each NAIC Designation Category Equivalent in the footnote should equal Line 8399999.
** SCHEDULE DA – PART 1
SHORT-TERM INVESTMENTS OWNED DECEMBER 31 OF CURRENT YEAR

** Columns 21 and 22 will be electronic only. **

<table>
<thead>
<tr>
<th>Column 21</th>
<th>Legal Entity Identifier (LEI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide the 20-character Legal Entity Identifier (LEI) for any issuer as assigned by a designated Local Operating Unit. If no LEI number has been assigned, leave blank.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 22</th>
<th>NAIC Designation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide the appropriate combination of NAIC Designation Equivalent (1 through 6) and NAIC Designation Modifier Equivalent (A through G) (see table below) for each security shown.</td>
<td></td>
</tr>
<tr>
<td>Exchange Traded Funds – as Identified by the SVO should be reported as perpetual securities.</td>
<td></td>
</tr>
<tr>
<td>The NAIC Designation Category will be two sub-columns in the data table.</td>
<td></td>
</tr>
<tr>
<td>- NAIC Designation Equivalent Column 22A</td>
<td></td>
</tr>
<tr>
<td>- NAIC Designation Modifier Equivalent Column 22B</td>
<td></td>
</tr>
<tr>
<td>On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier (e.g., “1.A”).</td>
<td></td>
</tr>
</tbody>
</table>

** NAIC Designation Equivalent:**

For the NAIC Designation Equivalent, use the NAIC designation that would have been used for the investment had it been reported on Schedule D, Part 1 if available. If no NAIC Designation is available, the reporting entity should use a NAIC Designation Equivalent most closely resembles their credit risk the investment.

** NAIC Designation Modifier Equivalent:**

Bonds (Lines 0199999 through 6599999)

Use the NAIC Designation Modifier that would have been used for the investment had it been reported on Schedule D, Part 1 if available.

If no NAIC Designation Modifier is available, the reporting entity should use a NAIC Designation Modifier Equivalent most closely resembles their credit risk the investment.

The NAIC Designation Modifier Equivalent should be left blank for the following lines:

- Parent, Subsidiaries and Affiliates – Mortgage Loans Line 8499999
- Parent, Subsidiaries and Affiliates – Other Short-Term Invested Assets Line 8599999
- Mortgage Loans Line 8799999
Other Short-Term Invested Assets

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments using an NAIC Designation 6, therefore, and the NAIC Designation Modifier field should be left blank.

Refer to the Purposes and Procedures Manual of the NAIC Investment Analysis Office for the application of these codes.

The NAIC Designation Category Equivalent is the combination of NAIC Designation Equivalent and NAIC Designation Modifier Equivalent. Valid combinations of NAIC Designation Equivalent and NAIC Designation Modifier Equivalent for NAIC Designation Category Equivalent are shown below:

<table>
<thead>
<tr>
<th>NAIC Designation Equivalent</th>
<th>NAIC Designation Modifier Equivalent</th>
<th>NAIC Designation Category Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>1B</td>
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</table>

DRAFTING NOTE: Electronic columns used for data table:

<table>
<thead>
<tr>
<th>22A</th>
<th>22B</th>
<th>22C</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>2</td>
<td>B</td>
<td></td>
</tr>
</tbody>
</table>

NAIC Designation Category Equivalent Footnote:

Provide the total book/adjusted carrying value amount by NAIC Designation Category Equivalent that represents the amount reported in Column 7.

The sum of the amounts reported for each NAIC Designation Category Equivalent in the footnote should equal Line 8399999.
SCHEDULE BA – PART 1

OTHER LONG-TERM INVESTED ASSETS OWNED DECEMBER 31 OF CURRENT YEAR

Column 7 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

This column must be completed for those investments included on Lines 0799999 and 1599999.

For Schedule BA investments with the underlying characteristics of a bond or a preferred stock instrument, insert the appropriate combination of the NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol. The List of valid SVO Administrative Symbols is shown below.

The listing of valid NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol combinations can be found on the NAIC’s website for the Securities Valuation Office (www.naic.org/svo.htm).

The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol will be shown as one column on the printed schedule but will be three sub-columns in the data table.

- NAIC Designation Column 7A
- NAIC Designation Modifier Column 7B
- SVO Administrative Symbol Column 7C

On the printed page the sub-columns should be displayed with a “.” between the NAIC Designation and the NAIC Designation Modifier with a space between the NAIC Designation Modifier and the SVO Administrative Symbol (e.g., “1.A YE”).

NAIC Designation Modifier:

The NAIC Designation Modifier should only be used for securities reported on the lines below if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), otherwise, the field should be left blank.

- Underlying Characteristics of Bonds Lines 0799999 through 0899999
- Underlying Characteristics of Preferred Stocks Line 1399999 through 1499999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, and the NAIC Designation Modifier field should be left blank.

Refer to the P&P Manual for the application of these modifiers.

SVO Administrative Symbol:

Following are valid SVO Administrative Symbols for bonds and preferred stock. Refer to the P&P Manual – Purposes and Procedures Manual of the NAIC Investment Analysis Office for the application of these symbols.

S Additional or other non-payment risk
YE Year-end carry over
FE Filing Exempt
F Sub-paragraph D Company – insurer self-designated
The NAIC designation NAIC Designation Modifier and SVO Administrative Symbol field should be left blank for those Schedule BA investments which have not been assigned an NAIC designation by the Securities Valuation Office (SVO) pursuant to the policies in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*.

The NAIC Designation Category is the combination of NAIC Designation and NAIC Designation Modifier. Valid combinations of NAIC Designation and NAIC Designation Modifier for NAIC Designation Category are shown below:

<table>
<thead>
<tr>
<th>NAIC Designation</th>
<th>NAIC Designation Modifier</th>
<th>NAIC Designation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>1A</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>1B</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>1C</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>1D</td>
</tr>
<tr>
<td></td>
<td>E</td>
<td>1E</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>1F</td>
</tr>
<tr>
<td></td>
<td>G</td>
<td>1G</td>
</tr>
<tr>
<td>2</td>
<td>A</td>
<td>2A</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>2B</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>2C</td>
</tr>
<tr>
<td>3</td>
<td>A</td>
<td>3A</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>3B</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>3C</td>
</tr>
<tr>
<td>4</td>
<td>A</td>
<td>4A</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>4B</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>4C</td>
</tr>
<tr>
<td>5</td>
<td>A</td>
<td>5A</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>5B</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>5C</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

*Detail Eliminated to Conserve Space*

**Column 26 – Maturity Date**

Use only for securities included in the following subtotal lines.

Fixed or Variable Interest Rate Investments that have the Underlying Characteristics of:

Mortgage Loans

- Unaffiliated............................................................................................................. 0999999
- Affiliated.............................................................................................................. 1099999

State the date the mortgage loan matures.

**NAIC Designation Category Footnote:**

Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount in reported in Column 12.

The sum of the amounts reported for each NAIC Designation Category in the footnote should equal the sum of Lines 0799999, 0899999, 1399999 and 1499999.
QUARTERLY STATEMENT BLANK – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE D – PART 3
Show All Long-Term Bonds and Stock Acquired During the Current Quarter

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>CUSIP Identification</td>
<td>Description</td>
<td>Foreign</td>
<td>Date Acquired</td>
<td>Name of Vendor</td>
<td>Number of Shares of Stock</td>
<td>Actual Cost</td>
<td>Par Value</td>
<td>Paid for Accrued Interest and Dividends</td>
<td>NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol (a)</td>
</tr>
<tr>
<td>---------------------</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

Detail Eliminated to Conserve Space

Columns used for data table:

<table>
<thead>
<tr>
<th>10</th>
</tr>
</thead>
</table>
| NAIC Designation,
NAIC Designation Modifier and SVO Administrative Symbol |
| 10A | 10B | 10C |

DRAFTING NOTE: The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol Column will appear as one column on the PDF and printed page but will be three sub-columns (10A, 10B and 10C) in the data table.
**SCHEDULE D – PART 4**
Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

![Table](image)

Columns used for data table:

<table>
<thead>
<tr>
<th>NAIC Designation</th>
<th>NAIC Designation Modifier and SVO Administrative Symbol</th>
</tr>
</thead>
<tbody>
<tr>
<td>22A</td>
<td>A FE</td>
</tr>
<tr>
<td>22B</td>
<td>B PLGI</td>
</tr>
</tbody>
</table>

**DRAFTING NOTE:** The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol Column will appear as one column on the PDF and printed page but will be three sub-columns (22A, 22B and 22C) in the data table.
### SCHEDULE DL – PART 1

**SEcurities Lending Collateral Assets**
Reinvested Collateral Assets Owned Current Statement Date
(Securities lending collateral assets reported in aggregate on Line 10 of the Assets page and not included on Schedules A, B, BA, D DB and E)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>CUSIP Identification</td>
<td>Description</td>
<td>Code</td>
<td>NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol</td>
<td>Fair Value</td>
<td>Book/Adjusted Carrying Value</td>
<td>Maturity Dates</td>
</tr>
</tbody>
</table>

**Detail Eliminated to Conserve Space**

Columns used for data table:

<table>
<thead>
<tr>
<th>4</th>
<th>NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4A</td>
</tr>
<tr>
<td>1</td>
<td>A</td>
</tr>
<tr>
<td>2</td>
<td>B</td>
</tr>
</tbody>
</table>

**DRAFTING NOTE:** The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol Column will appear as one column on the PDF and printed page but will be three sub-columns (4A, 4B and 4C) in the data table.
**SCHEDULE DL – PART 2
SECURITIES LENDING COLLATERAL ASSETS**

Reinvested Collateral Assets Owned Current Statement Date
(Securities lending collateral assets included on Schedules A, B, BA, D, DB and E and not reported in aggregate on Line 10 of the Assets page)

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CUSIP Identification</td>
<td>2</td>
<td>Description</td>
<td>3</td>
<td>NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
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</tr>
</tbody>
</table>

**Detail Eliminated to Conserve Space**

Columns used for data table:

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<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4A</td>
<td>4B</td>
<td>4C</td>
</tr>
<tr>
<td>1</td>
<td>A</td>
<td>FE</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>PLGI</td>
<td></td>
</tr>
</tbody>
</table>

**DRAFTING NOTE:** The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol Column will appear as one column on the PDF and printed page but will be three sub-columns (4A, 4B and 4C) in the data table.
**SCHEDULE BA – PART 2**

Showing Other Long-Term Invested Assets ACQUIRED AND ADDITIONS MADE During the Current Quarter

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>CUSIP Identification</td>
<td>Name or Description</td>
<td>Location City</td>
<td>Location State</td>
<td>NAIC Designation</td>
<td>NAIC Designation Modifier and SVO Administrative Symbol</td>
<td>Date Originally Acquired</td>
<td>Type and Strategy</td>
<td>Actual Cost at Time of Acquisition</td>
<td>Additional Investment Made After Acquisition</td>
<td>Amount Of Encumbrances</td>
<td>Commitment for Additional Investment</td>
<td>Percentage of Ownership</td>
</tr>
</tbody>
</table>

**Detail Eliminated to Conserve Space**

Columns used for data table:

<table>
<thead>
<tr>
<th>6</th>
<th>6A</th>
<th>6B</th>
<th>6C</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAIC Designation</td>
<td>Modifier and Symbol</td>
<td>NAIC Designation Modifier and Symbol</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>A</td>
<td>FE</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>PLGI</td>
<td></td>
</tr>
</tbody>
</table>

**DRAFTING NOTE:** The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol Column will appear as one column on the PDF and printed page but will be three sub-columns (6A, 6B and 6C) in the data table.
### Account 20: Administrative Symbol, NAC Designation, NAIC Designation, and SVO Designation

<table>
<thead>
<tr>
<th>Symbol</th>
<th>20A</th>
<th>20B</th>
<th>20C</th>
<th>20D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>FE</td>
<td>FGD</td>
</tr>
</tbody>
</table>

The NAIC Designation, NAC Designation Modifier, and SVO Administrative Symbol Column will appear as one column on the PDF and printed page, but will be three sub-columns (20A, 20B, and 20C) in the data table.

### Columns used for data table:

- Account Number
- Description
- Current Year
- Prior Year
- Per Share Value
- Per Share Change
- Per Share Value %
- Per Share Change %
- Net Change
- Net Change %
- Date Listed

### Drafting Note:

- The NAIC Designation, NAC Designation Modifier, and SVO Administrative Symbol Column will appear as one column on the PDF and printed page, but will be three sub-columns (20A, 20B, and 20C) in the data table.
# SCHEDULE D – PART 2 – SECTION 2

Showing all COMMON STOCKS Owned December 31 of Current Year

<p>| | | | | | | | | | | | | |</p>
<table>
<thead>
<tr>
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</tr>
</tbody>
</table>

| CUSIP | Description | Code | Number of Shares | Book/Adjusted Carrying Value | Fair Value | Fair Value | Cost | Actual Cost | Declared Int | Declared Dividend | Amount Received During Year | Unrealized Valuation Increase/Decrease | Net Realized Gain/(Loss) | Unrealized Valuation Increment Before Temporary Imbalance Recognized | Total Foreign Exchange Change in B/A/C Value | Total Foreign Exchange Change in B/A/C Source | Date Acquired | Date Modified |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**Columns used for data table:**

- **18 NAIC Designation**
- **and NAIC Designation Modifier and SVO Administrative Symbol**
  - 18A
  - 18B
  - 18C
  - 1
  - A
  - FE
  - 2
  - B
  - PLGI

**DRAFTING NOTE:** The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol Column will appear as one column on the PDF and printed page but will be three sub-columns (18A, 18B and 18C) in the data table.
## SCHEDULE DL – PART I

**SECURITIES LENDING COLLATERAL ASSETS**

Reinvested Collateral Assets Owned December 31 Current Year

(Securities lending collateral assets reported in aggregate on Line 10 of the Assets page and not included on Schedules A, B, BA, D DB and E)

<table>
<thead>
<tr>
<th>CUSIP Identification</th>
<th>Description</th>
<th>Code</th>
<th>NAIC Designation</th>
<th>NAIC Designation Modifiers and SVO Administrative Symbol</th>
<th>Fair Value</th>
<th>Book/Adjusted Carrying Value</th>
<th>Maturity Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Detail Eliminated to Conserve Space**

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
</tr>
</tbody>
</table>

### General Intergroup:

1. Total activity for the year  Fair Value  $ ____________  Book/Adjusted Carrying Value  $ ____________
2. Average balance for the year  Fair Value  $ ____________  Book/Adjusted Carrying Value  $ ____________
3. Book/Adjusted Carrying Value included in this schedule by NAIC Designation Category:

<table>
<thead>
<tr>
<th>1A</th>
<th>1B</th>
<th>1C</th>
<th>1D</th>
<th>1EE</th>
<th>1F</th>
<th>1G</th>
<th>2A</th>
<th>2B</th>
<th>2C</th>
<th>2D</th>
<th>2EE</th>
<th>2F</th>
<th>2G</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Columns used for data table:

<table>
<thead>
<tr>
<th>4</th>
<th>NAIC Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NAIC Designation Modifiers and SVO Administrative Symbol</td>
</tr>
<tr>
<td>4A</td>
<td>4B</td>
</tr>
<tr>
<td>1</td>
<td>A</td>
</tr>
<tr>
<td>2</td>
<td>B</td>
</tr>
</tbody>
</table>

**DRAFTING NOTE:** The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol Column will appear as one column on the PDF and printed page but will be three sub-columns (4A, 4B and 4C) in the data table.
**SCHEDULE DL – PART 2**

**SECURITIES LENDING COLLATERAL ASSETS**

Reinvested Collateral Assets Owned December 31 Current Year

(Securities lending collateral assets included on Schedules A, B, BA, D, DB and E and not reported in aggregate on Line 10 of the Assets page and not reported in aggregate on Line 10 of the Assets page)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>CUSIP Identification</td>
<td>Description</td>
<td>NAIC/Designation Code</td>
<td>NAIC/Designation Modifier and SVO Administrative Symbol</td>
<td>Fair Value</td>
<td>Book/Adjusted Carrying Value</td>
<td>Maturity Dates</td>
</tr>
<tr>
<td>XXXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

**General Interrogatories**

1. Total activity for the year
2. Average balance for the year

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair Value</td>
<td>Fair Value</td>
<td></td>
</tr>
</tbody>
</table>

**Columns used for data table:**

<table>
<thead>
<tr>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAIC Designation</td>
</tr>
<tr>
<td>NAIC Designation Modifier and SVO Administrative Symbol</td>
</tr>
<tr>
<td>4A</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>
| 2 | B | PLG |}

**DRAFTING NOTE:** The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol Column will appear as one column on the PDF and printed page but will be three sub-columns (4A, 4B and 4C) in the data table.
# SCHEDULE BA – PART 1

Showing Other Long-Term Invested Assets OWNED December 31 of Current Year

<table>
<thead>
<tr>
<th>CUSIP Identification</th>
<th>Name or Description</th>
<th>Code</th>
<th>City</th>
<th>State</th>
<th>NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol</th>
<th>Date Originally Acquired</th>
<th>Type and Strategy</th>
<th>Actual Cost</th>
<th>Book/Adjusted Carrying Value</th>
<th>Unrealized Valuation Increase/Decrease</th>
<th>Current Year’s Other-Than-Permanent Impairment Recognized</th>
<th>Capitalized Deferred Interest and Other</th>
<th>Total Foreign Exchange Change in BACV</th>
<th>Investment Income</th>
<th>Committed for Additional Investment</th>
<th>Percentage of Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Detail Eliminated to Conserve Space**

| 20199999 Total |                             |      |      |       |                                                                                      |                          |                 |            |                             |                                           |                                             |                                         |                                |                   |                                |                           |

Book/Adjusted Carrying Value included in this schedule by NAIC Designation Category:

<p>| | | | | | | | | | | | | | | | | |</p>
<table>
<thead>
<tr>
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Columns used for data table:

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</table>

**DRAFTING NOTE:** The NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol Column will appear as one column on the PDF and printed page but will be three sub-columns (7A, 7B and 7C) in the data table.
# SCHEDULE DA – PART 1

Showing all SHORT-TERM INVESTMENTS Owned December 31 of Current Year

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1 | Code | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|  | Description | Code | Date Acquired | Name of Vendor | Maturity Date | Book/Adjusted Carrying Value | Unrealized Valuation Increase/Decrease | Current Year’s Amortization | Current Year’s Other-Than-Temp. Impairment Recognized | Total Foreign Exchange Change in B/A/C | Par Value | Actual Cost | Accrued Date and Accrued (Dec. 31) of Current Year on Bond Not in Default | Non-Adjusted Due and Accrued | Rate of Effective Rate of | When Paid | Amount Received During Year | Par/Cost Accrued Interest |

## Detail Eliminated to Conserve Space

8899999 Total

Book/Adjusted Carrying Value included in this schedule by NAIC Designation Category:

<table>
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<tr>
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<th>1B</th>
<th>1C</th>
<th>1D</th>
<th>1E</th>
</tr>
</thead>
<tbody>
<tr>
<td>1G</td>
<td>2A</td>
<td>2B</td>
<td>2C</td>
<td>3A</td>
</tr>
<tr>
<td>3C</td>
<td>4A</td>
<td>4B</td>
<td>4C</td>
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# SCHEDULE E – PART 2 – CASH EQUIVALENTS

Show Investments Owned December 31 of Current Year

<p>| | | | | | | | | | | | | | |</p>
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<td>CUSIP</td>
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<td>Code</td>
<td>Date Acquired</td>
<td>Rate of Interest</td>
<td>Maturity Date</td>
<td>Book/Adjusted Carrying Value</td>
<td>Amount of Interest Due &amp; Accrued</td>
<td>Amount Received During Year</td>
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## Detail Eliminated to Conserve Space

8899999 Total Cash Equivalents

Book/Adjusted Carrying Value included in this schedule by NAIC Designation Category:

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<th>1E</th>
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W:\National Meetings\2019\Fall\TF\AppBlanks\WG\minutes\Art Two-B1_2019-18BWG_Modified.doc
Blanks (E) Working Group  
Editorial Revisions to the Blanks and Instructions  
*(presented at the August 20, 2019 Meeting)*  

*(adopted 12/15/2016 through 8/20/2019)*  

Statement Type:  
H = Health; L/F = Life/Fraternal Combined; P/C = Property/Casualty; SA = Separate Accounts; T = Title

<table>
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<tr>
<th>Effective</th>
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<th>Date Adopted</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
</table>
| 2019      | Schedule D, Part 1A, Section 2 | CHANGE TO BLANK  
Make the following changes for consistency with the bond categories for Schedule D, Part 1.  
Add the “Unaffiliated” to the description of Section 10.  
Add line for “Affiliated Bank Loans” and add “Unaffiliated” to the existing line for bank loans to Sections 11 through 14 of the schedule.  
Add lines for “Affiliated bank loans – issued” and “Affiliated bank loans – acquired” to Sections 8 and 11 of the schedule.  
Because the number of lines in some to the sections exceed 9, the format of the line numbers is changed from X.X to X.XX. | 08/20/2019 | H, L/F, P/C, T, SA | Annual |
| 2019      | Schedule D – Summary by Country | CHANGE TO BLANK  
For Lines 8 through 11, The description of bonds should be modified to refer to “Unaffiliated Bank Loans”. | 08/20/2019 | H, L/F, P/C, T, SA | Annual |
<table>
<thead>
<tr>
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<th>Table Name</th>
<th>Description</th>
<th>Date Adopted</th>
<th>Statement Type</th>
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<td><strong>CHANGE TO BLANK</strong>&lt;br&gt;Make change shown below:</td>
<td>08/20/2019</td>
<td>H, L/F, P/C, T</td>
<td>Annual</td>
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<td>Part 1</td>
<td>28.0597 For those firms/individuals listed in the table for Question 28.05,</td>
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<td>do any firms/individuals unaffiliated with the reporting entity (i.e.,</td>
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<td>designated with a “U”) manage more than 10% of the reporting entity’s</td>
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<td>invested assets?</td>
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<td>28.0598 For firms/individuals unaffiliated with the reporting entity (i.e.,</td>
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<td>designated with a “U”) listed in the table for Question 28.05, does the</td>
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<td>total assets under management aggregate to more than 50% of the reporting</td>
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<td>entity’s invested assets?</td>
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<tr>
<td>2020</td>
<td>General Interrogatories,</td>
<td><strong>CHANGE TO BLANK</strong>&lt;br&gt;Make change shown below:</td>
<td>08/20/2019</td>
<td>H, L/F, P/C, T</td>
<td>Quarterly</td>
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<tr>
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<td>Part 1</td>
<td>17.5097 For those firms/individuals listed in the table for Question 17.5,</td>
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<td>do any firms/individuals unaffiliated with the reporting entity (i.e.,</td>
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<td>designated with a “U”) manage more than 10% of the reporting entity’s</td>
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<td>invested assets?</td>
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<td>designated with a “U”) listed in the table for Question 17.5, does the</td>
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<td>total assets under management aggregate to more than 50% of the reporting</td>
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<td>entity’s invested assets?</td>
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<td>Filing Type</td>
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<td>2019</td>
<td>Summary Investment Schedule</td>
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</tbody>
</table>

**CHANGE TO INSTRUCTIONS**

Modify the line description for Line 12 to read "Other Invested Assets (Page 2, Line 11)." Line 12 is not a write-in line on this schedule.

**CHANGE TO INSTRUCTIONS**

Modify the line description as shown below. Line 12 is not a write-in line on this schedule. The included statement should read similar to the prior year.

Line 12 - Aggregate Write-Ins for Other Invested Assets (Page 2, Line 11).

The value of all other invested assets that have not been included in Lines 1 to 11 above, Enter the total of the write-ins listed in schedule detail line 12 for invested Assets.

Column 1 should equal the amount reported in Line 11, Column 1, Page 2, Assets.

Column 3 should equal the amount reported in Line 11, Column 3, Page 2, Assets.

**CHANGE TO INSTRUCTIONS**

For Column 6 delete the "AM" administrative symbol for the line in the instructions.
<table>
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<th>Annual/Quarterly</th>
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<tr>
<td>Date Adopted</td>
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</table>

### Change to Instructions

Make the changes below to reflect reporting of affiliated and unaffiliated bank loans on the schedule.

Section 10. Unaffiliated Bank Loans

Lines 659999 from Schedule D, Part 1, Column 11; Schedule DA, Part 1, Column 7, and Schedule E, Part 2, Column 7.

For each major section the following subgroups, which are described in the Investment Schedule General Instructions, shall be presented by maturity category:

- Sections 1 through 4:
  - Issuer Obligations
  - Residential Mortgage-Backed Securities
  - Commercial Mortgage-Backed Securities
  - Other Loan-Backed and Structured Securities

- Section 8:
  - Issuer Obligations
  - Residential Mortgage-Backed Securities
  - Commercial Mortgage-Backed Securities
  - Other Loan-Backed and Structured Securities

- Section 9:
  - Affiliated Bank Loans – Issued
  - Affiliated Bank Loans – Acquired
  - Exchange Traded Funds – as identified by...
<table>
<thead>
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<th>Table Name</th>
<th>Description</th>
<th>Date Adopted</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
</table>
| 2019      | Schedule D – Summary by Country | **CHANGE TO INSTRUCTIONS**  
Modify instruction as shown below  
Lines 8 through 11 – Bonds – Industrial and Miscellaneous, SVO Identified Funds, Unaffiliated Bank Loans and Hybrid Securities (Unaffiliated)  
Include: Bond Mutual Funds – as identified by the SVO and Exchange Traded Funds – as identified by the SVO reported in Schedule D, Part 1.  
Unaffiliated Bank Loans | 08/20/2019 | H, L/F, P/C, T | Annual |
<table>
<thead>
<tr>
<th>Effective</th>
<th>Table Name</th>
<th>Description</th>
<th>Date Adopted</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
</table>
| 2019      | Schedule D, Part 3  | **CHANGE TO INSTRUCTIONS**  
Line 8199999 – Affiliated Bank Loans should not be added to the list of line categories for the schedule as affiliated bank loans should be reported on Line 5599999 – Parent, Subsidiaries and Affiliates.  
SVO Identified Funds line number changes to 8099999. | 08/20/2019 | H, L/F, P/C, T | Annual         |
| 2019      | Schedule D, Part 4  | **CHANGE TO INSTRUCTIONS**  
Line 8199999 – Affiliated Bank Loans should not be added to the list of line categories for the schedule as affiliated bank loans should be reported on Line 5599999 – Parent, Subsidiaries and Affiliates.  
SVO Identified Funds line number changes to 8099999. | 08/20/2019 | H, L/F, P/C, T | Annual         |
| 2019      | Schedule D, Part 5  | **CHANGE TO INSTRUCTIONS**  
Line 8199999 – Affiliated Bank Loans should not be added to the list of line categories for the schedule as affiliated bank loans should be reported on Line 5599999 – Parent, Subsidiaries and Affiliates.  
SVO Identified Funds line number changes to 8099999. | 08/20/2019 | H, L/F, P/C, T | Annual         |
| 2020      | Schedule D, Part 3  | **CHANGE TO INSTRUCTIONS**  
Line 8199999 – Affiliated Bank Loans should not be added to the list of line categories for the schedule as affiliated bank loans should be reported on Line 5599999 – Parent, Subsidiaries and Affiliates.  
SVO Identified Funds line number changes to 8099999. | 08/20/2019 | H, L/F, P/C, T | Quarterly      |
<table>
<thead>
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<th>Table Name</th>
<th>Description</th>
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</table>
| 2020      | Schedule D, Part 4 | **CHANGE TO INSTRUCTIONS**  
Line 8199999 – Affiliated Bank Loans should not be added to the list of line categories for the schedule as affiliated bank loans should be reported on Line 5599999 – Parent, Subsidiaries and Affiliates.  
SVO Identified Funds line number changes to 8099999. |
| 2019      | General Interrogatories, Part 1 | **CHANGE TO INSTRUCTIONS**  
Make change shown below:  
28.0597 If the total assets under management of any the firms/individuals unaffiliated with the reporting entity (i.e., designated with a “U”) listed in the table for Question 28.05 are greater than 10% of the reporting entity’s invested assets (Line 12 of the Asset page), answer “YES” to Question 28.0597.  
28.0598 If the total assets under management of all the firms/individuals unaffiliated with the reporting entity (i.e., designated with a “U”) listed in the table for Question 28.05 are greater than 50% of the reporting entity’s invested assets (Line 12 of the Asset page), answer “YES” to Question 28.0598. When determining the aggregate total of assets under management, include all firms/individuals unaffiliated with the reporting entity not just those who manage more than 10% of the reporting entity’s assets. |
<p>|           |            | <strong>Date Adopted</strong> | <strong>Statement Type</strong> | <strong>Filing Type</strong> |
|           |            | 08/20/2019 | H, L/F, P/C, T | Quarterly |
|           |            | 08/20/2019 | H, L/F, P/C, T | Annual |</p>
<table>
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<th>Description</th>
<th>Date Adopted</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>General Interrogatories, Part 1</td>
<td><strong>CHANGE TO INSTRUCTIONS</strong>&lt;br&gt;Make change shown below:&lt;br&gt;17.5097 If the total assets under management of any the firms/individuals unaffiliated with the reporting entity (i.e., designated with a “U”) listed in the table for Question 17.5 are greater than 10% of the reporting entity's invested assets (Line 12 of the Asset page), answer “YES” to Question 17.5097.&lt;br&gt;17.5098 If the total assets under management of all the firms/individuals unaffiliated with the reporting entity (i.e., designated with a “U”) listed in the table for Question 17.5 are greater than 50% of the reporting entity's invested assets (Line 12 of the Asset page), answer “YES” to Question 17.5098. When determining the aggregate total of assets under management, include all firms/individuals unaffiliated with the reporting entity, not just those who manage more than 10% of the reporting entity's assets.</td>
<td>08/20/2019</td>
<td>H, L/F, P/C, T</td>
<td>Quarterly</td>
</tr>
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** NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

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<tr>
<th>CONTACT PERSON:</th>
<th>Todd Sells</th>
</tr>
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<tr>
<td>TELEPHONE:</td>
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<tr>
<td>EMAIL ADDRESS:</td>
<td></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>Liquidity Assessment (EX) Subgroup</td>
</tr>
<tr>
<td>NAME:</td>
<td>Justin Schrader (NE)</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Chair</td>
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<tr>
<td>AFFILIATION:</td>
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**DATE:** 07/16/2019

**FOR NAIC USE ONLY**

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<tr>
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<td>2020</td>
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<tr>
<td>Changes to Existing Reporting</td>
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<tr>
<td>New Reporting Requirement</td>
<td>[ ]</td>
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<tr>
<td>REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</td>
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<tr>
<td>No Impact</td>
<td>[ X ]</td>
</tr>
<tr>
<td>Modifies Required Disclosure</td>
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**DISPOSITION**

| [ ] | Rejected For Public Comment |
| [ ] | Referred To Another NAIC Group |
| [ ] | Received For Public Comment |
| [ X ] | Adopted Date 10/22/2019 |
| [ ] | Rejected Date |
| [ ] | Deferred Date |
| [ ] | Other (Specify) |

**BLANK(S) TO WHICH PROPOSAL APPLIES**

| [ X ] ANNUAL STATEMENT | [ X ] INSTRUCTIONS |
| [ ] QUARTERLY STATEMENT | [ ] BLANK |
| [ X ] Life, Accident & Health/Fraternal | [ ] Separate Accounts |
| [ ] Property/Casualty | [ ] Protected Cell |
| [ ] Health | [ ] Health (Life Supplement) |

Anticipated Effective Date: **Annual 2020**

**IDENTIFICATION OF ITEM(S) TO CHANGE**

For Note 33, modify the illustration to disclosure individually Separate Account with Guarantees products and Separate Account Nonguaranteed products.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to data capture individually Separate Account with Guarantees products and Separate Account Nonguaranteed products.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ____________________________

Other Comments:

**This section must be completed on all forms.**  Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

NOTES TO FINANCIAL STATEMENTS

33. Analysis of Life Actuarial Reserves by Withdrawal Characteristics

Instruction:

Disclose the amounts of account value, cash value and reserve for the breakouts of life insurance by withdrawal characteristics, separately for General Account products, Separate Account with Guarantees products and Separate Account Nonguaranteed products, as follows:

Note: The difference between the account value and the cash value is the surrender charge, if any. After the surrender period is over, there is no difference. Some contract types have no account value such as traditional whole life, term, etc. So, if there is no account value, leave it blank. UL typically has an account value and a cash surrender value.

Just as account values are not reduced for policy loans taken and outstanding, the cash value amount reported in this note should not be reduced for policy loans taken and outstanding. This will ensure the difference between account value and cash value is the actual surrender charge.

• A. Subject to discretionary withdrawal, surrender values, or policy loans:
  ❖ (1) Term Policies with Cash Value
  ❖ (2) Universal Life
  ❖ (3) Universal Life with Secondary Guarantees
  ❖ (4) Indexed Universal Life
  ❖ (5) Indexed Universal Life with Secondary Guarantees
  ❖ (6) Indexed Life
  ❖ (7) Other Permanent Cash Value Life Insurance
  ❖ (8) Variable Life
  ❖ (9) Variable Universal Life
  ❖ (10) Miscellaneous Reserves

• B. Not subject to discretionary withdrawal or no cash value:
  ❖ (1) Term Policies without Cash Value
  ❖ (2) Accidental Death Benefits
  ❖ (3) Disability - Active Lives
  ❖ (4) Disability - Disabled Lives
  ❖ (5) Miscellaneous Reserves

• C. Total (Gross: Direct + Assumed).

• D. Reinsurance ceded.

• E. Total (net) = (C) – (D).

  Total (net) = Total (Gross: Direct + Assumed) – Reinsurance ceded
- Reconcile total life insurance reserves amount disclosed to the appropriate sections of the Aggregate Reserves for Life Policies and Contracts Exhibit (Exhibit 5) of the Life, Accident and Health Annual Statement and the corresponding lines in the Separate Accounts Statement. The reconciliation is a single presentation including all amounts from the sections on Individual Life Insurance and Group Life Insurance.

**Illustration:**

>This exact format must be used in the preparation of this note for the table below. Reporting entities are not precluded from providing clarifying disclosure before or after this illustration.

<table>
<thead>
<tr>
<th>A. General Account</th>
<th>Account Value</th>
<th>Cash Value</th>
<th>Reserve</th>
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<tbody>
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<td>(1) Subject to discretionary withdrawal, surrender values, or policy loans:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>a. Term Policies with Cash Value</td>
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<tr>
<td>b. Universal Life</td>
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</tr>
<tr>
<td>c. Universal Life with Secondary Guarantees</td>
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<tr>
<td>d. Indexed Universal Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Indexed Universal Life with Secondary Guarantees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Indexed Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Other Permanent Cash Value Life Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Variable Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Variable Universal Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Miscellaneous Reserves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Not subject to discretionary withdrawal or no cash values</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Term Policies without Cash Value</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>b. Accidental Death Benefits</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>c. Disability - Active Lives</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>d. Disability - Disabled Lives</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>e. Miscellaneous Reserves</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>(3) Total (gross: direct + assumed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Reinsurance Ceded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Total (net) (3) - (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Separate Account with Guarantees</th>
<th>Account Value</th>
<th>Cash Value</th>
<th>Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Subject to discretionary withdrawal, surrender values, or policy loans:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Term Policies with Cash Value</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Universal Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Universal Life with Secondary Guarantees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Indexed Universal Life</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>e. Indexed Universal Life with Secondary Guarantees</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>f. Indexed Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Other Permanent Cash Value Life Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Variable Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Variable Universal Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Miscellaneous Reserves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Not subject to discretionary withdrawal or no cash values</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Term Policies without Cash Value</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>b. Accidental Death Benefits</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>c. Disability - Active Lives</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>d. Disability - Disabled Lives</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>e. Miscellaneous Reserves</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>(3) Total (gross: direct + assumed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Reinsurance Ceded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Total (net) (3) - (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### C. Separate Account Nonguaranteed

<table>
<thead>
<tr>
<th>Account Value</th>
<th>Cash Value</th>
<th>Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(1) Subject to discretionary withdrawal, surrender values, or policy loans:

<table>
<thead>
<tr>
<th>Account</th>
<th>Description</th>
<th>Account Value</th>
<th>Cash Value</th>
<th>Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Term Policies with Cash Value</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Universal Life</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Universal Life with Secondary Guarantees</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Indexed Universal Life</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>Indexed Universal Life with Secondary Guarantees</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td>Indexed Life</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>g.</td>
<td>Other Permanent Cash Value Life Insurance</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>h.</td>
<td>Variable Life</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>i.</td>
<td>Variable Universal Life</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>j.</td>
<td>Miscellaneous Reserves</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
</tbody>
</table>

(2) Not subject to discretionary withdrawal or no cash values

<table>
<thead>
<tr>
<th>Account</th>
<th>Description</th>
<th>Account Value</th>
<th>Cash Value</th>
<th>Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Term Policies without Cash Value</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Accidental Death Benefits</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Disability - Active Lives</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Disability - Disabled Lives</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>Miscellaneous Reserves</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
</tbody>
</table>

(3) Total (gross: direct + assumed) | XXX | XXX |             |

(4) Reinsurance Ceded | XXX | XXX |             |

(5) Total (net) (3) - (4) | XXX | XXX |             |

### A. Subject to discretionary withdrawal, surrender values, or policy loans:

<table>
<thead>
<tr>
<th>General Account</th>
<th>Separate Account – Guaranteed and Nonguaranteed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account Value</td>
<td>Reserve</td>
</tr>
<tr>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

### B. Not subject to discretionary withdrawal or no cash values

<table>
<thead>
<tr>
<th>General Account</th>
<th>Separate Account – Guaranteed and Nonguaranteed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account Value</td>
<td>Reserve</td>
</tr>
<tr>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

### C. Miscellaneous Reserves

<table>
<thead>
<tr>
<th>General Account</th>
<th>Separate Account – Guaranteed and Nonguaranteed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account Value</td>
<td>Reserve</td>
</tr>
<tr>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

### D. Reinsurance Ceded

<table>
<thead>
<tr>
<th>General Account</th>
<th>Separate Account – Guaranteed and Nonguaranteed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account Value</td>
<td>Reserve</td>
</tr>
<tr>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

### E. Total (net) (C) – (D)

<table>
<thead>
<tr>
<th>General Account</th>
<th>Separate Account – Guaranteed and Nonguaranteed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account Value</td>
<td>Reserve</td>
</tr>
<tr>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>
THIS EXACT FORMAT MUST BE USED IN THE PREPARATION OF THIS NOTE FOR THE TABLE BELOW. REPORTING ENTITIES ARE NOT PRECLUDED FROM PROVIDING CLARIFYING DISCLOSURE BEFORE OR AFTER THIS ILLUSTRATION. Amounts reported in F to D to balance to the appropriate amounts from the Sections A, B and C reported above.

<table>
<thead>
<tr>
<th>FD</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life &amp; Accident &amp; Health Annual Statement:</td>
<td></td>
</tr>
<tr>
<td>(1) Exhibit 5, Life Insurance Section, Total (net)</td>
<td>$ ________</td>
</tr>
<tr>
<td>(2) Exhibit 5, Accidental Death Benefits Section, Total (net)</td>
<td>________</td>
</tr>
<tr>
<td>(3) Exhibit 5, Disability – Active Lives Section, Total (net)</td>
<td>________</td>
</tr>
<tr>
<td>(4) Exhibit 5, Disability – Disabled Lives Section, Total (net)</td>
<td>________</td>
</tr>
<tr>
<td>(5) Exhibit 5, Miscellaneous Reserves Section, Total (net)</td>
<td>________</td>
</tr>
<tr>
<td>(6) Subtotal</td>
<td>________</td>
</tr>
<tr>
<td>Separate Accounts Annual Statement:</td>
<td></td>
</tr>
<tr>
<td>(7) Exhibit 3, Line 0199999, Column 2</td>
<td>________</td>
</tr>
<tr>
<td>(8) Exhibit 3, Line 0499999, Column 2</td>
<td>________</td>
</tr>
<tr>
<td>(9) Exhibit 3, Line 0599999, Column 2</td>
<td>________</td>
</tr>
<tr>
<td>(10) Subtotal (Lines (7) through (9))</td>
<td>________</td>
</tr>
<tr>
<td>(11) Combined Total ((6) and (10))</td>
<td>$ ________</td>
</tr>
</tbody>
</table>

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**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Pat Allison</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE:</td>
<td>816-783-8528</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:pallison@naic.org">pallison@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>LATF</td>
</tr>
<tr>
<td>NAME:</td>
<td>Mike Boerner, Chair</td>
</tr>
<tr>
<td>TITLE:</td>
<td></td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td></td>
</tr>
<tr>
<td>ADDRESS:</td>
<td></td>
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</table>

**FOR NAIC USE ONLY**

<table>
<thead>
<tr>
<th>Agenda Item #</th>
<th>2019-22BWG</th>
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<tbody>
<tr>
<td>Year</td>
<td>2020</td>
</tr>
<tr>
<td>Changes to Existing Reporting</td>
<td>[ X ]</td>
</tr>
<tr>
<td>New Reporting Requirement</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

| No Impact | [ X ] |
| Modifies Required Disclosure | [ ] |

**DISPOSITION**

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 10/22/2019
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [ X ] ANNUAL STATEMENT
- [ ] QUARTERLY STATEMENT
- [ X ] INSTRUCTIONS
- [ ] CROSSCHECKS
- [ X ] Life, Accident & Health/Fraternal
- [ ] Property/Casualty
- [ ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2020

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Add a question regarding the Executive Summary of the PBR Actuarial Opinion to the Supplemental Exhibits and Schedules Interrogatories.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to add a question regarding the Executive Summary of the PBR Actuarial Opinion to the Supplemental Exhibits and Schedules Interrogatories to enable regulators to see if the reporting entity has filed it.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018
## ANNUAL STATEMENT BLANK – LIFE/FRATERNAL

### SUPPLEMENTAL EXHIBITS AND SCHEDULES

**INTERROGATORIES**

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of **WAIVED** to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter **SEE EXPLANATION** and provide an explanation following the interrogatory questions.

### APRIL FILING

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>41.</td>
<td>Will the confidential Regulatory Asset Adequacy Issues Summary (RAAIS) required by the Valuation Manual be filed with the state of domicile by April 1?</td>
<td></td>
</tr>
<tr>
<td>42.</td>
<td>Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?</td>
<td></td>
</tr>
</tbody>
</table>

**Detail Eliminated To Conserve Space**

### AUGUST FILING

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>5051</td>
<td>Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation:**

**Bar code:**

W:\National Meetings\2019\Fall\TF\AppBlanksWG\minutes\Att Two-D_2019-22BWG.doc
**NAIC BLANKS (E) WORKING GROUP**

Blanks Agenda Item Submission Form

| CONTACT PERSON: | ____________________________ |
| TELEPHONE: | ____________________________ |
| EMAIL ADDRESS: | ____________________________ |
| ON BEHALF OF: | ____________________________ |
| NAME: | Dale Bruggeman |
| TITLE: | Chair SAPWG |
| AFFILIATION: | Ohio Department of Insurance |
| ADDRESS: | 50W. Town St., 3rd Fl., Ste. 300 Columbus, OH 43215 |

**FOR NAIC USE ONLY**

- Agenda Item # 2019-23BWG MOD
- Year 2020
- Changes to Existing Reporting [ X ]
- New Reporting Requirement [ ]

**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

- No Impact [ X ]
- Modifies Required Disclosure [ ]

**DISPOSITION**

- [ ] Rejected For Public Comment
- [ ] Referred To Another NAIC Group
- [ ] Received For Public Comment
- [ X ] Adopted Date 10/22/2019
- [ ] Rejected Date
- [ ] Deferred Date
- [ ] Other (Specify) ________________

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [ ] ANNUAL STATEMENT
- [ X ] QUARTERLY STATEMENT
- [ X ] INSTRUCTIONS
- [ X ] CROSSCHECKS
- [ X ] Life, Accident & Health/Fratal
- [ X ] Property/Casualty
- [ X ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)
- [ ] Title
- [ ] Other ________________

Anticipated Effective Date: 1st Quarterly 2020

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Modify the instructions and illustration for Note 8 – Derivatives for disclosures adopted by SSAP No. 108—Derivative Hedging Variable Annuity Guarantees. Add instruction and blank page for Schedule DB, Part E to the quarterly statement.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to add a Quarterly Schedule DB, Part E and Note 8 – Derivatives changes included in the annual statement. The quarterly version of the schedule and notes disclosures were not included in 2019-14BWG adopted on 06/24/2019 but is required by the changes to SSAP No. 108—Derivative Hedging Variable Annuity Guarantees.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ____________________________

Other Comments: ____________________________

**** This section must be completed on all forms. **Revised 7/18/2018**
### QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

**SCHEDULE DB – PART E**  
**Derivatives Hedging Variable Annuity Guarantees as of Current Quarter**

This schedule is specific for the derivatives and the hedging programs captured in SSAP No. 108.


| Column 1 – CDHS Identifier | Column 2 – CDHS Description | Column 3 – Prior Fair Value in Full Contract Cash Flows Attributed to Interest Rates | Column 4 – Ending Fair Value in Full Contract Cash Flows Attributed to Interest Rates | Column 5 – Fair Value Gains (Loss) in Full Contract Cash Flows Attributed to Interest Rates | Column 6 – Fair Value Gain (Loss) in Hedged Item Attributed to Hedged Risk | Column 7 – Current Year Increase (Decrease) in VM-21 Liability | Column 8 – Current Year Increase (Decrease) in VM-21 Liability Attributed to Interest Rates | Column 9 – Change in the Hedged Item Attributed to Hedged Risk Percentage | Column 10 – Current Year Increase (Decrease) in VM-21 Liability Attributed to Hedged Risk |
|---------------------------|---------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|
| Provide a unique identifier for each Clearly Defined Hedging Strategy (CDHS) reported on this schedule (e.g., 001, 002, etc.). This identifier will also be used for reporting of the SSAP No. 108 CDHS in Column 32 of Schedule DB, Part A, Section 1; Column 31 of Schedule DB, Part A, Section 2; Column 30 of Schedule DB, Part B, Section 1; and Column 26 of Schedule DB, Part B, Section 2. | Provide a description for each uniquely identified CDHS. | Prior period full contract fair value. This reflects all product cash flows, per SSAP No. 108. | Current period full contract fair value. This reflects all product cash flows, per SSAP No. 108. | Change in full contract fair value. This reflects all product cash flows, per SSAP No. 108. | Change in fair value attributable to hedged risk per SSAP No. 108. | VM-21 liability increase (decrease) from beginning of period to end of period. | VM-21 liability increase (decrease) attributable to interest rate movements. | Change in fair value attributed to hedged risk as a percentage of the change in full contract fair value, per SSAP No. 108. | VM-21 liability increase (decrease) attributed to hedged risk. |
| Column 11 | Prior Deferred Balance | Specific CDHS deferred liability (asset) balance at end of prior reporting period. |
| Column 12 | Current Year Fair Value Fluctuation of the Hedge Instruments | Current year total return Fair Value fluctuations in the hedging instruments, per SSAP 108. |
| Column 13 | Current Year Natural Offset to VM-21 Liability | Current year hedging instruments' total return Fair Value fluctuations that offset the current period change in the designated portion of the VM-21 liability. |
| Column 14 | Hedging Instruments’ Current Fair Value Fluctuation Not Attributed to Hedged Risk | Current year hedging instruments' total return Fair Value fluctuations not attributable to hedged risk, per SSAP 108. |
| Column 15 | Hedge Gain (Loss) in Current Year Deferred Adjustment | Current year hedging instruments' total return Fair Value fluctuations that do not offset the current period change in the designated portion of the VM-21 liability (recognized as deferred liabilities/(assets), per SSAP 108). |
| Column 16 | Current Year Prescribed Deferred Amortization | Current year deferred (liability)/asset amortization into realized gains/losses (straight line over a period not to exceed 10 years, per SSAP 108). |
| Column 17 | Current Year Additional Deferred Amortization | Current year deferred (liability)/asset accelerated amortization elected by the reporting entity, per SSAP 108. |
| Column 18 | Current Year Total Deferred Amortization | Total current year deferred (liability)/asset amortization into realized gains/losses. |
| Column 19 | Ending Deferred Balance | Specific CDHS Deferred Liability (Asset) balance at end of current reporting period. |
NOTES TO FINANCIAL STATEMENTS

The interim financial information shall include disclosures sufficient to make the information presented not misleading. It may be presumed that the users of the interim financial information have read or have access to the annual statement for the preceding period and that the adequacy of additional disclosure needed for a fair presentation, except in regard to material contingencies, may be determined in that context. Accordingly, footnote disclosure that would substantially duplicate the disclosure contained in the most recent annual statement or audited financial statements, such as a statement of significant accounting policies and practices, details of accounts that have not changed significantly in amount or composition since the end of the most recently completed fiscal year, may be omitted but the footnote number and annotation such as “no change” should be included. However, provide disclosure for annual Note 1A, 1C(2), 1C(6), 1D, 5D, 5E(3)b, 5F, 5G, 5H, 5I, 5M(2), 5M(3), 5N, 8A(8)H, 8B(2)a, 8B(2)b, 8B(2)c, 11B, 12A(4), 17B(2), 17B(4)a, 17B(4)b, 17C, 20, 24E and 25 in all quarters; and all other Notes where events subsequent to the end of the most recent fiscal year have occurred that have a material impact on the reporting entity. Disclosures shall encompass, for example, significant changes since the end of the period reported on the last annual statement in such items as statutory accounting principles and practices; estimates inherent in the preparation of financial statements; status of long term contracts; capitalization including significant new borrowings or modifications of existing financial arrangements; and the reporting entity resulting from business combinations or dispositions. Notwithstanding the above, where material noninsurance contingencies exist, disclosure of such matters shall be provided even though a significant change since year-end may not have occurred. If the reporting entity has changed the accounting policies since the end of its preceding year, the changes shall be disclosed in the quarterly financial statements. Information should be reported for current year-to-date.

8. Derivative Instruments

Instruction:

A. Derivatives under SSAP No. 86—Derivatives

Disclose the following information by category of derivative financial instrument:

H.(8) Disclose the aggregate, non-discounted total premium cost for these contracts and the premium cost due in each of the following four years, and thereafter. Include the aggregate fair value of derivative instruments with financing premiums, excluding the impact of the deferred or financing premiums.

B. Derivatives under SSAP No. 108—Derivative Hedging Variable Annuity Guarantees (Life/Fraternal Only)

(2) Recognition of gains/losses and deferred assets and liabilities

Provide the following:

Schedule showing the current period amortization, including any accelerated amortization elected by the reporting entity, and the future scheduled amortization of the deferred assets and deferred liabilities.

Information on derivative instruments that were originally captured in SSAP No. 108 and repurposed to be within scope of SSAP No. 86 (or vice versa). If the reporting entity has repurposed derivatives, information on the derivative to reconcile the fair value (realized/unrealize gains or losses) is required. (These disclosures should only be included if open derivatives were reclassified between SSAP No. 86 and SSAP No. 108. It is expected to be uncommon.)
The amortization of deferred assets and liabilities shall be completed on an annual basis only. Quarterly changes (resulting in new amortization projections) from the recognition of new deferred assets/liabilities shall be shown in the quarterly completion of Schedule DB, Part E.

Illustration:

A. Derivatives under SSAP No. 86—Derivatives

(4) 

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Derivative Premium Payments Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>a1 2020</td>
<td>$ \hdots</td>
</tr>
<tr>
<td>b2 2021</td>
<td>\hdots</td>
</tr>
<tr>
<td>e3 2022</td>
<td>\hdots</td>
</tr>
<tr>
<td>d4 2023</td>
<td>\hdots</td>
</tr>
<tr>
<td>e5 Thereafter</td>
<td>\hdots</td>
</tr>
<tr>
<td>f6 Total Future Settled Premiums</td>
<td>$ \hdots</td>
</tr>
</tbody>
</table>

(2)b.

<table>
<thead>
<tr>
<th>Undiscounted Future Premium Commitments</th>
<th>Derivative Fair Value with Premium Commitments (Reported on DB)</th>
<th>Derivative Fair Value Excluding Impact of Future Settled Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>a1 Prior Year</td>
<td>$ \hdots</td>
<td>$ \hdots</td>
</tr>
<tr>
<td>b2 Current Year</td>
<td>$ \hdots</td>
<td>$ \hdots</td>
</tr>
</tbody>
</table>

B. Derivatives under SSAP No. 108—Derivative Hedging Variable Annuity Guarantees

(2) Recognition of gains/losses and deferred assets and liabilities

a. Scheduled Amortization

<table>
<thead>
<tr>
<th>Amortization Year</th>
<th>Deferred Assets</th>
<th>Deferred Liabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 2020</td>
<td>\hdots</td>
<td>\hdots</td>
</tr>
<tr>
<td>2. 2021</td>
<td>\hdots</td>
<td>\hdots</td>
</tr>
<tr>
<td>3. 2022</td>
<td>\hdots</td>
<td>\hdots</td>
</tr>
<tr>
<td>4. 2023</td>
<td>\hdots</td>
<td>\hdots</td>
</tr>
<tr>
<td>5. 2024</td>
<td>\hdots</td>
<td>\hdots</td>
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<td>6. 2025</td>
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<td>7. 2026</td>
<td>\hdots</td>
<td>\hdots</td>
</tr>
<tr>
<td>8. 2027</td>
<td>\hdots</td>
<td>\hdots</td>
</tr>
<tr>
<td>9. 2028</td>
<td>\hdots</td>
<td>\hdots</td>
</tr>
<tr>
<td>10. 2029</td>
<td>\hdots</td>
<td>\hdots</td>
</tr>
<tr>
<td>11. Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

b. Total Deferred Balance * \hdots

* Should agree to Column 1819 of Schedule DB, Part E

c. Reconciliation of Amortization:

1. Prior Year Total Deferred Balance $ \hdots
<table>
<thead>
<tr>
<th></th>
<th>Current Year Amortization</th>
<th>$ ..................................</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>Current Year Deferred Recognition</td>
<td>$ ..................................</td>
</tr>
<tr>
<td>4.</td>
<td>Ending Deferred Balance [1-(2+3)]</td>
<td>$ ..................................</td>
</tr>
</tbody>
</table>
SCHEDULE DB – PART E

Derivatives Hedging Variable Annuity Guarantees as of Current Quarter

This schedule is specific for the derivatives and the hedging programs captured in SSAP No. 108

<table>
<thead>
<tr>
<th>Hedging Item</th>
<th>Hedging Instruments</th>
<th>Prior Fair Value</th>
<th>Description</th>
<th>Current Year Increase (Decrease) in VM-21 Liability</th>
<th>Change in current year attributable to hedged risk</th>
<th>Prior Deferred Balance</th>
<th>Current Year Fair Value Fluctuation of the Hedge Instruments</th>
<th>Current Year Increase (Decrease) in VM-21 Liability attributable to hedged risk</th>
<th>Current Year Additional Deferred Amortization</th>
<th>Current Year Total Deferred Amortization</th>
<th>Ending Deferred Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

(continued)
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Pat Allison</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE:</td>
<td>816-783-8528</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:pallison@naic.org">pallison@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>Life Actuarial (A) Task Force</td>
</tr>
<tr>
<td>NAME:</td>
<td>Mike Boerner, Chair</td>
</tr>
<tr>
<td>TITLE:</td>
<td></td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td></td>
</tr>
<tr>
<td>ADDRESS:</td>
<td></td>
</tr>
</tbody>
</table>

FOR NAIC USE ONLY

<table>
<thead>
<tr>
<th>Agenda Item #</th>
<th>2019-24BWG</th>
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<tbody>
<tr>
<td>Year</td>
<td>2020</td>
</tr>
<tr>
<td>Changes to Existing Reporting</td>
<td>[ X ]</td>
</tr>
<tr>
<td>New Reporting Requirement</td>
<td>[ ]</td>
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</tbody>
</table>

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

<table>
<thead>
<tr>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>Adopted Date</td>
<td>10/22/2019</td>
</tr>
<tr>
<td>Rejected For Public Comment</td>
<td>[ ]</td>
</tr>
<tr>
<td>Referred To Another NAIC Group</td>
<td>[ ]</td>
</tr>
<tr>
<td>Received For Public Comment</td>
<td>[ ]</td>
</tr>
<tr>
<td>Rejected Date</td>
<td>[ X ]</td>
</tr>
<tr>
<td>Deferred Date</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ X ] QUARTERLY STATEMENT
- [ X ] Life, Accident & Health/Fraternal
- [ X ] Property/Casualty
- [ X ] Health

- [ X ] INSTRUCTIONS
- [ ] BLANK
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)

<table>
<thead>
<tr>
<th>DISPOSITION</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Rejected For Public Comment</td>
<td>[ ]</td>
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<tr>
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<td>[ ]</td>
</tr>
<tr>
<td>Received For Public Comment</td>
<td>[ ]</td>
</tr>
<tr>
<td>Adopted Date</td>
<td>10/22/2019</td>
</tr>
<tr>
<td>Rejected Date</td>
<td>[ X ]</td>
</tr>
<tr>
<td>Deferred Date</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Anticipated Effective Date: 1st Quarter 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

Add a Life Experience Data Contact to the Electronic Jurat page for Life/Fraternal companies only. Health, Property and Title are included in the proposal due to the Jurat instructions being uniform for all statement types.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Under the Standard Valuation Law (SVL) and supporting Valuation Manual (VM) included in each state’s laws, NAIC serves as the data collection agent for various studies of data (e.g., mortality experience data). NAIC staff need a contact person from each legal entity life insurance company to facilitate communication regarding these data studies and submission of the data to the NAIC.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: ____________________________

Other Comments: _____________________________________________

** This section must be completed on all forms.

© 2019 National Association of Insurance Commissioners 1
ANNUAL AND QUARTERLY INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

JURAT PAGE

Detail Eliminated to Conserve Space

To be filed in electronic format only:

Detail Eliminated to Conserve Space

Life Insurance Policy Locator Contact (Not applicable to Property and Title companies)

Name
List person able to respond to calls regarding locating policies on lost or forgotten life insurance policies.

Address
May be a P.O. Box and the associated ZIP code.

Telephone Number
Telephone number should include area code and extension.

Email Address
Email address of the policy locator contact person as described above.

Life Experience Data Contact (Life/Fraternal companies only)

Name
List the name of the person able to facilitate communication regarding submission of company experience data to the NAIC (e.g., mortality experience data) as required by the Standard Valuation Law (SVL) and its supporting Valuation Manual (VM) included in each state’s laws.

Address
May be a P.O. Box and the associated ZIP code.

Telephone Number
Telephone number should include area code and extension.

Email Address
Email address of the life experience data contact person as described above.
Blanks (E) Working Group  
Editorial Revisions to the Blanks and Instructions  
*presented at the October 22, 2019, Meeting*  

Statement Type:  
H = Health; L/F = Life/Fraternal Combined; P/C = Property/Casualty; SA = Separate Accounts; T = Title

<table>
<thead>
<tr>
<th>Effective</th>
<th>Table Name</th>
<th>Description</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>General Interrogatories, Part 2</td>
<td><strong>CHANGE TO BLANK</strong></td>
<td>L/F</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The options for answering Questions 32.1 and 32.2 are reversed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>32.1 should be Yes or No.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>32.2 should be Yes, No or N/A.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>Notes to Financial Statement</td>
<td><strong>CHANGE TO INSTRUCTIONS</strong></td>
<td>H, L/F, P/C, T</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Change the Schedule DB, Part E column reference in Note 8B(2)b crosscheck in the illustration.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Total Deferred Balance * ...</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Should agree to Column 4819 of Schedule DB, Part E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>Schedule DB, Part E</td>
<td><strong>CHANGE TO BLANK</strong></td>
<td>H, L/F, P/C, T, SA</td>
<td>Annual, Quarterly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Column 9, Total Line should be XXX.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Change to Instructions

Add new Administrative Symbols to the List.

**Column 6** — NAIC Designation and Administrative Symbol

Provide the appropriate NAIC designation (1 through 6) and administrative symbol combination for each security. The list of valid administrative symbols is shown below.

The listing of valid NAIC designation and administrative symbol combinations can be found on the NAIC's website for the Securities Valuation Office (www.naic.org/svo.htm).

For Bond Mutual Funds – as identified by the SVO, enter 1.

Following are valid administrative symbols for bonds. Refer to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for the application of these symbols.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Additional or other non-payment risk</td>
</tr>
<tr>
<td>SYE</td>
<td>Additional or other non-payment risk - Year-end carry over</td>
</tr>
<tr>
<td>FE</td>
<td>Filing Exempt</td>
</tr>
<tr>
<td>FM</td>
<td>Financially Modeled RMBS/CMBS subject to SSAP 43R</td>
</tr>
<tr>
<td>YE</td>
<td>Year-end carry over</td>
</tr>
<tr>
<td>IF</td>
<td>Initial filing</td>
</tr>
<tr>
<td>PL</td>
<td>Private Letter Rating</td>
</tr>
<tr>
<td>PLGI</td>
<td>Private Letter Rating – reported on General Interrogatory</td>
</tr>
<tr>
<td>RT</td>
<td>Regulatory Transaction</td>
</tr>
<tr>
<td>RTS</td>
<td>Regulatory Transaction - SVO Reviewed</td>
</tr>
<tr>
<td>RTIF</td>
<td>Regulatory Transaction - Initial Filing Submitted to SVO</td>
</tr>
<tr>
<td>RTSYE</td>
<td>Regulatory Transaction - SVO Reviewed - Year-end carry over</td>
</tr>
<tr>
<td>Z</td>
<td>Insurer self-designated</td>
</tr>
<tr>
<td>GI</td>
<td>General Interrogatory</td>
</tr>
<tr>
<td>F</td>
<td>Sub-paragraph D Company – insurer self-designated</td>
</tr>
<tr>
<td>*</td>
<td>Limited to NAIC Designations 6</td>
</tr>
<tr>
<td>Effective</td>
<td>Table Name</td>
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<tr>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>2019</td>
<td>Schedule D, Part 2, Section 1</td>
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<tr>
<td>2019</td>
<td>Schedule BA, Part 1</td>
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<td>Effective</td>
<td>Table Name</td>
</tr>
<tr>
<td>-----------</td>
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<td>2020</td>
<td>Schedule D, Part 3</td>
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<td>Effective</td>
<td>Table Name</td>
</tr>
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<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>GI</td>
<td>General Interrogatory</td>
</tr>
<tr>
<td>F</td>
<td>Sub-paragraph D Company – insurer self-designated</td>
</tr>
<tr>
<td>*</td>
<td>Limited to NAIC Designations 6</td>
</tr>
</tbody>
</table>

Preferred Stock:

Following are valid administrative symbols for preferred stock. Refer to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for the application of these symbols.

- **S**: Additional or other non-payment risk
- **SYE**: Additional or other non-payment risk - Year-end carry over
- **FE**: Filing Exempt
- **YE**: Year-end carry over
- **IF**: Initial filing
- **PL**: Private Letter Rating
- **PLGI**: Private Letter Rating – General Interrogatory
- **RT**: Regulatory Transaction
- **RTS**: Regulatory Transaction - SVO Reviewed
- **RTIF**: Regulatory Transaction - Initial Filing Submitted to SVO
- **RTSYE**: Regulatory Transaction - SVO Reviewed - Year-end carry over
- **Z**: Insurer self-designated
- **GI**: General Interrogatory
- **F**: Sub-paragraph D Company – insurer self-designated
- *****: Limited to NAIC Designations 6

Common Stock:

For securities reported on Line 9499999 (Mutual Funds) provide the appropriate NAIC designation (1 through 6) as assigned by the Securities Valuation Office. For all other common stock, the NAIC designation and administrative symbol field should be left blank.
<table>
<thead>
<tr>
<th>Effective</th>
<th>Table Name</th>
<th>Description</th>
<th>Statement Type</th>
<th>Filing Type</th>
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</thead>
<tbody>
<tr>
<td>2020</td>
<td>Schedule D, Part 4</td>
<td>CHANGE TO INSTRUCTIONS</td>
<td>H, L/F, P/C, T</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

Add new Administrative Symbols to the List.

Column 22 – NAIC Designation and Administrative Symbol

Provide the appropriate combination of the NAIC designation (1 through 6) and administrative symbol (see below) at date of disposal for each security shown. The list of valid administrative symbols is shown below. Where multiple disposal transactions occurred for the same CUSIP, and those transactions are summarized on one line, enter the appropriate combination of NAIC designation and administrative symbol for the last disposal using the last available designation.

The listing of valid NAIC designation and administrative symbol combinations can be found on the NAIC’s website for the Securities Valuation Office (www.naic.org/svo.htm).

Long Term Bond:

For Bond Mutual Funds – as Identified by the SVO, enter 1.

Exchange Traded Funds – as Identified by the SVO should be reported as perpetual securities.

Following are valid administrative symbols for bonds. Refer to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for the application of these symbols:

- **S** Additional or other non-payment risk
- **YPE** Additional or other non-payment risk - Year-end carry over
- **FE** Filing Exempt
- **FM** Financially Modeled RMBS/CMBs subject to SSAP 43R
- **YE** Year-end carry over
- **IF** Initial filing
- **PL** Private Letter Rating
- **PLGI** Private Letter Rating – General Interrogatory
- **RT** Regulatory Transaction
- **RTS** Regulatory Transaction - SVO Reviewed
<table>
<thead>
<tr>
<th>Effective</th>
<th>Table Name</th>
<th>Description</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTIF</td>
<td>Regulatory Transaction - Initial Filing Submitted to SVO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTSYE</td>
<td>Regulatory Transaction - SVO Reviewed - Year-end carry over</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z</td>
<td>Insurer self-designated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GI</td>
<td>General Interrogatory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Sub-paragraph D Company – insurer self-designated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*</td>
<td>Limited to NAIC Designations 6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Preferred Stock:

Following are valid administrative symbols for preferred stock.

- **S**: Additional or other non-payment risk
- **SYE**: Additional or other non-payment risk - Year-end carry over
- **FE**: Filing Exempt
- **YE**: Year-end carry over
- **IF**: Initial filing
- **PL**: Private Letter Rating
- **PLGI**: Private Letter Rating – General Interrogatory
- **RT**: Regulatory Transaction
- **RTS**: Regulatory Transaction - SVO Reviewed
- **RTIF**: Regulatory Transaction - Initial Filing Submitted to SVO
- **RTSYE**: Regulatory Transaction - SVO Reviewed - Year-end carry over
- **Z**: Insurer self-designated
- **GI**: General Interrogatory
- **F**: Sub-paragraph D Company – insurer self-designated
- *****: Limited to NAIC Designations 6

Common Stock:

For securities reported on Line 9499999 (Mutual Funds) provide the appropriate NAIC designation (1 through 6) as assigned by the Securities Valuation Office. For all other common stock, the NAIC designation and administrative symbol field should be left blank.
<table>
<thead>
<tr>
<th>Effective</th>
<th>Table Name</th>
<th>Description</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
</table>
| 2020      | Schedule BA, Part 2 | **CHANGE TO INSTRUCTIONS**  
Add new Administrative Symbols to the List.  
Column 6 – NAIC Designation and Administrative Symbol  
This column must be completed for those investments included on Lines 0799999 and 1599999.  
For Schedule BA investments with the underlying characteristics of a bond or a preferred stock instrument, insert the appropriate combination of the NAIC designation (1 through 6) and administrative symbol. The list of valid administrative symbols is shown below.  
The listing of valid NAIC designation and administrative symbol combinations can be found on the NAIC’s website for the Securities Valuation Office (www.naic.org/svo.htm).  
Following are valid administrative symbols for bonds and preferred stock. Refer to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for the application of these symbols.  
S Additional or other non-payment risk  
SYE Additional or other non-payment risk - Year-end carry over  
YE Year-end carry over  
FE Filing Exempt  
RT Regulatory Transaction  
RTS Regulatory Transaction - SVO Reviewed  
RTIF Regulatory Transaction - Initial Filing Submitted to SVO  
RTSYE Regulatory Transaction - SVO Reviewed - Year-end carry over  
F Sub-paragraph D Company – insurer self-designated  
The NAIC designation and administrative symbol field should be left blank for those Schedule BA investments which have not been assigned an NAIC designation by the Securities Valuation Office (SVO) pursuant to the policies in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*. |
|           |                  | H, L/F, P/C, T | Quarterly |

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NAIC Proceedings – Fall 2019
Accounting Practices and Procedures (F) Task Force
Attachment Two-G
10-477
12/8/19
The Accounting Practices and Procedures (E) Task Force met via conference call, Aug. 22, 2019. The following Task Force members participated: Kent Sullivan, Chair, represented by Jamie Walker (TX); Jeff Rude, Vice Chair, represented by Linda Johnson (WY); Jim L. Ridling represented by Richard Ford and Sheila Travis (AL); Allen W. Kerr represented by Mel Anderson (AR); Ricardo Lara represented by Kim Hudson and Susan Bernard (CA); Andrew N. Mais represented by William Arfanis and Wanchin Chou (CT); Trinidad Navarro represented by Tom Hudson and Rylynn Brown (DE); David Altmaier represented by Robert Ridenour (FL); Dafne M. Shimizu represented by Alice Cruz (GU); Doug Ommen represented by Daniel Mathis and Jim Armstrong (IA); Stephen W. Robertson represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Nancy G. Atkins represented by Sandy Batts (KY); James J. Donelon represented by Rich Piazza and Stewart Guerin (LA); Gary Anderson represented by John Turchi (MA); Eric A. Cioppa represented by Vanessa Sullivan (ME); Anita G. Fox represented by Judy Weaver (MI); Steve Kelley represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by Debbie Doggett (MO); Mike Chaney represented by David Browning (MS); Jon Godfread represented by Matt Fischer (ND); Bruce R. Ramge represented by Justin Schrader and Lindsay Crawford (NE); John Elias represented by Doug Bartlett and Patricia Gosselin (NH); Marlene Caride represented by Steve Kerner (NJ); John G. Franchini represented by Letatrice Geckler (NM); Linda A. Lacewell represented by Christine Graiton (NY); Jillian Froment represented by Dale Bruggeman (OH); Glen Mulready represented by Joel Sander (OK); Jessica Altman represented by Joe DiMemmo (PA); Larry Deiter represented by Johanna Nickelson (SD); Carter Lawrence represented by Hui Wattanaskolpant (TN); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by David Smith and Doug Stolte (VA); Mark Afable represented by Amy Malm (WI); and James A. Dodrill represented by Jamie Taylor (WV).

1. **Adopted its 2020 Proposed Charges**

Ms. Walker directed the Task Force to the 2020 proposed charges of the Task Force and its working groups which were exposed at the Summer National Meeting. Robin Marcotte (NAIC) stated that the charges of Blanks (E) Working Group and the Task Force are proposed to remain unchanged. She stated that three of the Statutory Accounting Principles (E) Working Group charges, which were recommended to the Financial Condition (E) Committee by the Variable Annuities Issues (E) Working Group, are proposed for deletion. She stated that one of the charges proposed for deletion was completed with the adoption of Statement of Statutory Accounting Principle (SSAP) No. 108—Derivatives Hedging Variable Annuity Guarantees effective Jan. 1, 2020, with early adoption Jan. 1, 2019, permitted. She stated that a second charge to develop a change in valuation basis guidance for the implementation of the Variable Annuities (VA) Framework was completed with the change in valuation basis guidance, which was added to SSAP No. 51R—Life Contracts, which specifically notes Actuarial Guideline XLIII—CARVM for Variable Annuities (AG 43).

Ms. Marcotte stated that the Statutory Accounting Principles (E) Working Group has recommended to the Task Force that the charge to develop a model guideline to exceed state investment limitations for hedges be deleted. She stated that after a review of annual statement information on the extent of derivative investments, the Working Group does not believe such a model guideline is necessary. She stated that no comments were received by the Task Force on the exposed charges; therefore, the exposed charges are recommended for adoption.

Mr. Garn made a motion, seconded by Mr. Bruggeman, to adopt the Task Force’s 2020 proposed charges (see NAIC Proceedings – Fall 2019, Financial Condition (E) Committee, Attachment One-A)


Mr. Garn stated that the Blanks (E) Working Group met Aug. 20. He stated that the Working Group adopted its July 2 and June 24 minutes (Note that the actions from those meetings were adopted by the Task Force at the Summer National Meeting). He stated that the Working Group adopted the following two previously exposed proposals:
a. 2019-18BWG – Add an NAIC Designation Modifier to the “NAIC Designation” column for Schedule D, Schedule DL and Schedule BA to accommodate the NAIC Designation Category granularity framework adopted by the Valuation of Securities (E) Task Force with an annual 2020 effective date.

b. 2019-20BWG – Add “Qualification Documentation” to the Property and Casualty Actuarial Opinion instructions, as requested by the Casualty Actuarial and Statistical (C) Task Force and the Executive (EX) Committee, requiring the Appointed Actuary to maintain workpapers explaining how the actuary meets the definition of “Qualified Actuary.” The proposal provides a new objective definition of “Qualified Actuary” and the results of an assessment of actuarial educational syllabi in an “Accepted Actuarial Designation” section. The changes of the Task Force were adopted on June 11, and the additional changes were adopted by the Executive (EX) Committee on June 25.

Mr. Garn stated that proposal 2019-19BWG on unaffiliated certificates of deposit was withdrawn to allow NAIC staff to work with industry on a new proposal in the future. He said the Working Group deferred revisions to its procedures to allow for future discussion.

Mr. Garn said the Working Group exposed three proposals for a public comment period ending Oct. 8, and it adopted the editorial listing.

Mr. Garn stated that agenda item 2019-20BWG on the actuarial qualifications was adopted, but it was adopted with four no votes and one abstention during the Working Group’s Aug. 20 conference call. Ms. Walker stated that given that proposal 2019-20BWG on the actuarial qualification documentation had a split vote and some discussion during the Working Group’s Aug. 20 call, the Task Force will take a separate vote on that item.

Mr. Garn made a motion, seconded by Mr. Hudson to adopt the report of the Blanks (E) Working Group except for agenda item 2019-20BWG which would have a separate vote (Attachment Three-A).

3. Adopted Agenda Item 2019-20BWG

Ms. Walker called on Mr. Piazza, Chief Actuary in Louisiana, to introduce the proposal. Mr. Piazza noted that he previously chaired the Casualty Actuarial and Statistical (C) Task Force for seven years and vice-chaired it for three years. He noted that the proposed change to the Property/Casualty (P/C) Instructions sets forth a workable, objective and principle-based definition of a P/C qualified actuary, and it recognizes the Society of Actuaries’ (SOA) general insurance track, along with the Casualty Actuarial Society (CAS), as meeting the minimum basic education requirement for a qualified actuary.

Mr. Piazza said key elements of the proposal include that it provides guidance developed with a consultant to objectively define the qualified actuary and be transparent about what state insurance regulators want from an appointed actuary. He stated that the role of the appointed actuary is probably the most important role actuaries serve in the state insurance regulator’s eyes. He said state insurance regulators that review reserve adequacy for company solvency in order to protect the interests of their state’s consumers rely heavily upon the accuracy of the appointed actuary’s reserve assessment and information contained in the appointed actuary’s Statement of Actuarial Opinion (SAO). Mr. Piazza said the proposal adds the definition of qualified actuary which retains the CAS designations and adds the SOA general insurance track.

Mr. Piazza said the proposal also adds that the qualification documentation is the primary addition to the instructions. He said the documentation under existing qualification requirements should already exist, and it should not be a burden to any actuary. He stated that the proposal includes what is called qualification documentation, which effectively pulls together an actuary’s resumé and already required continuing education documentation as a workpaper so state insurance regulators can view that information if they wish and companies can use it in their governance review of the appointed actuary.

Mr. Piazza said the proposal has an effective date of year-end 2019, and the effective date was agreed to by all three actuarial organizations. He noted that the proposal has little impact on any actuary currently appointed, and all former Appointed Actuaries remain “qualified” under the new definition, with the only impact being that they have to document their qualifications.

Mr. Piazza then noted that he would be providing background on the project that led to the proposal. He said the project began almost seven years ago with the Casualty Actuarial and Statistical (C) Task Force, and it has been proceeding almost non-stop
since then. He said the Task Force was asked to evaluate the SOA’s general insurance track and determine if it should be accepted by state insurance regulators, just as the CAS’s membership is accepted. He stated that both of these organizations have been educating, testing and credentialing actuaries for decades, if not the past century, and both are really good at what they do for the actuarial profession.

Mr. Piazza noted that when the Casualty Actuarial and Statistical (C) Task Force was first asked to determine if the SOA’s general insurance track met minimum basic education expectations, there was no established standard to compare an education track against. He said there was some reluctance among the three actuarial organizations to take a direct role in creating an education standard suitable for a minimum basic education evaluation. He said the American Academy of Actuaries (Academy) was asked and declined to undertake the project, though it did say it would change its qualification requirements in accordance with revised instructions from the state insurance regulators. He said that this is why the Task Force took on this task itself.

Mr. Piazza noted that the Casualty Actuarial and Statistical (C) Task Force was a divided group, discussing at least four ways to tackle this task on how to address the SOA’s general insurance track with respect to the qualified actuary, but it could not reach an agreement on a path forward. He said after many open discussions, the Task Force requested outside help. He said the request went up to the Property and Casualty Insurance (C) Committee and then up to the Executive (EX) Committee. He said the Executive (EX) Committee first hired a consultant with the goal of evaluating whether any actuarial educational track meets industry standards to produce qualified actuaries.

Mr. Piazza noted that the consultant was asked to guide subject matter experts to define what an appointed actuary should know and do to be an appointed actuary. He said this set the basis for the educational standards developed by expert actuaries and began the work requested by the Executive (EX) Committee to develop an objective qualified actuary definition. He noted that 30 subject matter experts nominated by the three actuarial organizations to inform the consultant and the entire process. He said this project resulted in the proposal which defines a qualified actuary and recognizes the SOA’s track as meeting the minimum basic education requirement.

Mr. Piazza stated that the work starting seven years ago through today has not been performed in a vacuum, and the proposed instruction changes were vetted many times since the beginning of this project. He said in the past year-and-a-half, there were four exposures and one hearing. He noted that input was considered from interested parties, the Casualty Actuarial and Statistical (C) Task Force, and commissioners themselves. He noted that similar to other large, multi-faceted NAIC projects, there was a bit of compromise in the development of the proposal before you, and not all participants in the development process are 100% satisfied with the result. He said there was consensus by the respective groups.

Mr. Piazza stated that the commissioners at different levels discussed this proposal, and policy decisions were made culminating in a request from the Executive (EX) Committee for the Blanks (E) Working Group to implement the proposal before you. The proposal passed from the Blanks (E) Working Group on Aug. 20. He said the proposal clearly meets the Executive (EX) Committee’s objective at the start of the project by setting forth a workable, objective and principle-based “qualified actuary” definition that includes both the SOA and CAS basic education tracks found to meet the minimum basic education standard for an appointed actuary.

Mr. Chou noted appreciation for the hard work and time spent on the proposal. He indicated that his remarks were to better serve the actuarial professional for higher professional standards, and to help the insurance industry effectively, the qualified actuary proposal needs to be reviewed more and refined properly. He said it is better to be late than incomplete. He stated that the Academy worked well with volunteers from both the CAS and the SOA to provide professional standards and services for several decades. He noted that while they were not opposed to most of the good work in the proposal, there were concerns that the proposal does not mention that the Academy membership will cause some confusion in three areas.

Mr. Chou noted that excluding the requirement for Academy membership would continue inconsistency for the different annual statement blanks requirements between life, P/C and health. He noted that the P/C annual statement blank mentioned CAS membership only due to aggressive SOA merger talk. He noted that there are unresolved disagreements between the two societies on educational requirements.

Mr. Chou noted that adding a requirement to have Academy membership would not cause an issue with fees in Connecticut as all appointed actuaries are currently Academy members. He said there was not a good justification for the costs and benefits when the Executive (EX) Committee’s ad hoc group decided to delete the requirement for Academy membership.
Mr. Chou said his last point was being provided on behalf of Ralph Blanchard (Travelers) who could not be present during this conference call. He said Mr. Blanchard had concerns that omitting the requirement for Academy membership for actuaries seeking review under the exception process would add liability exposure to the Casualty Practice Council if it is the group to review non-Academy members.

Mr. Chou said the regulation responsibilities of the NAIC and the states are to regulate the insurance companies, not the professional members like actuary, account, etc. He stated that this proposal has set an unnecessary exception and practice. Mr. Bruggeman asked if the proposal includes the recommendations from the Casualty Actuarial and Statistical (C) Task Force and the Executive (EX) Committee’s ad hoc group. Mr. Piazza agreed that the proposal was a result of work from both groups. Mr. Bruggeman asked for confirmation that the Blanks (E) Working Group’s role is not policy making, but it is a group that determines the implementation of instructions for policies developed by other groups. He asked for confirmation that the Working Group’s role is the implementation of policies determined by other NAIC groups. Mr. Hudson, vice chair of the Working Group, and Mr. Garn, chair of the Working Group, both indicated that Mr. Bruggeman was correct regarding the role of the Working Group.

Ms. Walker said the term “NAIC Accepted Actuarial Designation” causes Texas some concerns because of legislative concerns about the incorporation by reference of NAIC requirements. She asked if the proposal provided the flexibility for the commissioner to approve actuaries with different requirements. Kay Noonan (NAIC) noted that her understanding of the proposal sets out a definition of a qualified actuary, but it also includes the ability for the insurance commissioner to approve other actuarial qualifications or requirements. She noted that originally, there was one educational track, but once there were two tracks, it was necessary to evaluate to ensure that both met minimum qualifications. Ms. Noonan stated that while this proposal was being developed, having NAIC in the title of the term did not receive much discussion that she was aware of. She noted that the NAIC was not necessary to the term name. She noted that the state insurance regulators would apply the standard and have the ability to accept a different actuarial educational track. Ms. Walker asked if modifying the term name would cause any concerns. Ms. Noonan stated the instructions include the requirements, and the terminology name would not change the requirements.

Mr. Chou asked if the Casualty Actuarial and Statistical (C) Task Force could consider a future discussion on the topic of the actuarial qualification instructions and the groups. Mr. Piazza noted that discussion on the requirements could occur with the Casualty Actuarial and Statistical (C) Task Force in the future if determined necessary. Mr. Piazza noted that he did not expect the Executive (EX) Committee’s ad hoc group to necessarily be involved in the future as the primary project that involved the Executive (EX) Committee would be complete. Ms. Noonan agreed that the Executive (EX) Committee was involved because of the request for assistance and the request to hire a supervisor. She noted that if the Task Force believes there are issues that need to be addressed in the future, the discussion would start at the Task Force, and it would not typically involve the Executive (EX) Committee unless there was a request for assistance. Ms. Walker asked Mr. Piazza if a technical change to the name of the term from “NAIC Accepted Actuarial Designation” to “Accepted Actuarial Designation” would be of concern. Mr. Piazza and Mr. Wattanaskolpant agreed that the technical change to the terminology name would not be a concern as it would not change the content.

Ms. Walker said to Mr. Chou that she did not view the role of the Accounting Practices and Procedures (E) Task Force to override the policy decisions that had been discussed by the Casualty Actuarial and Statistical (C) Task Force and the Executive (EX) Committee to not include the Academy membership requirements. She said harking back to Mr. Bruggeman’s comments, she did not believe that the role of the Task Force was to override policy decisions that had been thoroughly discussed by other groups. Mr. Chou thanked Ms. Walker and noted that he would report back regarding the discussion that the issues he raised were of a policy nature rather than a technical change.

Craig Hanna (Academy) stated that the Academy noted that it fully supported the comments from Connecticut. He noted agreement that this time was not the appropriate avenue, but at the appropriate time, the Academy would further pursue the inconsistencies in the different annual statement type requirements.

Mr. Piazza made a motion, seconded by Mr. Wattanaskolpant to adopt agenda item 2019-20BWG (Attachment Three-A) with the minor revision suggested by Texas, to modify the proposal to change the name of the term in the proposal from “NAIC Accepted Actuarial Designation” to “Accepted Actuarial Designation.” The motion passed, with Connecticut and Missouri dissenting.
4. **Discussed Other Matters**

Ms. Walker announced that the Accounting Practices and Procedures (E) Task Force report will be discussed via conference call by the Financial Condition (E) Committee on Aug. 29.

Having no further business, the Accounting Practices and Procedures (E) Task Force adjourned.
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: 06/25/2019

CONTACT PERSON: Kris DeFrain

TELEPHONE: 816-783-8229

EMAIL ADDRESS: kdefrain@naic.org

ON BEHALF OF: Executive (EX) Committee and Casualty Actuarial and Statistical (C) Task Force

TITLE: 

AFFILIATION: 

ADDRESS: 

FOR NAIC USE ONLY

Agenda Item # 2019-20BWG MOD
Year 2019
Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT
No Impact [ X ]
Modifies Required Disclosure [ ]

DISPOSITION
[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 08/20/2019
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify) 

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT
[ ] QUARTERLY STATEMENT
[ ] Life, Accident & Health/Fraternal
[ X ] Property/Casualty
[ ] Health

[ X ] INSTRUCTIONS
[ ] SEPARATE ACCOUNTS
[ ] PROTECTED CELL
[ ] Health (Life Supplement)

[ ] CROSSCHECKS
[ ] Title
[ ] Other 

Anticipated Effective Date: Annual 2019

IDENTIFICATION OF ITEM(S) TO CHANGE

The Casualty Actuarial and Statistical (C) Task Force proposes addition of “Qualification Documentation” so the Appointed Actuary would be required to maintain workpapers explaining how the actuary meets the definition of “Qualified Actuary.” These proposed changes were adopted by the Task Force on June 11, 2019.

The Executive (EX) Committee proposes the remainder of the changes, including a new objective definition of “qualified actuary” and the results of an assessment of actuarial educational syllabi in a “NAIC-Accepted Actuarial Designation” section. These proposed changes were adopted by the Committee on June 25, 2019.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

There are now competing property/casualty (P/C) actuarial educational organizations and no specific standards around the minimum level of education expected for an Appointed Actuary. The proposed change is designed to avoid any potential development of lower educational standards in a competitive environment, to ensure Appointed Actuaries can be expected to have a minimum level of basic education to perform the duties of an Appointed Actuary, and to provide regulatory expectations of a profession that provides a vital service for regulators and the public by issuance of the financial statement actuarial opinion. Regulators deemed it was important, especially in the absence of any licensure of Appointed Actuaries, to develop and maintain the definition of Qualified Actuary for the purpose of being an Appointed Actuary. (Note: professional actuarial associations are still allowed to implement stricter standards or modify the referenced documents/policies.)

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**Background on the Qualified Actuary Project**

Historically in the U.S., the Casualty Actuarial Society (CAS) provided actuarial education for property and casualty (P/C) actuaries. The NAIC’s definition of a qualified actuary to be eligible to be an Appointed Actuary currently includes membership in the CAS as a core requirement. When the Society of Actuaries (SOA) introduced a general insurance (GI—aka P/C) actuarial educational track, the SOA asked the NAIC to also include a Fellow of the Society of Actuaries (SOA) who had successfully completed the SOA GI track in the qualified actuary definition.

The Casualty Actuarial and Statistical (C) Task Force was first asked to evaluate the SOA’s GI track to determine if it was acceptable to be included in that definition. In 2015 the Task Force informed its parent committee, the Property and Casualty Insurance (C) Committee, of its preference to conduct an independent review of the SOA’s GI track. At the request of the Property and Casualty Insurance (C) Committee, the Executive (EX) Committee decided it would ask the NAIC to hire a consultant to conduct such a review and would assign an EX Ad Hoc Group of commissioners to oversee the project. The NAIC released the results of the consultant’s work in July 2017. The SOA’s GI track was found to lack necessary breadth and depth to meet minimum educational standards. The CAS membership was found acceptable, with some question about the associateship level and whether the advanced reserving on Exam 7 should be required in addition to the ACAS designation.

Upon receiving advice from a consultant on the NAIC’s definition of a “Qualified Actuary,” the NAIC began a project to re-define a Qualified Actuary using objective criteria. At the 2017 Summer National Meeting, the Executive (EX) Committee adopted a fiscal to hire a consultant to conduct a P/C Appointed Actuary Job Analysis. The NAIC then worked with the CAS, SOA, and the Academy of Actuaries (Academy) to develop an aggressive timeline to complete the job analysis, draft educational standards, conduct assessments of the CAS and SOA syllabi, and expose/implement revised actuarial opinion instructions. All parties agreed with the timeline and plan.

The Job Analysis was completed by the NAIC and numerous subject matter experts (nominated by the CAS, SOA, and Academy). The NAIC’s P/C Appointed Actuary Job Analysis Project resulted in documentation of knowledge statements, or what an Appointed Actuary needs to know and do for the P/C Appointed Actuary job. Following the job analysis, the NAIC’s P/C Educational Standards and Assessment Project resulted in documentation of which elements in each knowledge statement should be included in basic education as a minimum standard, with the remaining elements achievable through experience or continuing education. Using the minimum educational standards, the NAIC and subject matter experts assessed the CAS and SOA syllabi and reading materials. The CAS and SOA have made or agreed to make specific changes to their syllabi and/or reading materials to meet these minimum standards. The revised syllabi and reference materials are required to be in place by Jan. 1, 2021.

On May 31, 2019, the NAIC finalized the assessments of the CAS and SOA. With mutual agreement to make a few additional changes to syllabi, the following designations with particular exam requirements were recommended to be accepted by the NAIC:

- FCAS with successful completion of Exam 6-US
- ACAS with successful completion of Exam 6-US and Exam 7
- FSA with successful completion of the general insurance track, including the Financial and Regulatory Environment-U.S. Exam and the Advanced Topics in General Insurance Exam.

The exam requirements were added to meet the minimum educational standards when there are choices of examination. For example, both organizations have or will offer non-US regulatory and statutory accounting exams. The new definition requires the Appointed Actuary to have successfully completed the U.S. regulatory exam. In response to comments made, allowable substitutions for specific exams were added (e.g., having passed a U.S. regulatory exam under an old syllabi) and the Grandfathering clause was replaced with allowable substitutions. The desired impact is that the NAIC would not retroactively change requirements for Appointed Actuaries. However, the instructions include additional documentation that is required if an actuary previously met the 2018 qualified actuary definition but lacks the specific exams and/or tracks under the new definition. The table of substitutions was discussed with both the CAS and SOA and agreed upon prior to adoption.

Concurrently, the EX Ad Hoc Group drafted a revised definition of Qualified Actuary to be eligible to become a P/C Appointed Actuary in instructions for the P/C Statement of Actuarial Opinion. Instructions were exposed Dec. 2017, September 2018, December 2018, and May 2019 for public comment. A public hearing was conducted on March 22, 2019.
As a result of these NAIC projects, the definition of “Qualified Actuary” was crafted to include education requirements, experience requirements, and professionalism requirements (e.g. application of U.S. Qualification Standards, Code of Conduct, and Actuarial Board of Counseling and Discipline—ABCD). The definition of Qualified Actuary replaces the requirement to be “a member in good standing of the Casualty Actuarial Society” with a requirement to obtain and maintain an “NAIC-Accepted Actuarial Designation.” An NAIC-Accepted Actuarial Organization is one that was assessed by the NAIC to meet the NAIC’s minimum educational standards for an Appointed Actuary. Continued membership in either the CAS or SOA would be required for two reasons: 1) professionalism requirements, counseling, and discipline would be applied by these actuarial organizations and 2) the CAS and SOA have an audit process to evaluate actuarial qualifications regarding Continuing Education (CE) (which the Academy does not).

The 2018 definition of qualified actuary does not require a P/C Appointed Actuary to be a member of the Academy and there has not been such a requirement since the P/C actuarial opinion was first established. (There is mention of Academy membership in current instructions, but that is limited to a rare exception whereby the Appointed Actuary does not meet the definition of Qualified Actuary in the instructions and has been evaluated by the Academy.)

Through comment letters and oral testimony, the Academy suggested that the (iii) in the definition of Qualified Actuary could be modified to require Academy membership. The Executive (EX) Committee at its June 25th meeting, on the recommendation of the EX Ad Hoc Group, agreed that the Academy’s new proposal for mandatory membership is not necessary for the P/C Appointed Actuary.

The following describes the professionalism requirements for U.S. P/C Appointed Actuaries today:

1) All professionalism standards established by the Actuarial Standards Board (ASB) are required and the Actuarial Board of Counseling and Discipline (ABCD) is applicable for all CAS and SOA members;
2) The ASB and ABCD are included in the Academy’s corporate structure but one does not have to be an Academy member for professionalism requirements to apply; and
3) All U.S. P/C Appointed Actuaries pay dues to support the ASB and the ABCD, whether or not a member of the Academy.

The EX Ad Hoc Group sent a May 10, 2019, letter to the Academy explaining its reasoning for the proposal to not add an Academy membership requirement:

Regulators recognize the value in Academy membership, as well as the Academy’s contributions to the NAIC and the entire actuarial profession. However, we are not adding Academy membership to the Statement of Actuarial Opinion instructions as a requirement. Membership in the Academy does not guaranty that an Appointed Actuary receives any license, has participated in the Appointed Actuary opinion writing seminar, has participated in any particular Academy training, nor has been certified as being qualified. If the actuary chooses not to participate in Academy activities, such abstention does not compromise the qualification of that actuary. Our conclusion is that regulators cannot derive any significant additional information about an Appointed Actuary’s qualifications, experience, or knowledge from Academy membership beyond what they already know about the actuary that holds one of the new NAIC-Accepted Actuarial Designations.

We also did not add the membership in the Academy as a requirement for review by the Academy’s Casualty Practice Council. The Academy may establish that as a requirement, just as they may charge a fee or require particular documentation even if it is not in the instructions.

The NAIC process requires a recurring assessment every 5-10 years. The process to develop standards and assess the CAS and SOA has not impacted state regulators who did not volunteer to undertake the development and assessment. Regulators may continue to employ similar processes in future years without impact to non-volunteer states.

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** NAIC STAFF COMMENTS **

Comment on Effective Reporting Date:________________________________________

Other Comments:


** This section must be completed on all forms. **

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ACTUARIAL OPINION

1. There is to be included with or attached to Page 1 of the Annual Statement the statement of a Qualified Appointed Actuary, entitled “Statement of Actuarial Opinion” (Actuarial Opinion), setting forth his or her opinion relating to reserves specified in the SCOPE paragraph. The Actuarial Opinion, both the narrative and required Exhibits, shall be in the format of and contain the information required by this section of the Annual Statement Instructions – Property and Casualty.

Upon initial engagement, the Qualified Appointed Actuary must be appointed by the Board of Directors by Dec. 31 of the calendar year for which the opinion is rendered. The Company shall notify the domiciliary commissioner within five business days of the initial appointment with the following information:

a. Name and title (and, in the case of a consulting actuary, the name of the firm).

b. Manner of appointment of the Appointed Actuary (e.g., who made the appointment and when).

c. A statement that the person meets the requirements of a Qualified Actuary (or was approved by the domiciliary commissioner) and that documentation was provided to the Board of Directors.

Once this notification is furnished, no further notice is required with respect to this person unless the Board of Directors takes action to no longer appoint or retain the actuary or the actuary no longer meets the requirements of a Qualified Actuary.

The Appointed Actuary shall provide to the Board of Directors qualification documentation on occasion of their appointment, and on an annual basis thereafter, directly or through company management. The documentation should include brief biographical information and a description of how the definition of “Qualified Actuary” is met or expected to be met (in the case of continuing education) for that year. The documentation should describe the Appointed Actuary’s responsible experience relevant to the subject of the Actuarial Opinion. The Board of Directors shall document the company’s review of those materials and any other information they may deem relevant, including information that may be requested directly from the Appointed Actuary. The qualification documentation shall be considered workpapers and be available for inspection upon regulator request or during a financial examination.

If an actuary who was the Appointed Actuary for the immediately preceding filed Actuarial Opinion is replaced by an action of the Board of Directors, the Insurer shall within five (5) business days notify the Insurance Department of the state of domicile of this event. The Insurer shall also furnish the domiciliary commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former Appointed Actuary regarding the content of the opinion on matters of the risk of material adverse deviation, required disclosures, scope, procedures, type of opinion issued, substantive wording of the opinion or data quality. The disagreements required to be reported in response to this paragraph include both those resolved to the former Appointed Actuary’s satisfaction and those not resolved to the former Appointed Actuary’s satisfaction. The letter should include a description of the disagreement and the nature of its resolution (or that it was not resolved). Within this same ten (10) business days, the Insurer shall in writing also request such former Appointed Actuary to furnish a letter addressed to the Insurer stating whether the Appointed Actuary agrees with the statements contained in the Insurer’s letter and, if not, stating the reasons for which he or she does not agree. The former Appointed Actuary shall provide a written response to the insurer within ten (10) business days of such request, and the Insurer shall furnish such responsive letter from the former Appointed Actuary to the domiciliary commissioner together with its own responses.

The Appointed Actuary must report to the Board of Directors each year on the items within the scope of the Actuarial Opinion. The Actuarial Opinion and the Actuarial Report must be made available to the Board of Directors. The minutes of the Board of Directors should indicate that the Appointed Actuary has presented such information to the Board of Directors and identify the manner of presentation (e.g., webinar, in-person presentation, written). A separate Actuarial Opinion is required for each company filing an Annual Statement. When there is an affiliated company pooling arrangement, one Actuarial Report for the aggregate pool is sufficient, but there must be addendums to the Actuarial Report to cover non-pooled reserves for individual companies.
The Actuarial Opinion and the supporting Actuarial Report and workpapers should be consistent with the appropriate Actuarial Standards of Practice (ASOPs), including, but not limited to, ASOP No. 23, ASOP No. 36, ASOP No. 41 and ASOP No. 43, as promulgated by the Actuarial Standards Board, and Statements of Principles adopted by the Casualty Actuarial Society.

1A. Definitions

“Appointed Actuary” for purposes of these instructions is a Qualified Actuary (or individual otherwise approved by the domiciliary commissioner) appointed by the Board of Directors in accordance with Section 1 of these instructions.

“Board of Directors” for purposes of these instructions can include the designated Board of Directors, its equivalent or an appropriate committee directly reporting to the Board of Directors.

“Qualified Actuary” is a person who:

(i) meets the basic education, experience and continuing education requirements of the Specific Qualification Standard for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement, as set forth in the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States (U.S. Qualification Standards), promulgated by the American Academy of Actuaries (Academy), and is either:

(ii) has obtained and maintains an NAIC-Accepted Actuarial Designation; and

(iii) is a member of a professional actuarial association that requires adherence to the same Code of Professional Conduct promulgated by the Academy, requires adherence to the U.S. Qualification Standards, and participates in the Actuarial Board for Counseling and Discipline when its members are practicing in the U.S.

An exception to parts (i) and (ii) of this definition would be an actuary evaluated by the Academy’s Casualty Practice Council and determined to be a Qualified Actuary for particular lines of business and business activities.

(i) A member in good standing of the Casualty Actuarial Society; or

(ii) A member in good standing of the American Academy of Actuaries who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries.

“NAIC-Accepted Actuarial Designation” in item (ii) of the definition of a Qualified Actuary, is an actuarial designation accepted by the NAIC as meeting or exceeding the NAIC’s Minimum Property/Casualty (P/C) Actuarial Educational Standards for a P/C Appointed Actuary (published on the NAIC website). The following actuarial designations, with any noted conditions, are accepted by the NAIC as meeting or exceeding basic education minimum standards:

(i) Fellow of the CAS (FCAS) – Condition: basic education must include Exam 6 – Regulation and Financial Reporting (United States);

(ii) Associate of the CAS (ACAS) – Conditions: basic education must include Exam 6 – Regulation and Financial Reporting United States) and Exam 7 – Estimation of Policy Liabilities, Insurance Company Valuation, and Enterprise Risk Management;

(iii) Fellow of the SOA (FSA) – Conditions: basic education must include completion of the general insurance track, including the following optional exams: the United States’ version of the Financial and Regulatory Environment Exam and the Advanced Topics in General Insurance Exam.
The table below provides some allowable exam substitutions for (i), (ii) and (iii) in the definition of “NAIC-Accepted Actuarial Designation.” Noting that CAS exams have changed over time, exceptions for (i) and (ii) provide for FCAS/ACAS designations achieved before an exam was created (e.g., CAS Exam 6-US) or with an earlier version of an exam or exam topic (e.g., 2010 CAS Exam 6 instead of the current CAS Exam 7 Section A). FCAS/ACAS qualified under the 2018 and prior Statement of Actuarial Opinion instructions can use the noted substitution rules to achieve qualification under the new instructions by demonstrating basic and/or continuing education of the required topics including material in CAS Exam 6 (US) and section A of CAS Exam 7 (in the May 2019 CAS syllabus). Exceptions for (iii) for an FSA are also included in the table. The SOA exams completed in the general insurance track in 2019 and prior should be supplemented with continuing education and experience to meet basic education requirements in the *U.S. Qualification Standards.* For purpose of these instructions only, the table also includes specific exams from other organizations that are accepted by the NAIC as substitutes.

<table>
<thead>
<tr>
<th>Exception for (i), (ii), or (iii)</th>
<th>Exam:</th>
<th>Exam Substitution Allowed*</th>
</tr>
</thead>
</table>
| (i) and (ii)                    | CAS Exam 6 (US) | 1. Any CAS version of a U.S. P/C statutory accounting and regulation exam administered prior to creation of the CAS Exam 6 (US) in 2011.  
2. An FCAS or ACAS earned prior to 2021 who did not pass CAS Exam 6 (US) or an allowable exam substitution, may substitute experience and/or continuing education for CAS Exam 6 (US) provided the Appointed Actuary explains in his/her qualification documentation how knowledge of U.S. financial reporting and regulation was obtained.  
3. SOA FREU (US) Exam |
| (ii)                            | CAS Exam 7 | 1. Any CAS version of an exam including advanced P/C reserving administered prior to creation of Exam 7 in 2011.  
2. An ACAS earned prior to 2021 who did not pass CAS Exam 7 or an allowable exam substitution, may substitute experience and/or continuing education for CAS Exam 7 provided the Appointed Actuary explains in his/her qualification documentation how knowledge of the additional reserving topics in CAS Exam 7 (Section A) in the May 2019 syllabus was obtained.  
3. SOA Advanced Topics Exam (Note: The ERM portion of Exam 7 is not needed to meet NAIC educational standards, therefore SOA ERM Exam is not needed for the substitution for this purpose.) |
| (iii)                           | SOA FREU (US) Exam | 1. CAS Exam 6 (US)  
| (iii)                           | SOA Advanced Topics Exam | 1. CAS Exam 7  
2. Any CAS version of an exam containing the advanced techniques to estimate policy liabilities (i.e., advanced reserving). |

*Note: These exam substitutions only apply to these instructions and are not applicable for CAS or SOA exam waivers.*
“Insurer” or “Company” means an insurer or reinsurer authorized to write property and/or casualty insurance under the laws of any state and who files on the Property and Casualty Blank.

“Actuarial Report” means a document or other presentation prepared as a formal means of conveying to the state regulatory authority and the Board of Directors the Appointed Actuary’s professional conclusions and recommendations of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the Appointed Actuary’s opinion or findings, and of documenting the analysis underlying the opinion. The required content of the Actuarial Report is further described in paragraph 7. (Note that the inclusion of the Board of Directors as part of the intended audience for the Actuarial Report does not change the content of the Actuarial Report as described in paragraph 7. The Appointed Actuary should present findings to the Board of Directors in a manner deemed suitable for such audience.)

“Property and Casualty (P&C) Long Duration Contracts” refers to contracts (excluding financial guaranty contracts, mortgage guaranty contracts and surety contracts) that fulfill both of the following conditions: (1) the contract term is greater than or equal to 13 months; and (2) the insurer can neither cancel the contract nor increase the premium during the contract term. These contracts are subject to the three tests of SSAP No. 65—Property and Casualty Contracts of the NAIC Accounting Practices and Procedures Manual.

“Accident and Health (A&H) Long Duration Contracts” refers to A&H contracts in which the contract term is greater than or equal to 13 months and contract reserves are required. See Schedule H instructions for a description of categories of contract reserves, as well as policy features that give rise to contract reserves. Two specific examples of contracts that typically require contract reserves are long-term care and disability income insurance.

1B. Exemptions

An insurer who intends to file for one of the exemptions under this Section must submit a letter of intent to its domiciliary commissioner no later than December 1 of the calendar year for which the exemption is to be claimed. The commissioner may deny the exemption prior to December 31 of the same year if he or she deems the exemption inappropriate.

A copy of the approved exemption must be filed with the Annual Statement in all jurisdictions in which the company is authorized.

Exemption for Small Companies

An insurer that has less than $1,000,000 total direct plus assumed written premiums during a calendar year, and less than $1,000,000 total direct plus assumed loss and loss adjustment expense reserves at year-end, in lieu of the Actuarial Opinion required for the calendar year, may submit an affidavit under oath of an officer of the insurer that specifies the amounts of direct plus assumed written premiums and direct plus assumed loss and loss adjustment reserves.

Exemption for Insurers under Supervision or Conservatorship

Unless ordered by the domiciliary commissioner, an insurer that is under supervision or conservatorship pursuant to statutory provision is exempt from the filing requirements contained herein.

Exemption for Nature of Business

An insurer otherwise subject to the requirement and not eligible for an exemption as enumerated above may apply to its domiciliary commissioner for an exemption based on the nature of business written.
Financial Hardship Exemption

An insurer otherwise subject to this requirement and not eligible for an exemption as enumerated above may apply to the commissioner for a financial hardship exemption. Financial hardship is presumed to exist if the projected reasonable cost of the Actuarial Opinion would exceed the lesser of:

(i) One percent (1%) of the insurer’s capital and surplus reflected in the insurer’s latest quarterly statement for the calendar year for which the exemption is sought; or

(ii) Three percent (3%) of the insurer’s direct plus assumed premiums written during the calendar year for which the exemption is sought as projected from the insurer’s latest quarterly statements filed with its domiciliary commissioner.

1C. Reporting Requirements for Pooled Companies

For each company in the pool, the Appointed Actuary shall include a description of the pool, identification of the lead company and a listing of all companies in the pool, their state of domicile and their respective pooling percentages.

Exhibits A and B for each company in the pool should represent the company’s share of the pool and should reconcile to the financial statement for that company.

The following paragraph applies to companies that have a 0% share of the pool (no reported Schedule P data). The company shall submit an Actuarial Opinion that reads similar to that provided for the lead company. For example, the IRIS ratio and risk of material adverse deviation discussions, and other relevant comments shall relate to the risks of the lead company in the pool. The Exhibit B responses to question 5 should be $0 and to question 6 should be “not applicable.” Exhibits A and B of the lead company should be attached as an addendum to the PDF file and/or hard copy being filed (but would not be reported by the 0% companies in their data capture).

2. The Actuarial Opinion must consist of an IDENTIFICATION paragraph identifying the Appointed Actuary; a SCOPE paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the Appointed Actuary’s work; an OPINION paragraph expressing his or her opinion with respect to such subjects; and one or more additional RELEVANT COMMENTS paragraphs. These four sections must be clearly designated.

3. The IDENTIFICATION paragraph should indicate the Appointed Actuary’s relationship to the Company, qualifications for acting as Appointed Actuary, and date of appointment, and specify that the appointment was made by the Board of Directors.

If the Appointed Actuary was approved by the Academy to be a “Qualified Actuary,” with or without limitation, or if the Appointed Actuary is not a Qualified Actuary but was approved by the domiciliary commissioner, the company must attach, each year, the approval letter and reference such in the identification paragraph.

A member of the American Academy of Actuaries qualifying under paragraph 1A(ii) must attach, each year, a copy of the approval letter from the Academy.

These Instructions require that a Qualified Actuary prepare the Actuarial Opinion. Nevertheless, if a person who does not meet the definition of a Qualified Actuary has been approved by the insurance regulatory official of the domiciliary state, the Company must attach, each year, a letter from that official stating that the individual meets the state’s requirements for rendering the Actuarial Opinion.
4. The SCOPE paragraph should contain a sentence such as the following:

“I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 20__, and reviewed information provided to me through XXX date.”

Exhibit A should list those items and amounts with respect to which the Appointed Actuary is expressing an opinion.

The Appointed Actuary should state that the items in the SCOPE, on which he or she is expressing an opinion, reflect Disclosure items 8 through 13.2 in Exhibit B.

The SCOPE paragraph should include a paragraph such as the following regarding the data used by the Appointed Actuary in forming the opinion:

“In forming my opinion on the loss and loss adjustment expense reserves, I relied upon data prepared by __________ (officer name and title at the Company). I evaluated that data for reasonableness and consistency. I also reconciled that data to Schedule P, Part 1 of the Company’s current Annual Statement. In other respects, my examination included such review of the actuarial assumptions and methods used and such tests of the calculations as I considered necessary.”

5. The OPINION paragraph should include a sentence that at least covers the points listed in the following illustration:

“In my opinion, the amounts carried in Exhibit A on account of the items identified:

A. Meet the requirements of the insurance laws of (state of domicile).

B. Are computed in accordance with accepted actuarial standards and principles.

C. Make a reasonable provision for all unpaid loss and loss adjustment expense obligations of the Company under the terms of its contracts and agreements.”

If the Scope includes material Unearned Premium Reserves for P&C Long Duration Contracts or Other Loss Reserve items on which the Appointed Actuary is expressing an opinion, the Actuarial Opinion should contain language such as the following:

D. Make a reasonable provision for the unearned premium reserves for P&C Long Duration Contracts and/or <insert Other Loss Reserve item on which the Appointed Actuary is expressing an Opinion> of the Company under the terms of its contracts and agreements.

If there is any aggregation or combination of items in Exhibit A, the opinion language should clearly identify the combined items.

Insurance laws and regulations shall at all times take precedence over the actuarial standards and principles.

If the Appointed Actuary has made use of the analysis of another actuary not within the Appointed Actuary’s control (such as for pools and associations, for a subsidiary or for special lines of business) for a material portion of the reserves, the other actuary must be identified by name, credential and affiliation within the OPINION paragraph. If the Appointed Actuary has made use of the work of a non-actuary (such as for modeling) for a material portion of the reserves, that individual must be identified by name and affiliation and a description of the type of analysis performed must be provided.
A Statement of Actuarial Opinion should be made in accordance with one of the following sections (1 through 5). The Appointed Actuary must explicitly identify in Exhibit B which type applies.

1. **Determination of Reasonable Provision.** When the carried reserve amount is within the Appointed Actuary’s range of reasonable reserve estimates, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount makes a reasonable provision for the liabilities associated with the specified reserves.

2. **Determination of Deficient or Inadequate Provision.** When the carried reserve amount is less than the minimum amount that the Appointed Actuary believes is reasonable, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves. In addition, the Appointed Actuary should disclose the minimum amount that the Appointed Actuary believes is reasonable.

3. **Determination of Redundant or Excessive Provision.** When the carried reserve amount is greater than the maximum amount that the Appointed Actuary believes is reasonable, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves. In addition, the Appointed Actuary should disclose the maximum amount that the Appointed Actuary believes is reasonable.

4. **Qualified Opinion.** When, in the Appointed Actuary’s opinion, the reserves for a certain item or items are in question because they cannot be reasonably estimated or the Appointed Actuary is unable to render an opinion on those items, the Appointed Actuary should issue a qualified Statement of Actuarial Opinion. The Appointed Actuary should disclose the item (or items) to which the qualification relates, the reason(s) for the qualification and the amounts for such item(s), if disclosed by the Company. Such a qualified opinion should state whether the carried reserve amount makes a reasonable provision for the liabilities associated with the specified reserves, except for the item (or items) to which the qualification relates. The Appointed Actuary is not required to issue a qualified opinion if the Appointed Actuary reasonably believes that the item (or items) in question are not likely to be material.

5. **No Opinion.** The Appointed Actuary’s ability to give an opinion is dependent upon data, analyses, assumptions, and related information that are sufficient to support a conclusion. If the Appointed Actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions, or related information, then the Appointed Actuary may issue a statement of no opinion. A statement of no opinion should include a description of the reasons why no opinion could be given.

6. The Appointed Actuary must provide RELEVANT COMMENT paragraphs to address the following topics of regulatory importance.

   **A. Company-Specific Risk Factors**

   The Appointed Actuary should include an explanatory paragraph to describe the major factors, combination of factors or particular conditions underlying the risks and uncertainties the Appointed Actuary considers relevant. The explanatory paragraph should not include general, broad statements about risks and uncertainties due to economic changes, judicial decisions, regulatory actions, political or social forces, etc., nor is the Appointed Actuary required to include an exhaustive list of all potential sources of risks and uncertainties.

   **B. Risk of Material Adverse Deviation**

   The Appointed Actuary must provide specific RELEVANT COMMENT paragraphs to address the risk of material adverse deviation. The Appointed Actuary must identify the materiality standard and the basis for establishing this standard. The materiality standard must also be disclosed in U.S. dollars in Exhibit B: Disclosures. The Appointed Actuary should explicitly state whether or not he or she reasonably believes that there are significant risks and uncertainties that could result in material adverse deviation. This determination is also to be disclosed in Exhibit B.
C. Other Disclosures in Exhibit B

RELEVANT COMMENT paragraphs should describe the significance of each of the remaining Disclosure items (8 through 14) in Exhibit B. The Appointed Actuary should address the items individually and in combination when commenting on a material impact.

D. Reinsurance

RELEVANT COMMENT paragraphs should address reinsurance collectability, retroactive reinsurance and financial reinsurance.

The Appointed Actuary’s comments on reinsurance collectability should address any uncertainty associated with including potentially-uncollectable amounts in the estimate of ceded reserves. Before commenting on reinsurance collectability, the Appointed Actuary should solicit information from management on any actual collectability problems, review ratings given to reinsurers by a recognized rating service, and examine Schedule F for the current year for indications of regulatory action or reinsurance recoverable on paid losses over ninety (90) days past due. The comment should also reflect any other information the Appointed Actuary has received from management or that is publicly available about the capability or willingness of reinsurers to pay claims. The Appointed Actuary’s comments do not imply an opinion on the financial condition of any reinsurer.


Financial reinsurance refers to contracts referenced in SSAP No. 62R in which credit is not allowed for the ceding insurer because the arrangements do not include a transfer of both timing and underwriting risk that the reinsurer undertakes in fact to indemnify the ceding insurer against loss or liability by reason of the original insurance.

E. IRIS Ratios

If the Company’s reserves will create exceptional values under the NAIC IRIS Tests for One-Year Reserve Development to Policyholders’ Surplus, Two-Year Reserve Development to Policyholders’ Surplus or Estimated Current Reserve Deficiency to Policyholders’ Surplus, the Appointed Actuary must include RELEVANT COMMENT on the factors that led to the unusual value(s).

F. Methods and Assumptions

If there has been any significant change in the actuarial assumptions and/or methods from those previously employed, that change should be described in a RELEVANT COMMENT paragraph. If the Appointed Actuary is newly-appointed and does not review the work of the prior Appointed Actuary, then the Appointed Actuary should disclose this.

7. The Actuarial Opinion must include assurance that an Actuarial Report and underlying actuarial workpapers supporting the Actuarial Opinion will be maintained at the Company and available for regulatory examination for seven (7) years. The Actuarial Report contains significant proprietary information. It is expected that the Actuarial Report be held confidential and not be intended for public inspection. The Actuarial Report must be available by May 1 of the year following the year-end for which the Actuarial Opinion was rendered or within two (2) weeks after a request from an individual state commissioner.

The Actuarial Report should be consistent with the documentation and disclosure requirements of ASOP No. 41, Actuarial Communications. The Actuarial Report must contain both narrative and technical components. The narrative component should provide sufficient detail to clearly explain to Company management, the Board of Directors, the regulator or other authority the findings, recommendations and conclusions, as well as their significance. The technical component should provide sufficient documentation and disclosure for another actuary practicing in the same field to evaluate the work. This technical component must show the analysis from the basic data (e.g., loss triangles) to the conclusions.
Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) in the NAIC Accounting Practices and Procedures Manual requires a company with over 10,000 in force lives covered by long-term care (LTC) insurance contracts as of the valuation date to perform a stand-alone asset adequacy analysis for its in force long-term care (LTC) contracts. The Actuarial Report and workpapers summarizing the results, assumptions and testing procedures for the asset adequacy testing of LTC business must be in compliance with AG 51 requirements. When referring to AG 51, the term “Actuarial Memorandum” is synonymous with Actuarial Report and workpapers.

The Actuarial Report should contain disclosure of all reserve amounts associated with A&H Long Duration Contracts reported by the Company; the reserve amounts in the Actuarial Report should tie to the Annual Statement.

The Actuarial Report must also include:

A. A description of the Appointed Actuary’s relationship to the Company, with clear presentation of the Appointed Actuary’s role in advising the Board of Directors and/or management regarding the carried reserves. The Actuarial Report should identify how and when the Appointed Actuary presents the analysis to the Board of Directors and, where applicable, to the officer(s) of the Company responsible for determining the carried reserves.

B. An exhibit that ties to the Annual Statement and compares the Appointed Actuary’s conclusions to the carried amounts consistent with the segmentation of exposure or liability groupings used in the analysis. The Appointed Actuary’s conclusions include the Appointed Actuary’s point estimate(s), range(s) of reasonable estimates or both.

C. An exhibit that reconciles and maps the data used by the Appointed Actuary, consistent with the segmentation of exposure or liability groupings used in the Appointed Actuary’s analysis, to the Annual Statement Schedule P line of business reporting. An explanation should be provided for any material differences.

D. An exhibit or appendix showing the change in the Appointed Actuary’s estimates from the prior Actuarial Report, including extended discussion of factors underlying any material changes. The exhibit or appendix should illustrate the changes on a net basis, but should also include the changes on a gross basis, if relevant. If the Appointed Actuary is newly-appointed and does not review the work of the prior Appointed Actuary, then the Appointed Actuary should disclose this.

E. Extended comments on trends that indicate the presence or absence of risks and uncertainties that could result in material adverse deviation.

F. Extended comments on factors that led to unusual IRIS ratios for One-Year Reserve Development to Policyholders’ Surplus, Two-Year Reserve Development to Policyholders’ Surplus or Estimated Current Reserve Deficiency to Policyholders’ Surplus, and how these factors were addressed in prior and current analyses.

8. Both the Actuarial Opinion and the Actuarial Report should conclude with the signature of the Appointed Actuary responsible for providing the Actuarial Opinion and the respective dates when the Actuarial Opinion was rendered and the Actuarial Report finalized. The signature and date should appear in the following format:

___________________________________
Signature of Appointed Actuary
Printed name of Appointed Actuary
Employer’s name
Address of Appointed Actuary
Telephone number of Appointed Actuary
Email address of Appointed Actuary
Date opinion was rendered

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9. The Insurer required to furnish an Actuarial Opinion shall require its Appointed Actuary to notify its Board of Directors or its audit committee in writing within five (5) business days after any determination by the Appointed Actuary that the Actuarial Opinion submitted to the domiciliary commissioner was in error as a result of reliance on data or other information (other than assumptions) that, as of the balance sheet date, was factually incorrect. The Actuarial Opinion shall be considered to be in error if the Actuarial Opinion would have not been issued or would have been materially altered had the correct data or other information been used. The Actuarial Opinion shall not be considered to be in error if it would have been materially altered or not issued solely because of data or information concerning events subsequent to the balance sheet date or because actual results differ from those projected. Notification is required when discovery is made between the issuance of the Actuarial Opinion and Dec. 31 of that year. Notification should include a summary of such findings.

If the Appointed Actuary learns that the data or other information relied upon was factually incorrect, but cannot immediately determine what, if any, changes are needed in the Actuarial Opinion, the Appointed Actuary and the Company should quickly undertake procedures necessary for the Appointed Actuary to make such determination. If the Insurer does not provide the necessary data corrections and other support (including financial support) within ten (10) business days, the Appointed Actuary should proceed with the notification to the Board of Directors and the domiciliary commissioner.

An Insurer who is notified pursuant to the preceding paragraphs shall forward a copy of the amended Actuarial Opinion to the domiciliary commissioner within five (5) business days of receipt of such and shall provide the Appointed Actuary making the notification with a copy of the letter and amended Actuarial Opinion submitted to the domiciliary commissioner. If the Appointed Actuary fails to receive such copy within the five (5) business day period referred to in the previous sentence, the Appointed Actuary shall notify the domiciliary commissioner within the next five (5) business days that an amended Actuarial Opinion has been finalized.

No Appointed Actuary shall be liable in any manner to any person for any statement made in connection with the above paragraphs if such statement is made in a good faith effort to comply with the above paragraphs.

10. Data in Exhibits A and B are to be filed in both print and data capture format.

**Exhibit A: SCOPE**

**DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMATS**

<table>
<thead>
<tr>
<th>Loss and Loss Adjustment Expense Reserves:</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unpaid Losses (Liabilities, Surplus and Other Funds page, Col 1, Line 1)</td>
<td>$ _________</td>
</tr>
<tr>
<td>2. Unpaid Loss Adjustment Expenses (Liabilities, Surplus and Other Funds page, Col 1, Line 3)</td>
<td>$ _________</td>
</tr>
<tr>
<td>3. Unpaid Losses – Direct and Assumed (Should equal Schedule P, Part 1, Summary, Totals from Cols. 13 and 15, Line 12 * 1000)</td>
<td>$ _________</td>
</tr>
<tr>
<td>4. Unpaid Loss Adjustment Expenses – Direct and Assumed (Should equal Schedule P, Part 1, Summary, Totals from Cols. 17, 19 and 21, Line 12 * 1000)</td>
<td>$ _________</td>
</tr>
<tr>
<td>5. The Page 3 write-in item reserve, “Retroactive Reinsurance Reserve Assumed”</td>
<td>$ _________</td>
</tr>
<tr>
<td>6. Other Loss Reserve items on which the Appointed Actuary is expressing an Opinion (list separately, adding additional lines as needed)</td>
<td>$ _________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Premium Reserves:</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Reserve for Direct and Assumed Unearned Premiums for P&amp;C Long Duration Contracts</td>
<td>$ _________</td>
</tr>
<tr>
<td>8. Reserve for Net Unearned Premiums for P&amp;C Long Duration Contracts</td>
<td>$ _________</td>
</tr>
<tr>
<td>9. Other Premium Reserve items on which the Appointed Actuary is expressing an Opinion (list separately, adding additional lines as needed)</td>
<td>$ _________</td>
</tr>
</tbody>
</table>
Exhibit B: DISCLOSURES
DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMATS

NOTE: Exhibit B should be completed for Net dollar amounts included in the SCOPE. If an answer would be different for Direct and Assumed amounts, identify and discuss the difference within RELEVANT COMMENTS.

1. Name of the Appointed Actuary
   Last _______ First _____ Mid ______

2. The Appointed Actuary’s relationship to the Company
   Enter E or C based upon the following:
   E if an Employee of the Company or Group
   C if a Consultant

3. The Appointed Actuary’s NAIC-Accepted Actuarial Designation has the following designation (indicated by the letter code):
   F if a Fellow of the Casualty Actuarial Society (FCAS)
   A if an Associate of the Casualty Actuarial Society (ACAS)
   S if a Fellow of the Society of Actuaries (FSA) through the General Insurance track
   M if the actuary does not have an NAIC-Accepted Actuarial Designation, but is not a member of the Casualty Actuarial Society, but a Member of the American Academy of Actuaries (MAAA) approved by the Academy’s Casualty Practice Council, as documented with the attached approval letter.
   O for Other

4. Type of Opinion, as identified in the OPINION paragraph.
   Enter R, I, E, Q, or N based upon the following:
   R if Reasonable
   I if Inadequate or Deficient Provision
   E if Excessive or Redundant Provision
   Q if Qualified. Use Q when part of the OPINION is Qualified.
   N if No Opinion

5. Materiality Standard expressed in U.S. dollars (used to Answer Question #6) $ _______

6. Are there significant risks that could result in Material Adverse Deviation? Yes [ ] No [ ] Not Applicable [ ]

7. Statutory Surplus (Liabilities, Surplus and Other Funds page, Col 1, Line 37) $ _______

8. Anticipated net salvage and subrogation included as a reduction to loss reserves as reported in Schedule P (should equal Part 1 Summary, Col 23, Line 12 * 1000) $ _______

9. Discount included as a reduction to loss reserves and loss adjustment expense reserves as reported in Schedule P
   9.1 Nontabular Discount [Notes, Line 32B23, (Amounts 1, 2, 3 & 4)], Electronic Filing Cols 1, 2, 3, & 4 $ _______
   9.2 Tabular Discount [Notes, Line 32A23, (Amounts 1 & 2)], Electronic Filing Col 1 & 2 $ _______
10. The net reserves for losses and loss adjustment expenses for the Company’s share of voluntary and involuntary underwriting pools’ and associations’ unpaid losses and loss adjustment expenses that are included in reserves shown on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines $ _______

11. The net reserves for losses and loss adjustment expenses that the Company carries for the following liabilities included on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines *
   11.1 Asbestos, as disclosed in the Notes to Financial Statements (Notes, Line 33A03D, ending net asbestos reserves for current year) Electronic Filing Col 5 $ _______
   11.2 Environmental, as disclosed in the Notes to Financial Statements (Notes, Line 33D03D, ending net environmental reserves for current year), Electronic Filing Col 5 $ _______

12. The total claims made extended loss and loss adjustment expense, and unearned premium reserves (Greater than or equal to Schedule P Interrogatories)
   12.1 Amount reported as loss and loss adjustment expense reserves $ _______
   12.2 Amount reported as unearned premium reserves $ _______

13. The net reserves for the A&H Long Duration Contracts that the Company carries on the following lines on the Liabilities, Surplus and Other Funds page:
   13.1 Losses $ _______
   13.2 Loss Adjustment Expenses $ _______
   13.3 Unearned Premium $ _______
   13.4 Write-In (list separately, adding additional lines as needed, and identify (e.g., “Premium Deficiency Reserves”, “Contract Reserves other than Premium Deficiency Reserves” or “AG 51 Reserves”)) $ _______

14. Other items on which the Appointed Actuary is providing relevant comment (list separately, adding additional lines as needed) $ _______

* The reserves disclosed in item 11 above, should exclude amounts relating to contracts specifically written to cover asbestos and environmental exposures. Contracts specifically written to cover these exposures include Environmental Impairment Liability (post 1986), Asbestos Abatement, Pollution Legal Liability, Contractor’s Pollution Liability, Consultant’s Environmental Liability, and Pollution and Remediation Legal Liability.
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The Capital Adequacy (E) Task Force met in Austin, TX, Dec. 8, 2019. The following Task Force members participated:

- David Altmaier, Chair (FL); Todd E. Kiser, Vice Chair, represented by Dan Applegarth (UT); Lori K. Wing-Heier represented by Michael Ricker (AK); Jim L. Ridling represented by Sheila Travis (AL); Andrew N. Mais represented by Wanchin Chou (CT); Stephen C. Taylor represented by Philip Barlow (DC); Trinidad Navarro represented by Ryllyn Brown (DE); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Kevin Fry and Vincent Tsang (IL); Vicki Schmidt represented by Tish Becker (KS); Steve Kelley represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by Shannon Schmoeger (MO); Mike Causey represented by Jackie Obusek (NC); Marlene Caride (NJ); John G. Franchini represented by Anna Krylova (NM); Barbara D. Richardson represented by Stephanie McGee (NV); Jillian Froment represented by Tom Botsko and Dale Bruggeman (OH); Glen Mulready represented by Eli Snowbarger (OK); Elizabeth Kelleher Dwyer represented by John Tudino (RI); Kent Sullivan represented by Mike Boerner (TX); Mike Kreidler represented by Patrick McNaughton (WA); and Mark Afaile represented by Randy Milquet (WI).

1. **Adopted its Oct. 8 Minutes**

   The Task Force met Oct. 8 and took the following action: 1) adopted its Sept. 18 minutes, which was an e-vote to adopt its 2020 proposed charges; and 2) exposed its referrals: 1) NAIC Designations for Schedule D, Part 2, Section 2; 2) Mutual Funds; 3) Comprehensive Funds; and 4) Supplemental Investment Risk Interrogatories (SIRI).

   Ms. Orth made a motion, seconded by Mr. Botsko, to adopt the Task Force’s Oct. 8 minutes (Attachment One). The motion passed unanimously.

2. **Adopted its Working Group Reports**

   Mr. Barlow mentioned an addition to the Life Risk-Based Capital (E) Working Group’s summary report to include phase-in and spreading of variable annuity reserves capital.

   Mr. Milquet made a motion, seconded by Ms. Obusek, to adopt the following reports: Health Risk-Based Capital (E) Working Group, which met Dec. 8 (Attachment Two); Life Risk-Based Capital (E) Working Group, which met Dec. 7 (Attachment Three); and Property and Casualty Risk-Based Capital (E) Working Group, which met Dec. 8 (Attachment Four). The motion passed.

3. **Adopted its Working Agenda**

   Mr. McNaughton said the completion dates for stop loss insurance, health care receivables and the health test ad hoc group were extended to better reflect the expected completion of each of these projects. The referral letter to the Task Force on guaranty funds, long-term care (LTC) and health maintenance organizations (HMOs) and the review of LTC and long-term disability under the H2 component were removed from the agenda. The Health Risk-Based Capital (E) Working Group completed the memorandum on the LTC and guaranty funds and referred it to the Task Force, and the Working Group determined that due to materiality, the item on LTC and long-term disability would be removed and, if needed, can be reassessed in the future.

   Mr. Botsko summarized the changes to the to the 2020 Property and Casualty Risk-Based Capital (E) Working Group’s working agenda: 1) removed “evaluate the proposed changes from the Investment Risk-Based Capital (E) Working Group related to bond changes in the property/casualty (P/C) formula” in the new items section; and 2) added “evaluate the possibility of using the NAIC as a centralized location for reinsurer designations” and “evaluate the possibility of allowing additional third-party models to calculate the cat model losses” in the carry-over items and new items sections, respectively.

   Mr. Botsko summarized the changes to the to the 2020 Property and Casualty Risk-Based Capital (E) Working Group’s working agenda: 1) removed “evaluate the proposed changes from the Investment Risk-Based Capital (E) Working Group related to bond changes in the property/casualty (P/C) formula” in the new items section; and 2) added “evaluate the possibility of using the NAIC as a centralized location for reinsurer designations” and “evaluate the possibility of allowing additional third-party models to calculate the cat model losses” in the carry-over items and new items sections, respectively.

   Mr. Botsko said the Affiliated Investment Ad Hoc Group has continued its biweekly conference calls since the Summer National Meeting and met in person Dec. 6. The Ad Hoc Group has finalized the instructions for directly owned subsidiaries for all three forms. It also has made progress on the instructions for indirect-owned subsidiaries and alien subsidiaries. The Ad Hoc Group will continue to move forward with the remaining instructions over the next few months. Mr. Botsko said he plans to present the direct and indirect instructions to the respective working groups and the Task Force by the 2020 Spring National Meeting.

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Mr. Botsko made a motion, seconded by Mr. Boerner, to adopt its working agenda (Attachment Five). The motion passed.

4. **Received an LTC/Guaranty Fund Memorandum**

Mr. McNaughton summarized a referral from the Task Force regarding adopted amendments to the *Life and Health Insurance Guaranty Association Model Act* (#520) and to determine if changes were warranted to the health risk-based capital (RBC) formula. The health RBC formula currently includes a 0.5% charge on all premiums that are subject to a guaranty fund assessment.

Mr. McNaughton added that through their analysis: 1) that while some states have not yet adopted the model law changes, once adopted, a majority of the states will allow for a premium tax or corporate tax offset, or the ability to impose a minimal surcharge to help offset the assessment; 2) at a maximum, HMOs would incur a charge of 2% (depending upon each state’s guaranty fund law) and if they were unable to pay or meet this obligation, they could request a waiver from the guaranty fund of some or all of the assessment; and 3) given the differences and complexities between states in the regulation and taxation of HMOs and that the RBC formula is a generic formula, the goal of which is to be applied as uniformly as possible and not at such a granular level, it would be difficult to incorporate such changes into the formula that could address all the different scenarios needed to provide a different charge, offset or credit to such a distinct population in such diverse regulatory environments.

Mr. McNaughton said based on these findings, the Working Group does not recommend any changes to the health RBC formula (Attachment Six).

6. **Adopted the Proposals of the Property and Casualty Risk-Based Capital (E) Working Group**

   a. **Proposal 2019-11-P (Clarification to Instructions Regarding Lloyd’s of London) and the 2019 Reporting Guideline**

   Mr. Botsko said upon review of 2018 Annual Statement Schedule F, Part 3 filings, it was observed that many filers reported reinsurance recoverable amounts due from Lloyd’s of London syndicates as NAIC 6 – unrated; therefore, they are subject to the highest R3 charge. He stated that the purpose of this proposal is to clarify that the reinsurance recoverable from individual syndicates of Lloyd’s of London that are covered under the Lloyd’s Central Fund may use the lowest financial strength group rating received from an approved rating agency. He said that because the deadline for the change of the 2019 RBC instructions has passed, a guideline for 2019 RBC reporting will be posted to the Working Group’s web page pending the proposal’s adoption by the Working Group. He also stated that the Working Group received no comments during the exposure period.

   b. **Proposal 2019-12-P (Remove PR038 Adjustment for Reinsurance Penalty)**

   Mr. Botsko said that because the computation of the RBC charge for reinsurance recoverable amounts has been moved to the Annual Statement Schedule F, Part 3 in 2018 reporting, the adjustment for reinsurance penalty for affiliates applicable to Schedule F in PR038 is no longer needed. He stated that the purpose of this proposal is to eliminate the adjustment for reinsurance penalty for affiliates applicable to Schedule F section in PR038. Mr. Botsko also said the Working Group received no comments during the exposure period.


   Mr. Botsko said in order to avoid double-counting the catastrophe losses in the RBC formula, the U.S. and non-U.S. catastrophe event lists provide a routine annual update for those catastrophe events that should be excluded from the R5 calculation. He stated that the Subgroup exposed the list during its Nov. 8 conference call; no comments were received during the exposure period.

   Mr. Botsko indicated that any additional events that occur between Nov. 1 and Dec. 31 will be exposed during the first week of January 2020. The Subgroup will either schedule a conference call or conduct an e-vote to consider adoption of the updated list after the Committee Assignment Meeting.

Mr. Botsko made a motion, seconded by Mr. Chou, to adopt proposal 2019-11-P (Attachment Seven), proposal 2019-12-P (Attachment Eight) and proposal 2019-14-CR (Attachment Nine). The motion passed.
7. **Adopted the RBC Preamble**

Commissioner Altmaier said the purpose of the RBC preamble is to provide some history and background on the RBC as a reference when reviewing the numerous referrals and proposals that pass to the Capital Adequacy (E) Task Force and its working groups. He added that the preamble was re-exposed for a 30-day public comment period ending Sept. 4 and was modified to include comments received from America’s Health Insurance Plans (AHIP) (Attachment Eleven).

Bill Weller (AHIP) thanked the Task Force for including the changes suggested in AHIP’s comment letter.

Commissioner Altmaier said he received a comment that indicates there are some states that are allowing insurers’ permitted practices to adjust their RBC outside the accounting permitted practices to their financial statement. The wording in the preamble states that permitted practices are not allowed, and the Task Force was not aware that this was allowed by any state.

Ms. Brown said that if permitted practices are allowed, there should be some type of disclosure of the permitted practice and why it is allowed. She added that it is not a good idea to allow permitted practices in the RBC, which would be a disadvantage of companies that are following the rules.

Mr. Barlow said he has heard there are permitted practices in RBC, which he believes there should not be because of the significant solvency to the insurance company.

Mr. Bruggeman said RBC is a tool used to monitor solvency, and when a company’s RBC falls into various action levels that may require monitoring, adjusting those numbers will skew their results. He added that permitted practices are allowed in the financial statement and that is where they belong, not by adjusting the RBC numerator.

Mr. Fry said there may be state laws that allow for a permitted practice in RBC.

Mr. McNaughton said this tool is a cornerstone to solvency regulation, noting that the *Risk-Based Capital (RBC) for Insurers Model Act* (#312) and the *Risk-Based Capital (RBC) for Health Organizations Model Act #315* are part of the accreditation standards; therefore, if this is allowed, there is a risk of regulatory arbitrage.

Commissioner Altmaier said the paragraph in question would be paragraph 10 of Attachment Eleven, which states: “RBC instructions, RBC reports and adjusted report(s) are intended solely for use by the commissioner/state in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and are considered confidential. All domestic insurers are required to file an RBC report unless exempt by the Commissioner. There are no state permitted practices to modify the RBC formula, and all insurers are required to abide by the RBC instructions.” He said adoption would eliminate the state’s authority to allow permitted practices.

Mr. Fry suggested that the Task Force table this adoption.

Lou Felice (NAIC) said RBC should not allow for permitted practices to the denominator, which would change the RBC formula and factors. The denominator could be an accounting permitted practice, or a state permitted practice that flows into RBC.

Mr. Yanacheak said he is in favor of moving forward with the current wording today.

Commissioner Altmaier said, if adopted, the Task Force could look into the states that are allowing a permitted practice and if the numerator or denominator is being adjusted.

Mr. Yanacheak made a motion, seconded by Mr. Barlow, to adopt the RBC preamble (Attachment Ten). The motion passed.

8. **Heard Comments on Exposed Referrals**

Commissioner Altmaier said the Task Force has received numerous referrals regarding investments that could affect the RBC formula. Three referrals were exposed for a 30-day public comment period ending Nov. 8, and the Task Force requested that the following questions be considered: a) if changes to the RBC formula were appropriate; b) if so, what was the best way for the Task Force to move forward; and c) what resources should the Task Force consider for research and analysis of these investments.
a. Comprehensive Fund Referral

This exposure is outlined in two memorandums from the Statutory Accounting Principles (E) Working Group (Attachment Twelve and Attachment Thirteen).

Nancy Bennett (American Academy of Actuaries—Academy) said the risk in a single bond is not the same as the risk associated with comprehensive bonds. She added that using speculative risk analysis (default rate and credit experience) to rate bond funds may reduce the capital requirement for fund investments below state insurance regulators’ state statistical level. She said the Academy recommends further analysis so that similar treatment does not under mind the RBC calculation.

Josh Bean (Transamerica), representing the American Council of Life Insurers (ACLI) and the North American Securities Valuation Association (NASVA), said they encourage the Task Force to continue discussion on the bond. He said they prefer stock focused on fund structures’ risk profile and to determine a risk-based factor appropriate for this investment portfolio. Mr. Bean said these funds offer insurance companies access to diversification and solid risk adjusted returns, as well as liquidity and cash flows well suited to insurers asset/liability matching needs.

Chris Anderson (Anderson Insights) said, for regulatory purposes, open-end funds—which include exchange-traded funds (ETFs)—should not be treated like closed-end funds (actual bonds) and could encourage insurers to invest in assets with low C-1 factors for various reasons: 1) they do not have the same predictability and periodicity of cash flows of actual bonds; 2) they have indeterminate, not fixed, lives; 3) they do not offer promises of cash flows that insurers can use to provide their projected future liability needs, and due to time constraints, they will end on item; and 4) they are not subject to credit analysis because there is no party to be evaluated making specific promises concerning the amounts of future cash flows. He asked that the Task Force determine whether it is appropriate to assign the same risk factor for these funds as if they were a bond or preferred stock.

Commissioner Altmaier said the comment letter from Everest Reinsurance Company is included in the materials.

Erinn King (Payden & Rygel) said Payden & Rygel is in support of assigning bond factors for fixed income designation for all bond and preferred stock funds, and ETFs, both private and public, regardless of which schedule they are reported on in the annual financial statement that are determined/designated by the NAIC Securities Valuation Office (SVO). She added that funds allow smaller insurers to achieve better pricing economies of scale and diversification of investment risk than many can find purchasing individual securities, but the RBC charges are inconsistent across the formulas.

Kelly Sweppenhiser (Vanguard Institutional Investor Group) focused on two important points from Vanguard’s research: 1) there is 1/10 of 1% of bond mutual funds that apply for designations, so there is minimal impact to RBC; and 2) if bond funds were afforded bond-like treatment in RBC, that amount would slowly increase, and a small subset of U.S. Securities and Exchange Commission (SEC)-registered bonds would be submitted for designation.

Commissioner Altmaier asked the Task Force members to consider the comments heard today so, when the Task Force reconvenes, a determination can be made on how to move forward.

b. Structured Notes Referral

Mr. Bean stressed that the RBC should exclude nonadmitted structured notes from receiving an RBC charge. The RBC rules for P/C companies refer to the net book/adjusted carrying values (net of a nonadmit amount) when calculating RBC charges. This is inconsistent with the treatment in the life RBC formula (reducing statutory capital and surplus by 100% of the net book/adjusted carrying value of the asset), and the gross asset (before reducing it for nonadmitted) has an RBC charge associated with it. Mr. Bean said that should an insurer receive a permitted practice to admit structured notes as “other derivatives,” the ACLI and NASVA recommend the RBC rules associated with derivatives on Schedule DB be modified to treat such instruments like equity securities.

Commissioner Altmaier asked the Task Force members to consider the comments heard today so, when the Task Force reconvenes, a determination can be made on how to move forward.

10. Discussed Other Matters

Commissioner Altmaier thanked Mr. McNaughton for his years of service as chair of the Health Risk-Based Capital (E) Working Group, as well as for his expertise and diligence with the health RBC formula. Commissioner Altmaier expressed admiration for Mr. McNaughton receiving the Robert Dineen Award for Outstanding Service and Contribution and said he looks forward to seeing him participate in a non-regulatory capacity.

Having no further business, the Capital Adequacy (E) Task Force adjourned.
The Capital Adequacy (E) Task Force met via conference call Oct. 8, 2019. The following Task Force members participated: David Altmaier, Chair (FL); Todd E. Kiser, Vice Chair, represented by Jake Garn (UT); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais represented by Wanchin Chou (CT); Stephen C. Taylor represented by Philip Barlow (DC); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Kevin Fry (IL); Vicki Schmidt represented by Tish Becker (KS); Chlora Lindley-Myers (MO); Marlene Caride represented by Diana Sherman (NJ); John G. Franchini represented by Anna Krylova (NM); Jillian Froment represented by Dale Bruggeman (OH); Glen Mulready represented by Joel Sander (OK); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Kent Sullivan represented by Jamie Walker (TX); Mike Kreidler represented by Patrick McNaughton (WA); and Mark Afable represented by Randy Milquet (WI). Also participating was: Jim Everett (NY).

1. **Adopted its Sept. 18 Minutes**

The Task Force conducted an e-vote that concluded Sept. 18 to adopt its 2020 proposed charges.

Director Lindley-Myers made a motion, seconded by Mr. Bruggeman, to adopt the Task Force’s Sept. 18 minutes (Attachment One-A). The motion passed unanimously.

2. **Exposed its Referrals**

Commissioner Altmaier said the Task Force has received numerous referrals dating back to August 2018. The referrals relate to investments and various other groups under the Financial Condition (E) Committee, such as the Statutory Accounting Principles (E) Working Group and the Valuation of Securities (E) Task Force. The referrals indicate that some changes to the way certain investments are treated either from an accounting standpoint or an investment standpoint which may or may not result in necessary changes to the risk-based capital (RBC).

Due to the volume of referrals, Commissioner Altmaier said it is apparent that some can be grouped together, and the purpose of this call is to discuss a path forward. He said these items will be exposed for a 30-day public comment period ending Nov. 8 to receive input on how to approach each one of the referrals.

Commissioner Altmaier added that this is an opportunity for interested stakeholders to provide feedback to the Capital Adequacy (E) Task Force on how these referrals could help state insurance regulators identify insurance companies that might have issues from a capital standpoint and how the RBC formula can be more efficient to meet that goal by updating investment risk factors within the formula.

   a. **NAIC Designations for Schedule D, Part 2, Section 2 – Common Stocks**

   Mr. Fry said the Valuation of Securities (E) Task Force did look at this and item C – Comprehensive Funds, which are somewhat related, and he said the framework already allows for this investment through the Statement of Statutory Accounting Principles (SSAP) No. 26R—Other Admitted Assets; but was written a long time ago, and these investments are allowed on Schedule D, Part 1 and are given the same factor as bonds. He added that in the life and fraternal RBC, these funds are reported on Schedule BA and are given the same bond treatment.

   Mr. Fry said he believes that these funds should be given a designation similar to bonds instead of a factor similar to common stock, which is a fix flat factor charge of 15% for property/casualty (P/C) and health. He added that re-evaluating the funds would be a lengthy process and a quicker way of updating would be to treat it like a bond.

Commissioner Altmaier added that some of these referrals are similar to each other; although listed separately on the agenda, they can be lumped into one comment letter to the Capital Adequacy (E) Task Force.
Mr. Barlow added that the investments should be evaluated first to determine the appropriate charge, and he disagrees that just giving them the bond factor is wrong. He added, especially when the sole purpose of this referral is to change the RBC factor, he disagrees with changing the factor firsts and then evaluating what it should be later. He stressed that the analysis to determine the appropriate risk charge should be done first, and he stated that it is clear the proposal’s objective is to change the RBC charge. He asked for clarification on the exposure and whether these referrals will apply to all RBC formulas.

Commissioner Altmaier said for now, they will remain at the Task Force level; after the comments are reviewed, the Task Force will determine the appropriate direction, whether that will be to refer them to all RBC working groups for further review or not. He added that if any of the proposal moves beyond this exposure period, there will be other opportunities for further discussion on methodology and what changes should occur in the formulas.

b. Mutual Funds

Commissioner Altmaier pointed out that this referral was received some time ago and was also directed to the Valuation of Securities (E) Task Force.

Julie Gann (NAIC) said the Statutory Accounting Principle (E) Working Group already adopted this change based on feedback received during its exposure period and determined that it was previously included in SSAP No. 30R—Unaffiliated Common Stock and inadvertently excluded mutual funds reported on the common stock schedule. She added that a referral to the Blanks (E) Working Group to include designations for mutual funds and include them in the top 10 exposures based on diversified and non-diversified funds.

Hearing no comments, the Capital Adequacy (E) Task Force will consider this referral complete.

c. Comprehensive Funds

Commissioner Altmaier said both of these referrals came from the Valuation of Securities (E) Task Force regarding funds that predominately hold bonds.

Charles Therriault (NAIC) said the Securities Valuation Office (SVO) is charged with evaluating credit risk and assigning a designation based on that risk by looking into the required payments within the investment and what the source of those payments are (e.g., for a typical corporate bond, the source of those payments are the operating business entity whose financial statements are reviewed and analyzed along with the bond’s legal agreement, and an opinion is formed based on the likelihood that the contractual payments will be met; that opinion is provided by assigning a designation).

Mr. Therriault said funds are a portfolio of individual bonds, and the portfolio is the source of those payments. For example, if an investor holds 10 bonds directly, those 10 bonds would be exposed to a credit risk; therefore, the fund would be exposed to the same level of credit risk, assuming they all have the same market value change and credit events. The substance of the risk has not changed, just the legal form. The weighted average ratings factor (WARF) is applied to each underlying investment and reflects the relative risk of each of the delineations and credit risk A bonds with an A+ rating would get a factor of roughly 100. If compared to another bond with a rating of B+, it would get a factor of 50, 858 times the level of risk; and through the application of these rating factors to the underlying investments they are aggregated up to essentially become an aggregate fund, the risk level, which is why there is a lot of comfort in terms of the analysis process and how NAIC designations are assigned to this portfolio. Analysis would be difficult based on the number of different classes of investment included in a fund.

Mr. Everett said the first thing to consider is how many mutual funds and exchange-traded funds (ETFs) are being reported on Schedule D, Part 2, Section 2. Back in the time when ETFs were first given bond treatment, there were only two or three funds. Currently, these funds are receiving a 15% charge, same as common stock for the health and P/C RBC. It would be helpful to know what the growth rate is and what amount is being talked about. There are definitely more funds today, and if the market is much larger and the percentage of funds are at an increase, then it would seem that the best place to catch hold of it, if dealing with credit default risk and averaging ratings as opposed to averaging percentages of default, it would be helpful to capture that information on a separate schedule. He that it is important to understand the trend before factors are changed and its impact to RBC.

Commissioner Altmaier agreed and asked that NAIC staff provide any analysis already collected on these funds.
Mr. Barlow said it would also be helpful to find out where in the schedule these funds are currently reported; assuming that the volume is significant, there might be some benefit in either creating a specific schedule or an identifier to put all these funds together. He added that in a lot of cases, companies are misreporting and examiners have missed things or are not quite sure where they should be reported. If a separate schedule for these funds were added, only then could the real exposure be seen and the different funds and individual investments be differentiated.

Commissioner Altmaier said the Capital Adequacy (E) Task Force would welcome any feedback from the interested stakeholders on the referral or on any of the comments from the state insurance regulators’ discussion, these should be included in comments during the 30-day public comment period.

d. **Supplemental Investment Risk Interrogatories (SIRI)**

Ms. Gann explained that this was exposed at the Summer National Meeting, and the Statutory Accounting Principles (E) Working Group will discuss comments received during the Fall National Meeting. Pending comments, this proposal may not be finalized at that time. Her summary stated that if an equity exposure is diversified, open-end diversified funds would not necessarily have to be looked into to identify all exposures for aggregation. However, if a closed-end fund is not diversified or an open-end fund is not diversified, then the exposure would need to be looked through to identify what the exposures are, and it would need to aggregate those with other individual exposures. Essentially, it is preventing the inclusion of a fund environment to prevent identifying key exposures for an insurance entity. It was referred over simply because a comment was received that there could potentially be an RBC impact for this with regard to concentration risk.

Commissioner Altmaier said this referral will be moved to the top of the list, exposed for a 30-day public comment period and specifically, and he asked that any comments regarding its impact to RBC that the Capital Adequacy (E) Task Force should provide to the Working Group be provided within.

e. **Structured Notes**

Commissioner Altmaier said this referral includes revisions to several SSAPs—specifically, SSAP No. 2R—*Cash, Drafts, and Short-term Investments*; SSAP No. 26R—*Bonds*; SSAP No. 43R—*Loan-Backed and Structured Securities*; and SSAP No. 86—*Derivatives*—that affect structure notes, and revisions were adopted with a Dec. 31, 2019, effective date. The Capital Adequacy (E) Task Force will expose this referral for a 30-day public comment period to receive any feedback or objections to the changes.

Commissioner Altmaier reiterated that the referral for mutual funds is considered completed and the SIRI referral is open for comments by the Statutory Accounting Principles (E) Working Group, noting that the Working Group will allow the Capital Adequacy (E) Task Force until mid-November to provide comments. The common stocks, comprehensive funds and structured notes referrals will be exposed for a 30-day public comment period, asking specifically if these referrals affect RBC, what resources should be used to analyze the investments, and how the analysis should be done.

3. **Discussed its Working Agenda**

Commissioner Altmaier said the only updates to the working agenda will be to prioritize the referrals as “3 – low priority” during the exposure period.

Having no further business, the Capital Adequacy (E) Task Force adjourned.
The Capital Adequacy (E) Task Force conducted an e-vote that concluded Sept. 18, 2019. The following Task Force members participated: Todd E. Kiser, Vice Chair, represented by Jake Garn (UT); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Ricardo Lara represented by Rachel Hemphill (CA); Andrew N. Mais represented by Wanchin Chou (CT); Stephen C. Taylor (DC); Trinidad Navarro represented by Dave Lonchar (DE); Vicki Schmidt represented by Tish Becker (KS); Chlora Lindley-Myers represented by John Rehagen (MO); Mike Causey represented by Jackie Obusek (NC); Marlene Caride (NJ); John G. Franchini represented by Anna Krylova (NM); Barbara D. Richardson represented by Joel Bengo (NV); Jillian Froment represented by Tom Botsko and Dale Bruggeman (OH); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Kent Sullivan represented by Doug Slape (TX); Mike Kreidler represented by Patrick McNaughton (WA); and Mark Afable represented by Randy Milquet (WI).

1. **Adopted its 2020 Proposed Charges**

The Task Force conducted an e-vote to consider adoption of its 2020 proposed charges.

Mr. Broccoli made a motion, seconded by Ms. Krylova, to adopt the Task Force’s 2020 proposed charges (*see NAIC Proceedings – Fall 2019, Financial Condition (E) Committee, Attachment One-A*). The motion passed.

Having no further business, the Capital Adequacy (E) Task Force adjourned.
The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met in Austin, TX, Dec. 8, 2019. The following Working Group members participated: Patrick McNaughton, Chair, and Steve Drutz (WA); Steve Ostlund (AL); Eric Unger (CO); Wanchin Chou (CT); Carolyn Morgan (FL); Tish Becker (KS); Rhonda Ahrens (NE); Tom Dudek (NY); Kimberly Rankin (PA); and Mike Boerner (TX). Also participating was: Tom Botsko (OH); and Andrew Schallhorn (OK).

1. Adopted its October 21 and Sept. 9 Minutes

The Working Group met Oct. 21 and Sept. 9. During these meetings, the Working Group took the following action: 1) expose the health test language proposal to the Life Risk-Based Capital (E) Working Group and the Health Risk-Based Capital (E) Working Group for a 30-day public comment period ending Nov. 20; 2) discuss the field testing in relation to the proposed changes to the health test; 3) refer the long-term care (LTC) health maintenance organization (HMO) guaranty fund memorandum to the Capital Adequacy (E) Task Force; 4) receive comments and rejected proposal 2019-04-H for health care receivables and agreed to continue to look into the matter; 5) receive comments on the excessive growth charge and the health bond structure; 6) discussed the managed care credit; and 7) receive an update on the Health Test Ad Hoc Group.

The Working Group also met Oct. 10 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.

Mr. Ostlund made a motion, seconded by Mr. Chou, to adopt the Working Group’s Oct. 21 (Attachment Two-A) and Sept. 9 (Attachment Two-B) minutes. The motion passed.

2. Discussed the Draft Health Bond Structure

Mr. McNaughton said that over the last couple of years, the Working Group has discussed the proposed recommendations from the American Academy of Actuaries (Academy) on the bond factors. During that time period, the Working Group exposed the Academy’s report “An Update to the Property & Casualty and Health Risk-Based Capital Bond Factors: Report to the NAIC Investment Risk-Based Capital (E) Working Group, Health Risk-Based Capital (E) Working Group, and Property and Casualty Risk-Based Capital (E) Working Group” and a draft of the proposed structure changes (Attachment Two-C). The Working Group received comments from UnitedHealth Group and America’s Health Insurance Plans (AHIP) in which they raised concerns regarding the inclusion of investment income, factors for the Aaa and AA1 bonds, and the bond portfolio adjustment included in the factors for speculative grade bonds. The Working Group asked the Academy to review these comments and provide its feedback.

Mr. McNaughton summarized the comments received from UnitedHealth on the investment income (Attachment Two-D). He said that in the Academy’s response (Attachment Two-E), it was noted that the property/casualty formula used investment income in the development of the underwriting risk and considered it to be redundant to include it in the development of the bond factors. The Academy also noted that it was unclear if investment income was used in the development of the underwriting risk in the health formula and indicated that updating the factors to include the investment income would require a number of considerations and assumptions to accommodate the impact.

Mr. McNaughton said that NAIC reviewed past minutes for the Working Group and did not find any discussion that investment income was considered in the development of the underwriting portion of the health risk-based capital (RBC) formula. He said investment income does not seem to be of significant relevance due to the need to hold liquid assets to cover short-term liabilities and that while health insurers may not pay dividends to policyholders, it is not uncommon for larger profitable health insurers to pay dividends to stockholders from earnings, which would include investment income.

Mr. Ostlund asked the significance of including or not including it in the factor development. Crystal Brown (NAIC) said it is her understanding that the Academy would have to go back into the data and update the model for a number of considerations and assumptions to incorporate or identify the impact of the investment income into the factors. Mr. Ostlund said it seems that the Working Group is expending a lot of time on something that may not have much of an impact. Mr. McNaughton agreed
and said that RBC is a regulator-only tool and that making changes to the formula that do not have a material impact may not be in the best interest of the Working Group.

Donna Novak (Novarest Consulting) said she was one of the actuaries who worked with the Academy on the development of the original health RBC formula. She said she did the modeling for the underwriting risk and does not remember including investment income; it was based all on the claims.

Mr. McNaughton said that UnitedHealth also commented on the proposed factors of Aaa and Aa1 bonds. He indicated that those bonds are less risky than the Aa2 bonds and recommended that a lower factor should be applied to these types of bonds. UnitedHealth suggested factors of 0.03% and 0.07% as opposed to the proposed factor of 0.1% from the Academy. Mr. McNaughton noted that the Academy responded that the factor of 0.1% for Aaa, AA1 and Aa2 bonds was recommended for reasons of conservatism. He said that the Academy noted that in considering a minimum risk factor, it also took into consideration the risk charge associated to the cash. He said that the Academy noted that if cash had a risk charge, then bonds should have a charge at least as great and that there could be other risks outside of the modeled risk of misuse or loss that should also be taken into consideration. Mr. McNaughton said that from a solvency and conservatism perspective, he recommended that the Working Group consider retaining the factor of 0.1% for the Aaa and AA1 bonds.

Mr. McNaughton said that AHIP (Attachment Two-F) expressed concerns with the recommended Academy factors that included the bond portfolio adjustment for the speculative grade bonds. In its letter, AHIP noted that it could find no basis for the assumption that the statistical fluctuation based on the portfolio size from the default/no-default variation is appropriate for any presumed variation by portfolio size due to market value fluctuations.

Mr. McNaughton said that it is important to note that from a consistency basis, the health formula is deviating from the treatment of the bond portfolio adjustment used in the life and P/C formulas by incorporating the bond portfolio adjustment into the factor itself. He said it is also important to remember that the life and P/C formulas do not differentiate between investment grade and speculative grade bonds when calculating the bond portfolio adjustment. Therefore, excluding the bond portfolio adjustment from the speculative bond factors would be an additional inconsistency incorporated into the health formula.

Mr. McNaughton said that through additional discussions with the Academy, it indicated that the data was not split between investment grade and speculative grade bonds when the factors were developed. Therefore, the Academy would have to go back and re-evaluate the data, which could result in a significant amount of effort. The Academy indicated that by removing the bond portfolio adjustment from the speculative grade bond factors, it could increase the investment grade bond factors. Mr. Chou suggested caution in moving forward with any changes to the factors.

Mr. McNaughton said that a conference call will be scheduled the week of Dec. 16 for the Working Group to address this item further with the Academy and determine how to move forward.

3. Received an Update on the Health Test Ad Hoc Group and Discussed Comments Received on the Health Test Language Proposal

Mr. McNaughton said the ad hoc group was formed to look at the health test and the impact it had on the results received for health premiums written in the US. The Working Group exposed the initial draft of the health test language proposal (Attachment Two-G) during its Oct. 21 conference call, and one comment letter was received from the American Council of Life Insurers (ACLI).

Steve Clayburn (ACLI) summarized the ACLI’s comments (Attachment Two-H). He said the review of the exposure with the ACLI’s members raised some practical implications because reducing the premium threshold from 95% to 90% could cause some companies to move from blank to blank each year. He suggested that the test be strengthened to make it a two-way test and suggested that the premium threshold be characterized as a threshold rather than a passing/failing test.

Mr. McNaughton said that the ad hoc group is aware of the possible burden on industry and the concern of having to move back and forth across blanks. He said that there could be some changes to the language to move towards a threshold approach and to give states greater discretion in working with their domestic companies when those thresholds are triggered. He said the main purpose is to identify what kind of business that company is writing.
Mr. McNaughton said that the ad hoc group met Nov. 8 via conference call to discuss the exposure of the health test language and the possibility of field testing. He said that they continue to evaluate enhancements to the health test language based on comments received and ongoing feedback.

Mr. McNaughton said that the ad hoc group will continue to evaluate how to move forward with field testing. However, a review of data found approximately 40 companies that have moved from the life blank to the health blank in the last 10 years, and this could be used as a starting point to evaluate the potential impact of moving from one blank to another. Mr. McNaughton said that the comments received will be referred to the ad hoc group for further consideration.

4. **Exposed the Health Care Receivable Guidance**

Mr. McNaughton said the Working Group rejected proposal 2019-04-H for health care receivables during its Oct. 21 conference call. He said the Working Group agreed to draft guidance on the reporting of the health care receivables within the annual statement filing and provide an explanation of how this data will be used in the development and re-evaluation of the health care receivable factors in the health RBC formula. He asked industry and states to consider providing examples or concerns that they have encountered in completing the Exhibit 3, Exhibit 3A and U&I Part 2B that could be incorporated into the guidance.

Hearing no objections, the Working exposed the Health Care Receivable Guidance proposal for a 30-day public comment period ending Jan. 7, 2020.

5. **Adopted Updates to its 2020 Working Agenda**

Ms. Brown said the health RBC working agenda was revised to update the priority of item 22 to a 3 and the expected completion date to 2023; item 23 and item 24 were updated to change the expected completion dates to the 2023 and 2022, respectively; and item 25 and item 26 were removed. Item 25 was removed because the response memorandum was completed and referred to the Capital Adequacy (E) Task Force, and Item 26 was removed due to premium amounts reported and the limited number of health entities that write long-term care (LTC) and long-term disability.

Mr. Chou asked for further clarification on the reason for the change to the expected completion of the health test ad hoc group. Ms. Brown explained that the group is moving forward in a two-phase approach: 1) review of the health test language; and 2) review of the annual statement blank to consider changes to schedules or supplements. Mr. McNaughton said that due to deadlines in which to make changes in the various groups, it will likely be closer to 2022 for implementation.

Mr. Ostlund made a motion, seconded by Mr. Chou, to adopt the updates to the 2020 health RBC working agenda. The motion passed.

6. **Received an Update on the Excessive Growth Charge Ad Hoc Group**

Mr. Drutz said the Excessive Growth Charge ad hoc group is moving forward with the referral from the Operational Risk (E) Subgroup and is considering possible changes.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
Health Risk-Based Capital (E) Working Group
Conference Call
October 21, 2019

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call Oct. 21, 2019. The following Working Group members participated: Patrick McNaughton, Chair, and Steve Drutz (WA); Steve Ostlund (AL); Eric Unger and Rolf Kaumann (CO); Wanchin Chou (CT); Carolyn Morgan and Gilbert Moreau (FL); Tish Becker (KS); Kristi Bohn (MN); Michael Muldoon (NE); Christine Gralton (NY); and Aaron Hodges and Mike Boerner (TX).

1. Discussed Oct. 10 Regulator-to-Regulator Conference Call

The Working Group met Oct. 10 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings to: 1) hear a recap of the Health Care Receivable Project from the American Academy of Actuaries (Academy) as it relates to the misreporting of health care receivables; and 2) discuss the Health Care Receivables proposal.

2. Exposed a Health Test Proposal

Mr. McNaughton said the Health Test Ad Hoc Group was developed by the Working Group to look at the health test language in the annual financial statement instructions due to the significant amount of health business that is reported on the life blank. The ad hoc group began its work in 2018 and agreed to approach the review in two phases. The first phase was to look specifically at the health test language as it is in the annual financial statement instructions. The second phase is to review the life and health annual financial statement blanks and identify changes or supplemental schedules that can be incorporated into each of these annual financial statement blanks.

Mr. McNaughton said the ad hoc group has completed the initial draft of the health test language blanks proposal, and the language was significantly modified to remove the following components of the test: 1) reserve ratio; 2) entity is licensed and actively issuing and/or renewing business in five states or less; 3) at least 75% of the entity’s current year premiums are written in the domiciliary state; and 4) the values for the premium and reserve ratios equal 100% in both the reporting and prior year. The premium ratio was also changed in the proposal; currently, the premium ratio must equal or exceed 95% of premiums. The proposal lowers the premium ratio to 90%.

Mr. McNaughton said this change alone will transition a significant amount of the health business currently being reported on the life blank over to be filed on the health blank. He said changes were made to the section labeled as “Variances from following these instructions,” in an effort to create dialogue and discussion with the entity’s state insurance regulator should the entity fall below the 90% premium ratio. He said the ad hoc group discussed this in detail and felt that it did not want to create a scenario where an entity may be required to move back and forth between blanks if they fell below 90%. The language, as drafted, will allow the entity to discuss business changes with the domestic regulator and allow for flexibility if business writings change.

Hearing no objections, the Working Group agreed to expose the draft proposal to the Health Risk-Based Capital (E) Working Group and the Life Risk-Based Capital (E) Working Group for a 30-day public comment period ending Nov. 20.

Mr. McNaughton said it is anticipated that there will be at least one subsequent exposure after the first of the year, likely for a 60-day public comment period.

3. Discussed Field-Testing the Health Test

Mr. McNaughton said, in conjunction with the initial exposure of the health test language, the ad hoc group is moving forward with a possible field-test exercise. The purpose of this field-testing is two-fold: 1) it could assist in identifying changes needed to the health test language, as well as identifying possible changes to the annual financial statement blanks that will be reviewed as part of Phase 2; and 2) it will allow state insurance regulators to identify the potential risk-based capital (RBC) impact on an entity that has been reporting on the life blank.
Mr. McNaughton said if the entity passes the health test, it would then be required to report on the health blank. The field-testing will be strictly voluntary, and a confidentiality agreement would be drafted between the company and the NAIC indicating that this information would be used only for this project. The field-testing memo outlines this approach.

Mr. McNaughton said the ad hoc group would like to move forward with the project as outlined and reach out to those companies who would meet the proposed 90% premium ratio requirement to see if they would be willing to volunteer. The goal is to have field-testing complete by the end of the year, if possible, and it would be based on the 2018 annual financial statement filing.

Hearing no objections, the ad hoc group will move forward with field-testing the health test.

4. **Agreed to Refer a Memorandum Regarding an RBC Charge for Guaranty Association Assessment Risk to the Capital Adequacy (E) Task Force**

Mr. McNaughton said the Working Group previously received a request from the Capital Adequacy (E) Task Force to review the referral letter regarding adopted amendments to the *Life and Health Insurance Guaranty Association Model Act* (#520) and determine if changes were warranted to the health RBC formula. The referral outlined significant amendments to Model #520, including: 1) broadening the assessment base for long-term care insurance (LTCI) insolvencies to include both life and health insurers and splitting the assessment equally between the life and health insurers; 2) clarifying the guaranty associations’ coverage of LTCI; and 3) including health maintenance organizations (HMOs) as members of the guaranty association, similar to other health insurers.

Mr. McNaughton said the Working Group exposed a response letter during its May 13 conference call that addressed the items noted in the referral letter. Currently, the guaranty fund assessment risk charge under the H4 – Business Risk component is 0.5%, and it is applied to direct earned premiums (as reported in Schedule T) in any state in which the reporting entity is subject to guaranty fund assessments. He said, based on the current instructions and reporting, there do not appear to be any modifications needed to the health RBC formula as a result of this change at this time.

Mr. McNaughton noted that there were no comments received on the original exposure of the letter; however, the Working Group was asked by other state insurance regulators to perform additional analysis on the consideration of those HMOs that do not pay premium taxes and would not have a method to recoup those assessments other than through premium increases. He said he and NAIC staff further reviewed the changes to Model #520 and the potential impact it could have on the health RBC formula with respect to HMOs. Based on the additional analysis of data specific to the application of guaranty fund laws in each state, we continue to believe that no changes to the formula are needed at this time.

Through the additional analysis performed, it was found that: 1) while some states have not yet adopted the changes to Model #520, once adopted, a majority of the states will allow for a premium tax or corporate tax offset, or the ability to impose a minimal surcharge to help offset the assessment; 2) at a maximum, HMOs would incur a charge of 2% (depending on each state’s guaranty fund law), and if they were unable to pay or meet this obligation, they could request a waiver from the guaranty fund of some or all of the assessment (currently, this is a fairly frequent practice); and 3) given the differences and complexities between the statutes in the regulation and taxation of HMOs, and given that the RBC formula is a generic formula, the goal of which is to be applied as uniformly as possible and not at such a granular level, it would be difficult to incorporate such changes into the formula that could address all the different scenarios needed to provide a different charge, offset or credit to such a distinct population in such diverse regulatory environments.

Mr. Kaumann made a motion, seconded by Mr. Ostlund, to refer a memorandum regarding an RBC charge for guaranty association assessment risk to the Capital Adequacy (E) Task Force (see *NAIC Proceedings – Fall 2019, Capital Adequacy (E) Task Force, Attachment Six*). The motion passed unanimously.

5. **Rejected Proposal 2019-04-H**

Mr. McNaughton said the health care receivables proposal was developed due to misreporting problems identified by the Academy in its review of the data for the health care receivable factor development. The proposal was designed to apply an additional charge for receivable amounts that were accrued in the prior year, but not recovered in the current year. The recommendation was to implement the proposal on an informational-only basis for 2020 and 2021, with full implementation in 2022.
Mr. McNaughton said the Working Group exposed the proposal on two separate occasions with comments received from America’s Health Insurance Plans (AHIP) and UnitedHealth Group (UHG). He said the original intent of the proposal was to encourage companies to report the health care receivables correctly within the annual financial statement blank.

Mr. McNaughton proposed an alternative option for moving forward with the health care receivables factor review. He suggested that the Working Group: 1) reject proposal 2019-04-H; and 2) draft guidance on the problems encountered with the reporting of the health care receivable data in the annual financial statement. He said the Working Group can work with the trades, the Academy and companies to identify the reporting concerns. Through these avenues, the Working Group can then draft guidance for reporting health care receivables in Underwriting & Investment Exhibit, Part 2h, Exhibit 3, and Exhibit 3a. The guidance includes an explanation of how the data reported in these exhibits will be used in the development of the revised health care receivables factors, beginning with data year 2020–2022. Included in the guidance could be scenarios of items encountered and how to correct those. This guidance could then be posted on the health RBC web page and sent to companies’ financial and RBC contacts.

Mr. Ostlund made a motion, seconded by Mr. Boerner, to reject proposal 2019-04-H. The motion passed unanimously.

Mr. McNaughton said the Working Group will continue to move to look at the health care receivables factors, but in a different manner.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call Sept. 9, 2019. The following Working Group members participated: Patrick McNaughton, Chair, David Hippen and Steve Drutz (WA); Steve Ostlund (AL); Wanchin Chou (CT); Carolyn Morgan (FL); Tish Becker (KS); Kristi Bohn (MN); Lindsay Crawford and Michael Muldoon (NE); Annette James (NV); Christine Gralton (NY); Kimberly Rankin (PA); and Mike Boerner (TX).

1. **Received Comments on Proposal 2019-04-H**

Mr. McNaughton said that the health care receivable proposal 2019-04-H (Attachment Two-B1 was re-exposed to include instructions from the Working Group’s July 17 conference call for a 30-day public comment period. Comment letters were received from UnitedHealth Group (Attachment Two-B2) and America’s Health Insurance Plans (AHIP) (Attachment Two-B3).

Jim Braue (UnitedHealth Group) summarized UnitedHealth Group’s comment letter. UnitedHealth Group suggested: 1) changes to the mathematical structure of the formula; 2) a review of the asymmetry; 3) exclusion of remaining receivables; 4) lack of proportionality; and 5) limitation of one-year of history. He said that UnitedHealth Group thinks it is important the proposal be in as final a form as possible before being implemented on even an informational-only basis. This will provide more useful information in how the proposal would work in practice and how it will affect companies going forward. He said that it may be beneficial to delay moving the proposal forward for a year in order to ensure that it is correct. Mr. Braue said that UnitedHealth Group has suggested an alternative formula and provided an example.

Kevin Russell (American Academy of Actuaries—Academy) said the issue of proportionality makes sense and while it adds some complexity to the formula, it could readily be accomplished. He said that the proportionality change could have a limit on the impact that any change would have on this year’s factor and that this may be a reason for not looking back a full three years but instead just looking back one or two years. He said all the suggestions are something that could be incorporated into the proposed changes.

The Working Group agreed to take the recommendations under advisement and to continue to review the proposal and discuss on a future conference call.

2. **Received Comments on the Excessive Growth Charge**

Mr. McNaughton said the Working Group received the excessive growth charge referral letter (Attachment Two-B4) from the Operational (E) Risk Subgroup and established an ad hoc group at the Spring National Meeting. Prior to the ad hoc group meeting, the Working Group exposed the referral letter and will use comments received in evaluating how to move forward with the excessive growth charge. Comment letters were received from AHIP (Attachment Two-B5) and UnitedHealth Group.

Mr. Braue summarized UnitedHealth Group’s comment letter (Attachment Two-B6) and agreed that there should be a review of the charge. However, he noted that charges are typically updated as a result of new experience or due to enhancements in the models used to produce them. However, this is not the case for the excessive growth charge. He said that the excessive growth charge as it exists today was more judgmentally based, and the rationale for changing it should be based on a review of: 1) if it has been working adequately in the past; 2) if there have been issues; 3) if it has failed to reflect actual problems that have occurred; or 4) if it has resulted false positives.

Mr. McNaughton said that based on the referral letter and comments received, the ad hoc group will focus on the key elements outlined in the letter if the charge should be revised or kept as it is. He said the group may consider if the risk is appropriately accounted for and if not, the group may need to look at how to describe and quantify the risk along with the parameters that should be considered. He said the first conference call will be set up for late September or early October.
3. Received Comments on Health Bond Structure

Mr. McNaughton said the Working Group exposed the draft structure and instructions for the 20 designations for NAIC bonds and recommended factors during its June 24 conference call. Comment letters were received from AHIP (Attachment Two-F) and UnitedHealth Group.

Mr. Braue summarized UnitedHealth Group’s comment letter (Attachment Two-D) on the bond structure proposal. He suggested that the factors used for miscellaneous fixed income assets and unaffiliated preferred stock that were based on the original bond factors be updated to reflect these changes suggested for bonds. He said this would not preclude any future studies’ independent factors for these asset types. He said UnitedHealth Group has some continuing concerns related to the factors for investment income, investment grade bond factors and speculative grade bonds.

Tim Deno (Academy) summarized the Academy’s response letter (Attachment Two-E). He said that through the Joint P&C/Health Bond Factors Analysis Work Group, the Academy identified that the property/casualty (P/C) risk-based capital (RBC) formula does include a portion of investment income in the underwriting risk. It is not clear if investment income is currently included in the underwriting risk portion of the health RBC formula.

Mr. Deno said that a minimum factor was set for the investment grade bonds because there is a minimum risk charge for cash. He said an appropriate relationship between the investment grade bond factors and cash factor should be considered.

Mr. Deno said that the life and P/C formulas include speculative grade bonds in the bond size adjustment, and for consistency purposes, speculative grade bonds were included in health. He said when the factors were developed, the data did not distinguish between the number of issuers on investment grade and speculative grade bonds, and if they were split, the data would have to be re-evaluated. He said that by doing this, in theory, the investment grade bond factors would raise some while speculative grade bond factors would go down slightly because of the volume that is there. He said a review of what assumptions are driving conservatism versus what assumptions are driving aggressiveness may need to be reviewed and to make sure that the Working Group is comfortable with these assumptions.

Crystal Brown (NAIC) said that the focus of the proposal at this time will be to update only the bond factors, with the recognition that there are other asset types whose factors were based on the original bond factors that will need to be looked at separately from the bonds. Ms. Brown said language could be added to the instructions for these other asset types indicating that the current factors were based on the original bond factors.

The Working Group asked NAIC staff to research through historical minutes to try to identify if investment income is currently included in the health formula. The Working Group will also research the inclusion of speculative grade bonds in the bond portfolio adjustment.

4. Discussed MCC

Mr. McNaughton said a question was brought to the Working Group in December 2018 pertaining to the execution of a risk-sharing contract with providers, which shifted paid claims from “Category 1 – Payments Made According to Contractual Arrangements” to “Category 2 – Payments Made Subject to Withholds or Bonuses That Are Otherwise Managed Care Category 1,” specifically when the change is modeled. There does not appear to be much of a benefit or change in credit when shifting from Category 1 to Category 2B. Mr. McNaughton said this resulted in a broader question: What was the original intent of the formula? Was it that the formula would yield the same managed care credit (MCC) (e.g., a 15% result) under Category 1 and 2B, even though the underlying arrangements are subject to different MCCs on their own? Or should a company get an additional credit under 2B compared to a 15% result under 1?

Mr. McNaughton said NAIC staff have reviewed the past minutes of the Health Risk-Based Capital (E) Working Group and found the original instructions. The instructions direct that the maximum credit for Category 2 withhold arrangements was 25% based upon a calculation that determines the ratio of withholds returned/bonuses paid to providers during the year prior to the reporting year to total withholds/bonuses during such year and then applies that ratio to the average provider withhold rate for the same prior year. If the underlying payment arrangement would otherwise fall under Category 1, and the MCC credit calculated under this category is less than 15%, the managed care organization (MCO) may use the Category 1 credit above and eliminate the effect of these payments on the calculation of the Category 2 credit. However, where payments that would otherwise fall under Category 0 are the only payments included in the credit calculation, the maximum credit is 15%. Mr. McNaughton reminded the Working Group that only one category may be used for each dollar of claims payment. Additional instructions and clarifications have been incorporated over time.
Ms. Rankin said that this could still be evolving with some of the federal Centers for Medicare & Medicaid Services (CMS) benefits and the rural hospital model as there could be some new factors that may affect this going forward.

The Working Group directed NAIC staff to continue to investigate how the formula is being calculated in comparison to the instructions.

5. Heard an Update on the Health Test Ad Hoc Group

Mr. McNaughton said the Health Test Ad Hoc Group met Aug. 26 and continued its discussion of revisions to the health test language that include: 1) removal of the reserve ratio requirement; and 2) added language that would provide guidance to state insurance regulators as to when a company would or would not move blanks if premium ratio falls below 90%. He said that the group also discussed the possibility of field testing. The group would like life insurers that meet the revised health test requirements to volunteer to complete the health RBC forecasting spreadsheet. This would assist state insurance regulators with understanding the overall impact of moving from the life RBC formula to the health RBC formula, as well as assist in identifying schedules that may be considered as supplements across blanks. He said the ad hoc group will next meet Sept. 27.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

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Capital Adequacy (E) Task Force

RBC Proposal Form

[ ] Catastrophe Risk (E) Subgroup  [ ] Investment RBC (E) Working Group  [ ] SMI RBC (E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup  [ ] P/C RBC (E) Working Group  [ ] Stress Testing (E) Subgroup

DATE:  3-6-19

CONTACT PERSON:  Crystal Brown

TELEPHONE:  816-783-8146

EMAIL ADDRESS:  cbrown@naic.org

ON BEHALF OF:  Health RBC (E) Working Group

NAME:  Patrick McNaughton

TITLE:  Chief Financial Examiner/Chair

AFFILIATION:  WA Office of Insurance Commissioner

ADDRESS:  PO Box 40255

Olympia, WA 98504-0255

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Agenda Item #:  2019-04-H

Year  2020

DISPOSITION

[ ] ADOPTED

[ ] REJECTED

[ ] DEFERRED TO

[ ] REFERRED TO OTHER NAIC GROUP

[ x ] EXPOSED  May 7, 2019, Aug. 18, 2019

[ ] OTHER (SPECIFY)

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

[ x ] Health RBC Blanks  [ ] Property/Casualty RBC Blanks  [ ] Life RBC Instructions
[ ] Fraternal RBC Blanks  [ x ] Health RBC Instructions  [ ] Property/Casualty RBC Instructions
[ ] Life RBC Blanks  [ ] Fraternal RBC Instructions  [ ] OTHER ______________

DESCRIPTION OF CHANGE(S)

Add a break out for health care receivables accrued vs. recovered from the CY and PY.

REASON OR JUSTIFICATION FOR CHANGE **

The purpose of the proposal is to apply an additional charge for receivable amounts that were accrued in the PY but not recovered in the CY.

Additional Staff Comments:

The proposal is being exposed would be on an informational only basis for 2020 & 2021 reporting with full implementation to the formula in 2022. The factors and instructions will be discussed in more detail on future calls and will exposed around the Summer National Meeting.

The proposed calculations include the current 5% and 19% factors for the health care receivables, additional consideration to change the factors will be addressed by the Working Group after 2020 data has been received.

4-7-19 cg The WG exposed the proposal along with a copy of the numeric examples for a 30-day comment period ending on 5-7-19.

5-7-19 cg Comment letter received from UnitedHealth Group.

7-17-19 cg Instructions were incorporated into the proposal. The WG agreed to re-expose the proposal for comment on the structure including annual statement references and instructions for a 30-day comment period ending on 8-19-19.

** This section must be completed on all forms.
XR020 - Other Receivables – L(25) through L(31)

There is an RBC requirement of 1 percent of the annual statement amount of investment income receivable and an RBC requirement of 5 percent of the annual statement amount for pharmaceutical rebates and amounts due from parents, subsidiaries, and affiliates, and aggregate write-ins for other than invested assets and an RBC requirement of 19 percent of the annual statement amount for all other health care receivables reported in Lines (26.2) through (26.6). Enter the appropriate value in Lines (25) through (31).

Line (26.1). Pharmaceutical rebates are arrangements between pharmaceutical companies and reporting entities in which the reporting entities receive rebates based upon the drug utilization of its subscribers at participating pharmacies. These rebates are sometimes recorded as receivables by reporting entities using estimates based upon historical trends which should be adjusted to reflect significant variables involved in the calculation, such as number of prescriptions written/filled, type of drugs prescribed, use of generic vs. brand-name drugs, etc. In other cases, the reporting entity determines the amount of the rebate due based on the actual use of various prescription drugs during the accumulation period and then bills the pharmaceutical company. Oftentimes, a pharmacy benefit management company may determine the amount of the rebate based on a listing (of prescription drugs filled) prepared for the reporting entity’s review. The reporting entity will confirm the listing and the pharmaceutical rebate receivable. Pharmaceutical rebates may relate to insured plans or uninsured plans. Only the receivable amount related to the insured plans should be reported on this line. Amount comes from annual statement Exhibit 3, Column 7, Line 0199999.

Line (26.2). Claim overpayments may occur as a result of several events, including but not limited to claim payments made in error to a provider. Reporting entities often establish receivables for claim overpayments. Amount comes from annual statement Exhibit 3, Column 7, Line 0299999.

Line (26.3). A health entity may make loans or advances to large hospitals or other providers. Such loans or advances are supported by legally enforceable contracts and are generally entered into at the request of the provider. In many cases, loans or advances are paid monthly and are intended to represent one month of fee-for-service claims activity with the respective provider. Amount comes from annual statement Exhibit 3, Column 7, Line 0399999.

Line (26.4). A capitation arrangement is a compensation plan used in connection with some managed care contracts in which a physician or other medical provider is paid a flat amount, usually on a monthly basis, for each subscriber who has elected to use that physician or medical provider. In some instances, advances are made to a provider under a capitation arrangement in anticipation of future services. Amount comes from annual statement Exhibit 3, Column 7, Line 0499999.

Line (26.5). Risk sharing agreements are contracts between reporting entities and providers with a risk sharing element based upon utilization. The compensation payments for risk sharing agreements are typically estimated monthly and settled annually. These agreements can result in receivables due from the providers if annual utilization is different than that used in estimating the monthly compensation. Amount comes from annual statement Exhibit 3, Column 7, Line 0599999.

Line (26.6). Any other health care receivable not reported in Lines (26.1) through (26.5). Amount comes from annual statement Exhibit 3, Column 7, Line 0699999.

Line (27). Only include on this line amounts receivable related to pharmaceutical rebates on uninsured plans that are in excess of the liability estimated by the reporting entity for the portion of such rebates due to the uninsured accident and health plans.
XR020-A Other Receivables for Informational Purposes Only

There is an RBC requirement of 1 percent of the annual statement amount of investment income receivable and an RBC requirement of 5 percent of the annual statement amount for amounts receivable relating to uninsured accident and health plans, amounts due from parents, subsidiaries, and affiliates, and aggregate write-ins for other than invested assets.

An additional charge will be applied to health care receivables amounts reported in Lines (30) through (35) that were accrued in the prior year but not recovered in the current year.

An example of the calculation is included below:

Example 1:

Claim overpayment receivable as of 12/31/2020 with substantial recoveries (but still a little less than the accrual)

a. Claim overpayment receivable as of 12/31/2020 of $1,000,000
b. Claim overpayment receivable as of 12/31/2019 of $900,000
c. Claim overpayment recoveries of $800,000 reported achieved in 2020 against accruals at 12/31/2019
d. Current formula amount: $1,000,000 x 0.19 = $190,000
e. Informational formula amount =
   = $1,000,000 x 0.19 + (1 - 0.19) x max(0, $900,000 - (1 + 0.19) x $800,000)
   = $190,000 + 0.81 x max(0, $900,000 - $952,000)
   = $190,000 + 0.81 x max(0, -$52,000)
   = $190,000

Example 2:

Claim overpayment receivable as of 12/31/2020, but with no recoveries:

a. Claim overpayment receivable as of 12/31/2020 of $1,000,000
b. Claim overpayment receivable as of 12/31/2019 of $900,000
c. Claim overpayment recoveries of $0 reported achieved in 2020 against accruals at 12/31/2019
d. Current formula amount: $1,000,000 x 0.19 = $190,000
e. Informational formula amount =
   = $1,000,000 x 0.19 + (1 - 0.19) x max(0, $900,000 - (1 + 0.19) x $0)
   = $190,000 + 0.81 x max(0, $900,000)
   = $190,000 + 0.81 x $900,000
   = $190,000 + $729,000
   = $919,000
Example 3:

Claim overpayment receivable as of 12/31/2020, but with recoveries of half the amount of the accrual:

a. Claim overpayment receivable as of 12/31/2020 of $1,000,000
b. Claim overpayment receivable as of 12/31/2019 of $900,000
c. Claim overpayment recoveries of $450,000 reported achieved in 2020 against accruals at 12/31/2019
d. Current formula amount: $1,000,000 x 0.19 = $190,000
e. Informational formula amount =

\[ \text{Amount} = 1,000,000 \times 0.19 + (1 - 0.19) \times \max(0, 900,000 - (1 + 0.19) \times 450,000) \]
\[ = 190,000 + 0.81 \times \max(0, 900,000 - 535,500) \]
\[ = 190,000 + 0.81 \times 364,500 \]
\[ = 190,000 + 295,245 \]
\[ = 485,245 \]
### Other Receivables (excluding Health Care Receivables)

<table>
<thead>
<tr>
<th>Item</th>
<th>Annual Statement Source</th>
<th>Amount</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(25) Investment Income Receivable</td>
<td>Page 2, Col. 3, Line 14</td>
<td></td>
<td>0.010</td>
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<tr>
<td>(26) Accounts Receivable Relating to Uninsured Accident and Health Plans</td>
<td>Included in Page 2, Col. 3, Line 17</td>
<td>0.050</td>
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<tr>
<td>(27) Amounts Due from Parents, Subs, and Affiliates</td>
<td>Page 2, Col. 3, Line 23</td>
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<td>0.050</td>
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</tr>
<tr>
<td>(28) Aggregate Write-Ins For Other Than Invested Assets</td>
<td>Page 2, Col. 3, Line 25</td>
<td></td>
<td>0.050</td>
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<tr>
<td>(29) Sub-Total Other Receivables RBC</td>
<td>Sum L(25) through L(28)</td>
<td></td>
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</tbody>
</table>

### Health Care Receivables

<table>
<thead>
<tr>
<th>Item</th>
<th>Annual Statement Source</th>
<th>Amount</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(30.1) Pharmaceutical Rebate Receivables – Current Year</td>
<td>Exhibit 3, Col. 7, Line 0199999 (CY)</td>
<td></td>
<td>0.050</td>
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</tr>
<tr>
<td>(30.2) Pharmaceutical Rebate Receivables – Prior Year</td>
<td>Exhibit 3, Col. 7, Line 0199999 (PY)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(30.3) Pharmaceutical Rebates – Prior Year Collected in the Current Year</td>
<td>Exhibit 3A, Col. 1, Line 1 ??</td>
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<td>#</td>
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<tr>
<td>(31.1) Claim Overpayment Receivables – Current Year</td>
<td>Exhibit 3, Col. 7, Line 0299999 (CY)</td>
<td></td>
<td>0.190</td>
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<tr>
<td>(31.2) Claim Overpayment Receivables – Prior Year</td>
<td>Exhibit 3, Col. 7, Line 0299999 (PY)</td>
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<td>(31.3) Claim Overpayment Rebates – Prior Year Collected in the Current Year</td>
<td>Exhibit 3A, Col. 1, Line 2 ??</td>
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<tr>
<td>(32.1) Loan and Advances to Providers – Current Year</td>
<td>Exhibit 3, Col. 7, Line 0399999 (CY)</td>
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<td>0.190</td>
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<tr>
<td>(32.2) Loan and Advances to Providers – Prior Year</td>
<td>Exhibit 3, Col. 7, Line 0399999 (PY)</td>
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<td></td>
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<tr>
<td>(33.1) Captation Arrangement Receivables – Current Year</td>
<td>Exhibit 3, Col. 7, Line 0499999 (CY)</td>
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<td>0.190</td>
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<tr>
<td>(33.2) Captation Arrangement Receivables – Prior Year</td>
<td>Exhibit 3, Col. 7, Line 0499999 (PY)</td>
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<tr>
<td>(33.3) Captation Arrangement Receivables – Prior Year Collected in the Current Year</td>
<td>Exhibit 3A, Col. 1, Line 3 ??</td>
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<td>*</td>
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<tr>
<td>(34.1) Risk Sharing Receivables – Current Year</td>
<td>Exhibit 3, Col. 7, Line 0599999 (CY)</td>
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<td>0.190</td>
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<tr>
<td>(34.2) Risk Sharing Receivables – Prior Year</td>
<td>Exhibit 3, Col. 7, Line 0599999 (PY)</td>
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<td>(34.3) Risk Sharing Receivables – Prior Year Collected in the Current Year</td>
<td>Exhibit 3A, Col. 1, Line 4 ??</td>
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<tr>
<td>(35.1) Other Health Care Receivables – Current Year</td>
<td>Exhibit 3, Col. 7, Line 0699999 (CY)</td>
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<td>0.190</td>
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<tr>
<td>(35.2) Other Health Care Receivables – Prior Year</td>
<td>Exhibit 3, Col. 7, Line 0699999 (PY)</td>
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<td></td>
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<tr>
<td>(35.3) Other Health Care Rebates – Prior Year Collected in the Current Year</td>
<td>Exhibit 3A, Col. 1, Line 6 ??</td>
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</tr>
<tr>
<td>(36) Sub-Total Health Care Receivables</td>
<td>Sum of Line (30.1) through Line (35.3)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(37) Total Other Receivables RBC</td>
<td>Line (29) + Line (36)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(38) Adjusted Informational Credit RBC</td>
<td>Line (17) + Line (29) + Line (37)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Denotes items that must be manually entered on filing software.

- For Pharmaceutical Rebates: [Greater of 0 or L(30.2) minus (1 + .05) times Line (30.3)] times (1 - .05)
- For Claim Overpayment, Loan and Advances to Providers, Captation Arrangements, Risk Sharing, and Other Health Care Receivables: [Greater of 0 or L(3.2) minus (1 + .19) times L(3.3)] times (1 - .19)
## CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

### H3 - CREDIT RISK

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>Total Reinsurance RBC</td>
<td>XR019, Credit Risk Page, L(17)</td>
</tr>
<tr>
<td>29</td>
<td>Intermediaries Credit Risk RBC</td>
<td>XR019, Credit Risk Page, L(24)</td>
</tr>
<tr>
<td>30</td>
<td>Total Other Receivables RBC</td>
<td>XR020, Credit Risk Page, L(30)</td>
</tr>
<tr>
<td>31</td>
<td>Total H3</td>
<td>Sum L(28) through L(30)</td>
</tr>
</tbody>
</table>

### H3A - CREDIT RISK - (Informational Purposes Only)

<table>
<thead>
<tr>
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<th>Description</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>28A</td>
<td>Total Reinsurance RBC</td>
<td>XR019, Credit Risk Page, L(17)</td>
</tr>
<tr>
<td>29A</td>
<td>Intermediaries Credit Risk RBC</td>
<td>XR019, Credit Risk Page, L(24)</td>
</tr>
<tr>
<td>30A</td>
<td>Total Other Receivables RBC</td>
<td>XR020A, Credit Risk Page, L(37)</td>
</tr>
<tr>
<td>31A</td>
<td>Total H3</td>
<td>Sum L(28A) through L(30A)</td>
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</table>

### H4 - BUSINESS RISK

<table>
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<tr>
<th></th>
<th>Description</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>Administrative Expense RBC</td>
<td>XR021, Business Risk Page, L(7)</td>
</tr>
<tr>
<td>33</td>
<td>Non-Underwritten and Limited Risk Business RBC</td>
<td>XR021, Business Risk Page, L(11)</td>
</tr>
<tr>
<td>34</td>
<td>Premiums Subject to Guaranty Fund Assessments</td>
<td>XR021, Business Risk Page, L(12)</td>
</tr>
<tr>
<td>35</td>
<td>Excessive Growth RBC</td>
<td>XR021, Business Risk Page, L(19)</td>
</tr>
<tr>
<td>36</td>
<td>Total H4</td>
<td>Sum L(32) through L(35)</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>RBC after Covariance Before Basic Operational Risk</td>
<td>H0 + Square Root of (H1^2+H2^2+H3^2+H4^2)</td>
</tr>
<tr>
<td>38</td>
<td>Basic Operational Risk</td>
<td>0.030 x L(37)</td>
</tr>
<tr>
<td>39</td>
<td>C-4a of U.S. Life Insurance Subsidiaries</td>
<td>Company Records</td>
</tr>
<tr>
<td>40</td>
<td>Net Basic Operational Risk</td>
<td>Line (38) - Line (39) (not less than zero)</td>
</tr>
<tr>
<td>41</td>
<td>RBC After Covariance Including Basic Operational Risk</td>
<td>L(37) + L(40)</td>
</tr>
<tr>
<td>42</td>
<td>Authorized Control Level RBC</td>
<td>.50 x L(41)</td>
</tr>
</tbody>
</table>

**For Informational Purposes Only**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>37A</td>
<td>RBC after Covariance Before Basic Operational Risk</td>
<td>H0 + Square Root of (H1^2+H2^2+H3^2+H4^2)</td>
</tr>
<tr>
<td>38A</td>
<td>Basic Operational Risk</td>
<td>0.030 x L(37A)</td>
</tr>
<tr>
<td>39A</td>
<td>C-4a of U.S. Life Insurance Subsidiaries</td>
<td>Company Records</td>
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<tr>
<td>40A</td>
<td>Net Basic Operational Risk</td>
<td>Line (38A) - Line (39A) (not less than zero)</td>
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<td>41A</td>
<td>RBC After Covariance Including Basic Operational Risk</td>
<td>L(37A) + L(40A)</td>
</tr>
<tr>
<td>42A</td>
<td>Authorized Control Level RBC</td>
<td>.50 x L(41A)</td>
</tr>
</tbody>
</table>

Denotes items that must be manually entered on filing software.
August 15, 2019

Mr. Patrick McNaughton, Chair
Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO  64106-2197

Via electronic mail to Crystal Brown.

Re: Proposal 2019-04-H

Dear Mr. McNaughton:

I am writing on behalf of UnitedHealth Group Incorporated. We appreciate the opportunity to comment on RBC Proposal 2019-04-H, exposed for comment by the Health Risk-Based Capital (E) Working Group on July 19, 2019. The proposal seeks to alter the risk charges applied to health care receivables, on an informational-only basis in 2020 and 2021, with the expectation of full implementation in 2022. The current proposal is a modification, adding instructional language, of the proposal exposed on April 8, 2019.

Need for changes to the proposal.

The currently exposed proposal, while adding instructional language to the previously exposed proposal, does not make any substantive changes to that proposal. In particular, it does not address any of the points raised in our May 7, 2019, comment letter, which we have attached for reference.

We recognize that initially the proposed charge for health care receivables would be used for informational purposes only, and would not affect the Risk-Based Capital measures on which regulatory action may be based. We also recognize that, at least in part, the proposed charge is intended to encourage accurate financial reporting by penalizing entities that fail to properly report their experience with the collection of health care receivables. However, once the proposed charge becomes fully implemented in 2022, its use as a penalty will no longer be appropriate; the charge will affect the solvency regulation of insurance companies and HMOs, and must be directed solely to that purpose. Therefore, before 2022, the charge for health care receivables must be put in a form that will enhance solvency regulation. As explained in our
previous comment letter, the current formulation of the charge does not seem to serve that purpose well.

As the charge will not be fully implemented until 2022, there is still time to refine it. However, the informational phase of the charge will be most useful if the informational formula is as close as possible to what will ultimately be implemented. The entities subject to RBC will also be able to plan more effectively if the informational charge closely represents the ultimate form. Therefore, as far as possible, any anticipated changes to the charge should be made now, at the beginning of the informational period.

We note again that while this charge probably will not be significant for most reporting entities, it may be significant in specific cases. If that were never true, there would be no purpose in revising the charge at all. Therefore, if the charge is indeed to be revised, it should be revised to be as appropriate and effective as possible.

Specific recommendations.

It seems clear to us that some changes to the proposal are indeed necessary. The changes that we recommend, and the rationales for those changes, are addressed in detail in the attached comments from May 7; but we will summarize them here, for convenience.

Mathematical structure of the formula.

The mathematical structure of the exposed formula is unintuitive. A simpler form is recommended, which would have a more obvious interpretation.

Asymmetry.

Under the current proposal, reporting entities are penalized for poor collection experience, but receive no benefit from good collection experience. This does not seem to reflect relative risks properly. We recommend that the formula also allow a charge below the current standard factor, with a floor of 1%.

Exclusion of remaining receivables.

The current proposal reflects only those amounts collected in the following year, and not amounts outstanding at the end of the year that are still expected to be received. This is especially problematic for items such as loans and advances to providers, which may not ever have been intended to be collected in full within the first year. We recommend that the receivables still outstanding at the end of the year also be reflected.

Lack of proportionality.

The proposed add-on charge is based on the prior-year receivable. We recommend that it be scaled proportionally to the current-year receivable, as better reflecting the current risk profile of the reporting entity.
Limitation to one year of history.

The proposed charge is based on one year of run-out. The result could be distorted by one-time issues, as well as normal year-to-year fluctuations in experience. A longer, but still relatively current, time period should be used. We recommend the use of three years of experience (including, as noted above, any receivables still remaining at the end of each year). Although there was some concern expressed by members of the Working Group that this would add complexity, the necessary data would be readily available and the complexity is more an appearance than an actual practical hindrance. A more stable and meaningful result would justify the use of the additional years of data.

Recommended formula.

Based on the matters discussed above, we recommended the following formula for the risk charge for each category of health care receivables.

(A) Sum of receivables for the preceding three years.

(B) Sum of collections of those receivables in the subsequent year, plus any amount of such receivables that remained outstanding at the end of the subsequent year.

(C) Shortfall percentage: \[1 - \frac{(B)}{(A)}\]

(D) Receivable for the current year.

(E) Risk charge: greater of \[0.01 \cdot (D)\] and \[(C) \cdot (D)\].

There may be instances where an entity does not have recent history for a particular type of receivable (e.g., because a provider risk-sharing arrangement produced a payable rather than a receivable in the prior year). This would probably occur less frequently if the calculation used three years of history, as we have recommended, but might still occur. In such cases, it would be appropriate for the risk charge to default to the current standard factor (i.e., 5% for pharmacy rebate receivables and 19% for other categories of health care receivables) multiplied by the current receivable amount.

Instructional language.

The instructional language that was added to the latest exposed proposal seems appropriate for the proposal as such. However, it would need to be modified to reflect the recommendations stated above. Such modified language follows the body of this letter.

* * * * * *

We appreciate your consideration of our comments, and we would be happy to discuss this matter further with the Working Group.
James R. Braue
Director, Actuarial Services
UnitedHealth Group

Attachment: UnitedHealth Group comment letter of May 7, 2019

cc: Crystal Brown, NAIC
    Randi Reichel, UnitedHealth Group
XR020-A Other Receivables for Informational Purposes Only

There is an RBC requirement of 1 percent of the annual statement amount of investment income receivable and an RBC requirement of 5 percent of the annual statement amount for amounts receivable relating to uninsured accident and health plans, amounts due from parents, subsidiaries, and affiliates, and aggregate write-ins for other than invested assets.

An additional charge will be applied to health care receivables amounts reported in Lines (30) through (35) that were accrued in prior years but not recovered in later years.

Examples of the calculations are included below:

Example 1:
Claim overpayment receivable as of 12/31/2020 with substantial recoveries (but still a little less than the accrual)
   a. Claim overpayment receivable as of 12/31/2020 of $1,000,000
   b. Claim overpayment receivable as of 12/31 in 2017 through 2019 totaling $2,700,000
   c. Claim overpayment recoveries of $2,400,000 received or accrued in 2018-2020 against accruals at 12/31 for 2017-2019
   d. Shortfall percentage: \((1 - \frac{2,400,000}{2,700,000}) = 11.1111\%\)
   e. Informational formula amount = 
     \[= \max(1\%, 11.1111\%) \times \$1,000,000\]
     \[= \$111,111\]

Example 2:
Claim overpayment receivable as of 12/31/2020, but with no recoveries:
   a. Claim overpayment receivable as of 12/31/2020 of $1,000,000
   b. Claim overpayment receivable as of 12/31 in 2017 through 2019 totaling $2,700,000
   c. Claim overpayment recoveries of $0 received or accrued in 2018-2020 against accruals at 12/31 for 2017-2019
   d. Shortfall percentage: \(1 - \frac{0}{2,700,000} = 100\%\)
   e. Informational formula amount = 
     \[= \max(1\%, 100\%) \times \$1,000,000\]
     \[= \$1,000,000\]

Example 3:
Claim overpayment receivable as of 12/31/2020, but with recoveries of half the amount of the accrual:
   a. Claim overpayment receivable as of 12/31/2020 of $1,000,000
   b. Claim overpayment receivable as of 12/31 in 2017 through 2019 totaling $2,700,000
   c. Claim overpayment recoveries of $1,350,000 received or accrued in 2018-2020 against accruals at 12/31 for 2017-2019
   d. Shortfall percentage: \((1 - \frac{1,350,000}{2,700,000}) = 50\%\)
e. Informational formula amount = 
   = max(1%, 50%) x $1,000,000 
   = $500,000
May 7, 2019

Mr. Patrick McNaughton, Chair
Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Via electronic mail to Crystal Brown.

Re: Proposal 2019-04-H

Dear Mr. McNaughton:

I am writing on behalf of UnitedHealth Group, Incorporated. We appreciate the opportunity to comment on RBC Proposal 2019-04-H, exposed for comment by the Health Risk-Based Capital (E) Working Group on April 8, 2019. The proposal seeks to alter the risk charges applied to health care receivables, on an informational-only basis in 2020 and 2021, with the expectation of full implementation in 2022.

We understand the purpose of the changes being proposed. We do have several concerns, however, about how the underlying intent would be implemented by this proposal. Our concerns relate to several areas, as indicated by the headings below.

Mathematical structure of the formula.

The proposed risk charge formula can be summarized as follows, where “f” means the factor of 0.05 for pharmaceutical rebate receivables and 0.19 for all other categories of health care receivables; “CY” and “PY” refer to “current year” and “prior year” receivables, respectively; and “COLL” is the collections during the current year on the prior-year receivable. The proposed risk charge is equal to the currently applicable risk charge, $f \cdot CY$, plus an add-on equal to the greater of zero and the following:

\[(1 - f) \cdot (PY - [1+f] \cdot COLL)\]

This add-on (when not zero) can be restated as:

\[(1 - f) \cdot PY - (1 - f^2) \cdot COLL\]
The proper interpretation of this expression is not clear. The motivation for the add-on perhaps is that if the shortfall in collections of the prior-year receivable exceeds the risk charge that the existing formula would have produced, the excess should be treated as an additional risk charge. However, that is not the outcome of the formula as proposed. For that purpose, the formula should be comparing the prior-year risk charge, \((f \cdot PY)\), to the shortfall in collections, \((PY - COLL)\). In that case, the add-on would be the greater of zero and \((PY - COLL - f \cdot PY)\); that last expression can also be written as \(((1-f) \cdot PY - COLL)\).

Note that the add-on as currently proposed is either greater than or equal to the revised add-on suggested above.

**Asymmetry.**

As currently proposed, the add-on is one-sided: reporting entities are penalized for poor collection experience, but receive no benefit from good collection experience. Even if the entity collects every dollar which it reported as receivable — in fact, even if it recovers more than it conservatively expected to — it receives no reduction from the standard risk charge.

This is particularly troublesome with respect to the categories of health care receivables to which the factor of 0.19 applies. As we explained in our letter of May 20, 2016, regarding RBC Proposal 2016-06-H, we have several concerns about the analysis that led to the adoption of the 0.19 factor. Given the tenuous basis for that factor, it should not be considered a floor. At a minimum, the add-on should be allowed to be negative, at least to the extent that it reduced the effective factor to the original level of 0.05.

However, it is questionable whether even 0.05 should be the floor. The 0.05 factor was intended to cover a fairly wide range of possible outcomes, in order to provide the appropriate level of conservatism for RBC. If a wider range of unfavorable outcomes will be addressed by the add-on, then presumably a lower factor can be applied to the entities with favorable outcomes. A minimum of 0.01 (which is the maximum charge for non-controlled assets, the charge for NAIC 2 bonds and preferred stock, and the charge for investment income receivable) might be more appropriate.

**Exclusion of remaining receivables.**

Based on the tentative references in the proposal, which refer to Exhibit 3A column 1 only and not to column 3, only actual collections during the subsequent year would be recognized in determining the add-on. For some receivables, such as pharmaceutical rebate receivables, it might be reasonable to suppose that substantially all collections would take place within one year. However, for other receivables, such as loans and advances to providers, the intention of the parties may very well have been that the amount would be repaid over a longer period of time. Therefore, not only the subsequent-year collections, but any receivable remaining at the end of the year, should be reflected in calculating the add-on. That is to say, both column 1 and column 3 of Exhibit 3A should be used (or, equivalently, column 5, which is the sum of columns 1 and 3).
We realize that there may have been some concern about the collectability of any receivable remaining after the passage of a full year. However, we note that the reporting entity is required to perform an analysis of the collectability of its receivables, and to write off any amounts if it is probable that they are uncollectable (per Statement of Statutory Accounting Principles No. 84). This analysis is subject to review by the entity’s auditors and examination by the entity’s regulators. It does not seem appropriate to completely exclude assets that are deemed to have value under the NAIC’s accounting rules.

We note furthermore that the remaining receivable will in fact be subject to a credit risk charge, along with all other health care receivables reported at year-end. Therefore, the collectability of such receivables will be addressed by the credit risk charge calculation.

**Lack of proportionality.**

The add-on is based on the prior-year receivable; but this is appropriate only if the level of receivables is reasonably stable from year to year. Receivables for pharmaceutical rebates are likely to be stable if the volume of business is stable, but receivables for provider risk-sharing can be quite volatile; and even receivables for pharmaceutical rebates can change greatly from year to year if there is significant growth or decline in the book of business. This could, in some cases, lead to the total risk charge (basic risk plus add-on) actually exceeding the current-year receivable, which seems wholly unreasonable.

To address this problem, it would be appropriate to scale the add-on based on the relationship of the current-year receivable to the prior-year receivable.

**Limitation to one year of history.**

The add-on is calculated based on one year of run-out for the most recent prior-year receivable. This could lead to the results being distorted by a non-recurring issue, e.g., difficulty in collecting claim overpayments from a provider group that has been terminated from the network. Since the group has been terminated, it will not be producing additional receivables subject to collection; but the proposed formula will penalize the entity for that past problem, regardless of its applicability to the future.

One way to address this is to look at the collection history over a longer period. It is true that a longer period might mute the effect of changes in methodology (either estimation methodology or collection methodology); however, such changes would not be picked up in the year they occurred in any case. That said, it is true that the longer the historical period that is reviewed, the less relevance it may have to current conditions. Therefore, it seems appropriate to use an intermediate-length period such as three years.

Because of the possibility of non-recurring issues, and just normal year-to-year fluctuations in experience, the add-on factor could be highly variable in amount from year to year. This creates problems for the reporting entities, which will find capital planning much more difficult. It also creates problems for the regulator, as it calls into question the meaningfulness of RBC if the
amount changes significantly from year to year for a reasonably stable book of business. The use of a multi-year experience period will help to smooth out this volatility.

We understand the Working Group’s preference to use only information that is available from the current year’s Annual Statement. However, there are other portions of the Health RBC formula that use information available only from company records. As in those cases, it seems that here the advantages of using extra information outweigh the disadvantages, especially since the extra information can be verified from previous years’ Annual Statements rather than relying on internal company records.

Conclusion

We have discussed above the problems that we perceive to exist with the proposal, related to the interpretation of the add-on charge, the asymmetry of that charge, the exclusion of the receivables remaining at the end of the year, the non-proportionality of the charge, and the volatility of the charge. We believe that all of those problems can be addressed, by using a calculation such as the following:

(A) Sum of receivables for the preceding three years.

(B) Sum of collections of those receivables in the subsequent year, plus any amount of such receivables that remained outstanding at the end of that subsequent year.

(C) Shortfall percentage: [1 – (B) / (A)].

(D) Receivable for the current year.

(E) Risk charge: greater of [0.01 • (D)] and [(C) • (D)].

(Note that (C) is based on the sum of three years’ amounts, rather than the average of percentages calculated separately for each year. This is so that a small amount in one year will not be given undue weight.)

It might be suggested that this somewhat more complicated formula is not warranted, because the covariance adjustment will greatly reduce the impact of this risk charge. While that may be true in general, the charge could be significant for specific reporting entities. If that were not the case — if this charge were never significant — then there would be no need to alter the formula at all. If any change is to be contemplated, it should be designed to address the concerns that we have stated above.

We appreciate your consideration of our comments, and we would be happy to discuss this matter further with the Working Group.
James R. Braue
Director, Actuarial Services
UnitedHealth Group

cc: Crystal Brown, NAIC
Randi Reichel, UnitedHealth Group
August 19, 2019

Mr. Patrick McNaughton
Chair, Health Risk-Based Capital Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri  64108-2662

Re: Comments on Exposure of Proposed 2019-04-H

Dear Mr. McNaughton:

America’s Health Insurance Plans (AHIP) appreciates the opportunity to provide these comments on the exposure of 2019-04-H with respect to Healthcare Receivables.

We understand that the general approach as outlined by the Academy’s proposal is trying to address the issue that a number of companies do not report significant payments against the various Healthcare Receivable amounts established at each year-end. Because this is more than just a few companies, the factor applied to the year-end admitted asset to be higher than necessary. We have some concern with using the RBC filing to address financial reporting issues that are more a financial analysis function. That being said, if the resulting approach reduces the RBC requirement for those companies that are correctly reporting payments of these receivables and/or increases the accuracy of the reporting of payments, we can support the temporary use of the proposed informational filing, thus giving time for the actual issue to be addressed in the proper forum.

We would support small modifications to the proposal as recommended by UnitedHealth Group as follows:

1. Adjust the portion of the uncovered Healthcare receivable from the prior year by the ratio of the current year amount to the prior year amount. We would recommend that this be done during the test phase in two parts – (i) for Pharmacy Rebates and (ii) for all other types combined. This is because there is less credible data for the types of receivables other than Pharmacy rebates and the same average factor is applied to all other types. We also recommend that this ratio factor be limited to a minimum of not more than 2.00 so that a small amount of prior year receivable amounts do not overly increase the RBC for the assumed non-recovery for the current year receivable amounts.

2. Adjust the factor applied to the current year-end amount to 60-75% of the current factor to recognize that the new approach applies a significant factor to address the under-reporting of payments against these receivables. Since the large under-reporting is the cause of the use of a higher factor than if such under-reporting did not occur (i.e. if there was only mis-estimation of the amount to be recovered, the factor should be significantly lower), the test
AHIP Comments on HRBCWG Exposure 2019-04-H
August 19, 2019
Page 2

should assume that, after review of the information reported in 2020-2021, the Academy will be recommending some reduction from the 5% or 19% current factors.

To make the above changes (using 60% of the current factor) on page XR020A, the factor in line (30.1) would be 0.030 and the factor in Lines (31.1, 32.1, 33.1, 34.1 and 35.1) would be 0.120. In addition, the footnotes on page XR020A would be changed to:

# For Pharmaceutical Rebates: [Greater of 0 or L(30.2) minus (1+.03) times Line (30.3)] times (1-.03) times [min 2, {Line (30.1) divided by Line (30.2)}] \(^1\)

* For Claim Overpayment, Loan and Advances to Providers, Capitation Arrangements and Risk Sharing, and Other Health Care Receivables: [Greater of 0 or (L3.2 minus (1+.12) times L(3.3)] times (1-.12) times [min 2, {Sum of L(31.1) + L(32.1) + L(33.1) + (L34.1) + L35.1) divided by Sum of L(31.2) + L(32.2) + L(33.2) + (L34.2) + L35.2)] \(^2\)

Attached are our recommended revisions to the instructions consistent with the above changes to the formula.

We would be happy to address any questions the Working Group has with these comments.

Sincerely,

William C. Weller
Actuarial Consultant to AHIP

c/c: Crystal Brown, NAIC
       Candy Gallaher, AHIP

\(^1\) If Line 30.2 is zero use a ratio factor of 1.
\(^2\) If the sum of Lines 31.2 + 32.2 + 33.2 + 34.2 + 35.2 is zero use a ratio factor of 1.
XR020 - Other Receivables – L(25) through L(31)

There is an RBC requirement of 1 percent of the annual statement amount of investment income receivable and an RBC requirement of 5 percent of the annual statement amount for pharmaceutical rebates and amounts due from parents, subsidiaries, and affiliates, and aggregate write-ins for other than invested assets and an RBC requirement of 19 percent of the annual statement amount for all other health care receivables reported in Lines (26.2) through (26.6). Enter the appropriate value in Lines (25) through (31).

Line (26.1). Pharmaceutical rebates are arrangements between pharmaceutical companies and reporting entities in which the reporting entities receive rebates based upon the drug utilization of its subscribers at participating pharmacies. These rebates are sometimes recorded as receivables by reporting entities using estimates based upon historical trends which should be adjusted to reflect significant variables involved in the calculation, such as number of prescriptions written filled, type of drugs prescribed, use of generic vs. brand-name drugs, etc. In other cases, the reporting entity determines the amount of the rebate due based on the actual use of various prescription drugs during the accumulation period and then bills the pharmaceutical company. Occasionally, a pharmacy benefit management company may determine the amount of the rebate based on a listing (of prescription drugs filled) prepared for the reporting entity’s review. The reporting entity will confirm the listing and the pharmaceutical rebate receivable. Pharmaceutical rebates may relate to insured plans or uninsured plans. Only the receivable amount related to the insured plans should be reported on this line. Amount comes from annual statement Exhibit 3, Column 7, Line 01999999.

Line (26.2). Claim overpayments may occur as a result of several events, including but not limited to claim payments made in error to a provider. Reporting entities often establish receivables for claim overpayments. Amount comes from annual statement Exhibit 3, Column 7, Line 02999999.

Line (26.3). A health entity may make loans or advances to large hospitals or other providers. Such loans or advances are supported by legally enforceable contracts and are generally entered into at the request of the provider. In many cases, loans or advances are paid monthly and are intended to represent one month of fee-for-service claims activity with the respective provider. Amount comes from annual statement Exhibit 3, Column 7, Line 03999999.

Line (26.4). A capitation arrangement is a compensation plan used in connection with some managed care contracts in which a physician or other medical provider is paid a flat amount, usually on a monthly basis, for each subscriber who has elected to use that physician or medical provider. In some instances, advances are made to a provider under a capitation arrangement in anticipation of future services. Amount comes from annual statement Exhibit 3, Column 7, Line 04999999.

Line (26.5). Risk sharing agreements are contracts between reporting entities and providers with a risk sharing element based upon utilization. The compensation payments for risk sharing agreements are typically estimated monthly and settled annually. These agreements can result in receivables due from the providers if annual utilization is different than that used in estimating the monthly compensation. Amount comes from annual statement Exhibit 3, Column 7, Line 05999999.

Line (26.6). Any other health care receivable not reported in Lines (26.1) through (26.5). Amount comes from annual statement Exhibit 3, Column 7, Line 06999999.

Line (27). Only include on this line amounts receivable related to pharmaceutical rebates on uninsured plans that are in excess of the liability estimated by the reporting entity for the portion of such rebates due to the uninsured accident and health plans.

XR020-A Other Receivables for Informational Purposes Only
There is an RBC requirement of 1 percent of the annual statement amount of investment income receivable and an RBC requirement of 5 percent of the annual statement amount for amounts receivable relating to uninsured accident and health plans, amounts due from parents, subsidiaries, and affiliates, and aggregate write-ins for other than invested assets. These are intended to reflect the potential for mis-estimation of the amount to be received in the following year as well as a small amount to reflect the potential for non-payment.

For health care receivable amounts, there is an additional risk that repayments will not occur or will not be appropriately reported as repayments. This makes it more difficult to use a single factor to reflect both risks. This informational filings will address these risks separately. There is an RBC requirement of 3% of the annual statement amount for pharmacy rebates and an RBC requirement of 12 percent of the annual statement amount for the other health care receivables reported as lines 31.1 through 35.1 and an additional charge will be applied to health care receivables amounts reported in Lines 35.0 through 35.3 where the amount accrued in the prior year was not recovered in the current year calculated as a factor times the current year amount times the ratio of the current year amount reported as a receivable to the prior year amount reported as a receivable. For pharmacy rebates this calculation is done for that line itself. For the other health care receivables a single ratio is calculated and applied to lines 31.3 through 35.3. To avoid applying too large a factor, the ratio has a maximum value of 2. Where the prior year receivable amount(s) used for a ratio is zero, a factor of 1 is used.

Examples of the calculation are included below but do not include the use of a common ratio of prior year amounts repaid to prior year receivable:

Example 1:

Claim overpayment receivable as of 12/31/2020 with substantial recoveries that still a little less than the accrual.

a. Claim overpayment receivable as of 12/31/2020 of $1,000,000 (col (1) Line 31.1)
b. Claim overpayment receivable as of 12/31/2019 of $900,000 (col (1) Line 31.2)
c. Claim overpayment recoveries of $80,000 reported achieved in 2020 against accruals at 12/31/2019 (col (1) Line 31.3)
d. Current formula amount: $1,000,000 x 0.19 = $190,000 X R020 (col (3) Line 30.2)
e. Informational formula amount XR020

\[
\text{XR020} = \begin{cases} 
1000000 \times 0.19 = 190000 & \text{if } \min(0, 900000 \times (1 - 1.2) - 840000) = 0 \\
0 \times (1 - 1.2) \times \text{Min}(\min(0, 900000 \times (1 - 1.2) - 840000), 35) & \text{else}
\end{cases}
\]

Example 2:

Claim overpayment receivable as of 12/31/2020, but with no recoveries:

a. Claim overpayment receivable as of 12/31/2020 of $1,000,000
b. Claim overpayment receivable as of 12/31/2019 of $900,000
c. Claim overpayment recoveries of 0 reported achieved in 2020 against accruals at 12/31/2019
d. Current formula amount: $1,000,000 x 0.19 = $190,000 X R020 (col (3) Line 30.2)
e. Informational formula amount:

\[
\text{XR020} = \begin{cases} 
1000000 \times 0.19 = 190000 & \text{if } \min(0, 900000 \times (1 - 1.2) - 840000) = 0 \\
0 \times (1 - 1.2) \times 35 & \text{else}
\end{cases}
\]
Example 3:

Claim overpayment receivable as of 12/31/2020, but with recoveries of half the amount of the accrual:

- Claim overpayment receivable as of 12/31/2020 of $1,000,000 (col (1) Line 31.1)
- Claim overpayment receivable as of 12/31/2019 of $900,000 (col (1) Line 31.2)
- Claim overpayment recoveries of $400,000 reported achieved in 2020 against accruals at 12/31/2019 (col (1) Line 31.3)
- Current formula amount: $1,000,000 x 0.19 = $190,000
- Total RBC = $120,000 + $387,200 = $507,200

Example 4:

Claim overpayment receivable as of 12/31/2020, but with recoveries of half the amount of the accrual which is much smaller than current year receivable:

- Claim overpayment receivable as of 12/31/2020 of $1,000,000 (col (1) Line 31.1)
- Claim overpayment receivable as of 12/31/2019 of $900,000 (col (1) Line 31.2)
- Claim overpayment recoveries of $100,000 reported achieved in 2020 against accruals at 12/31/2019 (col (1) Line 31.3)
- Current formula amount: $1,000,000 x 0.19 = $190,000
- Total RBC = $120,000 + $354,880 = $474,880
- Total RBC = $120,000 + $387,200 = $507,200
MEMORANDUM

TO: Patrick McNaughton, Chair, Health Risk-Based Capital (E) Working Group

FROM: Stephen Wiest, Chair, Operational Risk (E) Subgroup

DATE: February 26, 2019

RE: Referral for Further Work on Health Growth Operational Risk

The operational Risk (E) Subgroup believes that there is an opportunity to improve the assessment of growth risk in the Health Risk-based Capital (HRBC) formula. While alternatives to the existing growth risk methodology that have been tested by the Subgroup have not proved to be better indicators of risk, there are reasons to consider whether the existing methodology is working as intended. The Health RBC (E) Working Group is best positioned to continue the review. The Operational Risk (E) Subgroup recommends that the review focus on the existing growth risk by forming an ad hoc subgroup of regulators and interested parties familiar with the HRBC formula similar to what was utilized to review the existing growth risk methodology and factors in the Property RBC formula. This document should be used as a starting point for that review. That ad hoc group would provide suggestions for potential enhancements to the existing growth charge to the HRBCWG. The review could include:

- Given the current array of company types that now file Health RBC, should the variables used in the application of the 10% threshold be reversed (i.e., the charge is assessed if risk revenue is increasing faster than RBC)?
- Determine if a 10% threshold is still reasonable.
- Should the normal growth risk calculation (existing or as adjusted) apply to start-up companies? If not, what adjustments should be applied to the calculation for start-ups?
- Should the Health RBC growth risk methodology (existing or as adjusted) be adopted into the Life RBC formula for companies that write a material amount (e.g. > X%) of their premiums in health business, where such business would be subject to the growth risk calculation in the Health RBC formula?

Background

How the Existing Growth Risk Charge Works:

- Growth in Underwriting Risk RBC year over year is measured against growth in underwriting risk revenue year over year. Thus, the formula recognized that as risk was added, revenue should respond accordingly.
- If growth Underwriting Risk RBC exceeds growth in underwriting risk revenue by greater than 10%, growth risk is triggered.
- A factor of 50% is applied to the excess of growth in Underwriting Risk RBC above the 10% threshold.
Considerations in Developing the Existing Methodology:

- The risk of growth, while included in H-4, is most related to increased pricing risk caused by growth rather than increased operational risk that that may be caused by rapid growth.
- The methodology is better designed to capture change in product mix or introductions of new managed care products with differing levels of managed care features.
- At the time that the HRBC formula was being developed, there were significant issues around transfer of risk to providers which were driving a change from capitated arrangements and HMO products to greater use of contractual fee-for-service and withholds / incentives in provider agreements and PPO and POS products.
- The developers of the HRBC formula considered the potential for premium rate impact related to increasing competition from national carriers into local markets, and consolidation in the market.

Reasons to Consider a Change to the Existing Methodology:

- The original Health Organizations RBC (HQRBC) formula applied primarily to HMOs and Not-for-profit health plans (e.g., hospital and medical indemnity plans). In the early 2000s, with the adoption of Statutory Accounting Principles and the Health financial reporting blank (and the addition of a health test to that reporting blank), insurers became subject to the renamed Heath RBC (HRBC) formula.
- Relatively few entities triggered the current growth risk charge, even during recent periods of rapid growth caused by the ACA.
- The application of growth risk to new entities is unclear. A number of entities that were new to the market and which grew rapidly in 2014 and 2015 ultimately failed regardless of original projections. If sufficient capital was put in place during the licensing process based on reasonably accurate projections, then there should be little impact from growth risk. If not, perhaps growth risk should be recognized as an early warning indicator. The growth should smooth out over time and the charge removed.
- For various reasons, neither the informational approach nor other alternatives explored thus far by the Operational Risk (E) Subgroup have indicated a significantly improved ability to identify companies that are not sufficiently capitalized to absorb the impact of rapid growth.
- Companies that file the Life RBC formula, but write the same type of health business written by companies that are required to file the Health RBC formula are not currently subject to a growth risk capital requirement.
July 29, 2019

Mr. Patrick McNaughton
Chair, Health Risk-Based Capital Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

Re: Comments on Health Growth Risk Analysis

Dear Mr. McNaughton:

America’s Health Insurance Plans (AHIP) appreciates the opportunity to provide these comments on the potential review of changes to the manner in which growth risk is addressed by the Health RBC formula.

We have followed the extensive work done within the Operations Risk WG to look at alternatives to the current growth risk. It does not appear that any of the potential ways that were reviewed changed the number of companies that had an increase in their RBC values when a changed growth approach was applied to several prior years data. We note that different approaches for a growth risk charge caused different companies to have an increase in their RBC values. That analysis did not show whether any of the companies with such an added charge fell into lower RBC levels or insolvency in the immediate following two years. We believe that only if another approach proved more useful in identifying such failing companies should the current growth risk approach be changed for mature companies.

With respect to non-mature companies in their first five or so years, we believe that the current growth risk approach does address changes in “mix” of the managed care credit for the coverage provided and that that issue is important for the regulators to be aware of. The actual growth in premium volume and number of covered lives necessary for a new company to reach maturity is much higher than any “normal” growth risk. The actual growth should be compared to the planned growth for such companies. Where actual growth exceeds planned growth by a significant amount, revised plans would be a more appropriate vehicle for regulatory review than RBC reporting – it does not require waiting for annual RBC reporting or the use of an average growth assumption.

Finally, we do not support the inclusion of a separate health growth risk adjustment in the Life RBC formula. Whether or not the companies using the Life Blank that write significant amounts

1 We recommend excluding companies with less than five years of RBC reporting experience for this part of future analysis.
AHIP Comments on Health Growth Risk Review  
July 24, 2019  
Page 2

Of health premium are impacted by changes to the Health Test and the results of any application of a growth segment to the Life RBC formula are ongoing considerations that must be addressed first. We believe that it would be necessary to establish some link between continuing declines and ultimate insolvency of Life companies and their health lines of business before any such extensive changes are considered.

We would be happy to address any questions the Working Group has with these comments.

Sincerely,

William C. Weller  
Actuarial Consultant to AHIP

c/c: Crystal Brown, NAIC  
Candy Gallahe, AHIP
July 23, 2019

Mr. Patrick McNaughton, Chair  
Health Risk-Based Capital (E) Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO  64106-2197

Via electronic mail to Crystal Brown.

Re: Excessive Growth Charge Referral Letter

Dear Mr. McNaughton:

I am writing on behalf of UnitedHealth Group, Incorporated. We appreciate the opportunity to comment on the memorandum addressed to you from the chair of the Operational Risk (E) Subgroup, dated February 26, 2019, on the subject, “Referral for Further Work on Health Growth Operational Risk.” This referral memorandum recommended that your Working Group review certain aspects of the Excessive Growth Risk charge as it currently exists in the Health Risk-Based Capital formula. For the reasons set forth below, we do not believe any change to the RBC Excessive Growth Risk charge (except perhaps for start-up companies) is necessary or appropriate.

We will examine each of the areas recommended for review below, but first we must address the need for review in general. Where factors within the RBC formula are developed from theoretically appropriate models using actual historical data, it is reasonable to periodically review and possibly revise those factors to reflect updated information (and perhaps enhancements to the models). In this case, however, where the RBC charge was not based on historical data, there can be no updated data that would compel an update to the charge. The only reason for a change would be if the existing Excessive Growth Risk charge has not been performing adequately. So far, no evidence has been presented that would indicate that this has been the case, especially with respect to established companies that have significant experience and expertise in health insurance. It is important that any changes to the formula be based on an
analysis of how the Excessive Growth Risk charge has performed historically, especially if the changes being contemplated might result in a broader application or more burdensome level of the charge.

The referral memorandum cites the experience of certain new entities in 2014 and 2015. However, these entities were all or nearly all CO-OPs established under the ACA, and they are not relevant for several reasons. First, the CO-OPs were not just growing rapidly; they were start-ups, with no operating history at all. That is very different from rapid growth of an established book of business. Second, the CO-OPs were operating in a marketplace that was undergoing significant disruption, where pricing was particularly difficult because of the lack of relevant historical data. Third, the pricing difficulties were severely exacerbated by the failure of the federal government to meet its obligations arising from the ACA Risk Corridor program. Fourth, the non-profit structure of the majority of the CO-OPs meant that they did not have ready access to additional capital. These conditions were unique to the CO-OPs and that specific period of time, and have nothing to do with how the health insurance market generally functions.

Therefore, while there may be some rationale for revisiting the application of the formula to start-up companies, we suggest that any more general review should be preceded by an evaluation of how the existing Excessive Growth Risk charge has performed historically. If there are instances (other than the CO-OPs as just cited) where excessive growth has led to financial difficulties for an entity, and the Excessive Growth Risk charge did not properly reflect those circumstances, they should be identified and thoroughly discussed prior to determining if any changes are necessary. If there are no such instances, then presumably the Excessive Growth Risk charge is working as intended, and no further review is needed.

With that preface, we address in more detail each of the areas recommended for review by the referral memorandum.

1. **Given the current array of company types that now file Health RBC, should the variables used in the application of the 10% threshold be reversed (i.e., the charge is assessed if risk revenue is increasing faster than RBC)?**

There is no evident rationale for such a change. Reversing the calculation would suggest that an entity has greater risk if its growth is in lower-risk products. That could only occur if those products were not actually lower-risk, which would call into question the remainder of the underwriting risk charges in the Health RBC formula. As we explain below, if the concern is simply that there is a shift to new products, that is adequately addressed by the current structure of the Excessive Growth risk charge.

There is a clear rationale for the Excessive Growth Risk charge as it exists today in the Health RBC formula, and the charge serves to capture operational risk as opposed to pure underwriting risk. To the extent that underwriting (pricing) risk increases proportionately with growth in business volume, the additional risk is reflected in the H-2 (Underwriting Risk) section of the formula. In contrast, the Excessive Growth Risk charge is applicable when underwriting risk is
growing significantly faster than business volume. There are a variety of reasons why this might occur, including the following:

- The business mix may be shifting from provider payment mechanisms that control underwriting risk to a higher degree (such as capitations) to mechanisms that provide less control (such as payment at usual and customary rates).

- The business mix may be shifting from products that are considered to have a lower degree of risk (such as Medicare Supplement) to products that are deemed higher-risk (such as Comprehensive Medical).

- The degree of risk control provided via premium stabilization reserves may have been reduced as such reserves decrease.

- The loss ratio for the business may be deteriorating for some reason other than the three just listed.

In each of those situations, pricing is made more difficult by changing from a less-risky to a more-risky environment. However, the reporting entity’s risk increases disproportionately only if its pricing and underwriting processes are unable to deal with that change (and the fourth situation above may in fact be evidence of such an inability); otherwise, the change in risk is captured adequately by the H-2 section of the RBC formula. But the failure of the entity’s pricing and underwriting processes to appropriately address these changes is in fact a form of operational risk, as that has been defined by the NAIC. Therefore, very clearly, the existing Excessive Growth Risk charge is structured appropriately to address the operational risks that arise from excessively rapid growth.

It is true that the current Excessive Growth Risk charge is focused on the failure of one category of operational functions. However, this category — that is, pricing and underwriting processes — is the category that is most likely to be adversely affected by dramatic growth in business, and therefore should in fact be the focus of the Excessive Growth Risk charge.

Another potential financial problem arising from rapid growth is the entity’s inability to process claims properly, leading to excessive losses. This would lead to the fourth situation in the list above, and therefore also would be addressed by the existing Excessive Growth Risk charge.

We also point out that, if the growth were occurring in products that were nominally lower-risk, but the extent of the growth was causing operational issues, those issues would be reflected in the manner described above.

Accordingly, we believe that the structure of the Excessive Growth Risk charge as it exists currently in the Health RBC formula is an appropriate means to address any additional risk that arises from excessive growth in business.
2. Determine if a 10% threshold is still reasonable.

In our comments on area #1 above, we noted that we believe the existing structure of the Excessive Growth Risk charge is appropriate. That does not automatically imply that the 10% threshold itself is appropriate. As we discussed in our opening comments, any revision of this aspect of the formula should be based on a review of how the Excessive Growth Risk charge has performed historically. The only way to know whether the 10% threshold is reasonable is to determine whether it has excluded some entities that suffered operational failures from excessive growth (i.e., the threshold is too high), or has included entities that were growing but did not experience material adverse effects from growth (i.e., the threshold is too low). Without such a review, we see no way to make a determination as to the reasonableness of the 10% threshold.

3. Should the normal growth risk calculation (existing or as adjusted) apply to start-up companies? If not, what adjustments should be applied to the calculation for start-ups?

As we state above, there may be some justification for reconsidering how the Excessive Growth Risk charge should apply to start-up entities. We will note again, though, that the problems cited in the referral memorandum had causes that went far beyond excessive growth.

We also note that applying too high a charge to start-up business would discourage entry into a market by new parties, which would tend to limit competition to the detriment of consumers.

Accordingly, we suggest that the treatment applied to start-ups should not reflect all the problems underlying the failures previously cited, but should be focused on excessive growth per se, as being more relevant to the broader industry; and we believe the resulting capital requirement should not be so onerous as to discourage new entries into the marketplace.

4. Should the Health RBC growth risk methodology (existing or as adjusted) be adopted into the Life RBC formula for companies that write a material amount (e.g. > X%) of their premiums in health business, where such business would be subject to the growth risk calculation in the Health RBC formula?

As we have discussed above, having seen no evidence to the contrary, we suggest that the Excessive Growth Risk charge as it currently exists in the Health RBC formula is performing as it was intended, addressing the risk that arises from immoderate growth. Therefore, we see no compelling reason why it should not be imported into the Life RBC formula as well.

We are not certain that a percentage threshold for health business is necessary. If health business represents only a small part of an entity’s business, then any Excessive Growth Risk charge would presumably have negligible impact on the entity’s Company Action Level, especially when the effect of the covariance adjustment is taken into account. A threshold for application would be necessary only if the data collection and entry for the Excessive Growth Risk component of the formula were deemed to be a material burden.
We appreciate your consideration of our foregoing comments. We would be happy to discuss the matter with you further.

James R. Braue  
Director, Actuarial Services  
UnitedHealth Group

cc:  Crystal Brown, NAIC  
Randi Reichel, UnitedHealth Group
## Off-Balance Sheet Security Lending Collateral and Schedule DL, Part 1 Assets

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

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Attachment Two-C

Capital Adequacy (E) Task Force

NAIC Proceedings – Fall 2019
### FIXED INCOME ASSETS

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<th>Bonds</th>
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<th>NAR 01 - U.S. Government Direct and Guaranteed (Sch DA, P1, C7, 1,059,9999)</th>
<th>SVO Identified Funds - Bond Mutual Funds (Sch DA, P1, C11, 1,059,9999)</th>
<th>Total Bonds (Sch E, P1, C7)</th>
<th>NAR 01 - U.S. Government Direct and Guaranteed (Sch E, P1, C7, 1,059,9999)</th>
<th>SVO Identified Funds - Bond Mutual Funds (Sch D, P1, C11, 1,059,9999)</th>
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<th>NAR 01 - U.S. Government Direct and Guaranteed (Sch E, P2, C7, 1,059,9999)</th>
<th>SVO Identified Funds - Bond Mutual Funds (Sch D, P1, C11, 1,059,9999)</th>
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Denotes items that must be vendor linked.
### FIXED INCOME ASSETS (cont.)

#### MISCELLANEOUS FIXED INCOME ASSETS

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

* These bonds appear in Schedule D Part 1A Section 1 and are already recognized in the Bond portion of the formula.
## EQUITY ASSETS

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(Should equal Page 2, Col 3, Line 2.1 less Sch D Sum, Col 1, L18)

### HYBRID SECURITIES - UNAFFILIATED

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<td>Sch D, Pt 1A, Sn 1, Col 7, Line 7.4</td>
<td>0.045</td>
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<td>(12)</td>
<td>NAIC 05 Hybrid Securities</td>
<td>Sch D, Pt 1A, Sn 1, Col 7, Line 7.5</td>
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<td>(13)</td>
<td>NAIC 06 Hybrid Securities</td>
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<td>0.300</td>
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<td>Subtotal - Hybrid Securities</td>
<td>Sum of Lines (8) through (13)</td>
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<tr>
<td>(15)</td>
<td>Total Unaffiliated Preferred Stock and Hybrids</td>
<td>Line (7) + Line (14)</td>
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### COMMON STOCK - UNAFFILIATED

<table>
<thead>
<tr>
<th></th>
<th>Annual Statement Source</th>
<th>B/A/Carrying Value</th>
<th>Factor</th>
<th>B/C Requirement</th>
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<tr>
<td>(8)</td>
<td>Federal Home Loan Bank Stock</td>
<td>Company Records</td>
<td>0.023</td>
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<td>(9)</td>
<td>Non-Government Money Market Funds</td>
<td>Sch D Pt 2 Sn 2 Col 6 Line 9199999</td>
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<td>(10)</td>
<td>Total Common Stock</td>
<td>Sch D, Summary, Col 1, Line 25</td>
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<td>(11)</td>
<td>Affiliated Common Stock</td>
<td>Sch D, Summary, Col 1, Line 24</td>
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<td>Other Unaffiliated Common Stock</td>
<td>L(10)-L(9)-L(12)</td>
<td>S0 0.150</td>
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<tr>
<td>(13)</td>
<td>Total Unaffiliated Common Stock</td>
<td>L(8)+L(9)+L(12)</td>
<td>S0</td>
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Denotes items that must be manually entered on filing software.
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<tr>
<th>Issuer Name</th>
<th>Bk/Adj Carrying Value</th>
<th>Factor</th>
<th>Additional RBC</th>
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<td>(1) NAIC Designation Category 2.A Bonds</td>
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<td>(2) NAIC Designation Category 2.B Bonds</td>
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<td>(3) NAIC Designation Category 2.C Bonds</td>
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<tr>
<td>(4) NAIC Designation Category 3.A Bonds</td>
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<td>(5) NAIC Designation Category 3.B Bonds</td>
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<td>(6) NAIC Designation Category 3.C Bonds</td>
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<td>(7) NAIC Designation Category 4.A Bonds</td>
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<td>(8) NAIC Designation Category 4.B Bonds</td>
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<td>(9) NAIC Designation Category 4.C Bonds</td>
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<td>(10) NAIC Designation Category 5.A Bonds</td>
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<td>(11) NAIC Designation Category 5.B Bonds</td>
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<td>(12) NAIC Designation Category 5.C Bonds</td>
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<td>(13) Collateral Loans</td>
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<td>(14) Mortgages</td>
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<tr>
<td>(15) NAIC 02 Unaffiliated Preferred Stock</td>
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<td>(16) NAIC 03 Unaffiliated Preferred Stock</td>
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<td>(17) NAIC 04 Unaffiliated Preferred Stock</td>
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<td>(18) NAIC 05 Unaffiliated Preferred Stock</td>
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<td>### NAIC 02 Hybrid Securities</td>
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<tr>
<td>### NAIC 03 Hybrid Securities</td>
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<tr>
<td>### NAIC 04 Hybrid Securities</td>
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<td>### NAIC 05 Hybrid Securities</td>
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<tr>
<td>(19) Other Long-Term Invested Assets</td>
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<tr>
<td>(20) NAIC 02 Working Capital Finance Investments</td>
<td>0.0125</td>
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<td>(21) Federal Guaranteed Low Income Housing Tax Credits</td>
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<td>(22) Federal Non-Guaranteed Low Income Housing Tax Credits</td>
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<tr>
<td>(23) State Guaranteed Low Income Housing Tax Credits</td>
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<tr>
<td>(24) State Non-Guaranteed Low Income Housing Tax Credits</td>
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<tr>
<td>(25) All Other Low Income Housing Tax Credits</td>
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<td>(26) Unaffiliated Common Stock</td>
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<tr>
<td>(27) Total of Issuer = Lines (1) through (26)</td>
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Note: Ten issuer sections and a grand total page will be available on the filing software. The grand total page is calculated as the sum of issuers 1-10 by asset type.

Denotes items that must be manually entered on filing software.
**CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE**

### H0 - AFFILIATES W/RBC AND MISC. OTHER AMOUNTS

<table>
<thead>
<tr>
<th></th>
<th>RBC Amount</th>
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<tbody>
<tr>
<td>(1) Off-Balance Sheet Items</td>
<td>XR005, Off-Balance Sheet Page, L(21)</td>
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<tr>
<td>(2) Directly Owned Insurer Subject to RBC</td>
<td>XR003, Affiliates Page, L(1)</td>
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<td>(3) Indirectly Owned Insurer Subject to RBC</td>
<td>XR003, Affiliates Page, L(2)</td>
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<tr>
<td>(4) Directly Owned Health Entity Subject to RBC</td>
<td>XR003, Affiliates Page, L(3)</td>
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<tr>
<td>(5) Indirectly Owned Health Entity Subject to RBC</td>
<td>XR003, Affiliates Page, L(4)</td>
</tr>
<tr>
<td>(6) Directly Owned Alien Insurer</td>
<td>XR003, Affiliates Page, L(7)</td>
</tr>
<tr>
<td>(7) Indirectly Owned Alien Insurers</td>
<td>XR003, Affiliates Page, L(8)</td>
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<tr>
<td>(8) Total H0</td>
<td>Sum L(1) through L(7)</td>
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### H1 - ASSET RISK - OTHER

<table>
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<tr>
<th></th>
<th>RBC Amount</th>
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<tbody>
<tr>
<td>(9) Investment Affiliates</td>
<td>XR003, Affiliates Page, L(5)</td>
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<tr>
<td>(10) Holding Company Excess of Subsidiaries</td>
<td>XR003, Affiliates Page, L(6)</td>
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<tr>
<td>(11) Investment in Parent</td>
<td>XR003, Affiliates Page, L(9)</td>
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<tr>
<td>(12) Other Affiliates</td>
<td>XR003, Affiliates Page, L(10)</td>
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<tr>
<td>(13) Fair Value Excess Affiliate Common Stock</td>
<td>XR003, Affiliates Page, L(11)</td>
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<tr>
<td>(14) Fixed Income Assets</td>
<td>XR006, Off-Balance Sheet Collateral, L(27) + L(37) + L(38) + L(39) + XR007.2, Fixed Income Assets Page, L(52)</td>
</tr>
<tr>
<td>(15) Replication &amp; Mandatory Convertible Securities</td>
<td>XR008, Replication/MCS Page, L(9999999)</td>
</tr>
<tr>
<td>(16) Unaffiliated Preferred Stock and Hybrid Securities</td>
<td>XR006, Off-Balance Sheet Collateral, L(34) + XR009, Equity Assets Page, L(7)</td>
</tr>
<tr>
<td>(17) Unaffiliated Common Stock</td>
<td>XR006, Off-Balance Sheet Collateral, L(35) + XR009, Equity Assets Page, L(13)</td>
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<tr>
<td>(18) Property &amp; Equipment</td>
<td>XR006, Off-Balance Sheet Collateral, L(36) + XR010, Prop/Equip Assets Page, L(9)</td>
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<tr>
<td>(19) Asset Concentration</td>
<td>XR011, Grand Total Asset Concentration Page, L(27)</td>
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<tr>
<td>(20) Total H1</td>
<td>Sum L(9) through L(19)</td>
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### H2 - UNDERWRITING RISK

<table>
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<tr>
<td>(21) Net Underwriting Risk</td>
<td>XR012, Underwriting Risk Page, L(21)</td>
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<tr>
<td>(22) Other Underwriting Risk</td>
<td>XR014, Underwriting Risk Page, L(25.3)</td>
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XR024
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<tr>
<td>23</td>
<td>Disability Income</td>
<td>XR014, Underwriting Risk Page, L(26.3)+L(27.3)+L(28.3)+(29.3)+(30.6)+(31.3)+(32.3)</td>
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<td>24</td>
<td>Long-Term Care</td>
<td>XR015, Underwriting Risk Page, L(41)</td>
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<tr>
<td>25</td>
<td>Limited Benefit Plans</td>
<td>XR016, Underwriting Risk Page, L(42.2)+L(43.6)+L(44)</td>
</tr>
<tr>
<td>26</td>
<td>Premium Stabilization Reserve</td>
<td>XR016, Underwriting Risk Page, L(45)</td>
</tr>
<tr>
<td>27</td>
<td>Total H2</td>
<td>Sum L(21) through L(26)</td>
</tr>
</tbody>
</table>

Denotes items that must be manually entered on filing software.
OFF-BALANCE SHEET SECURITY LENDING COLLATERAL AND SCHEDULE DL, PART 1 ASSETS
XR006

Security lending programs are required to maintain collateral. Some entities post the collateral supporting security lending programs on their financial statements, and incur the related risk charges on those assets. Other entities have collateral that is not recorded on their financial statements. While not recorded on the financial statements of the company, such collateral has risks that are not otherwise captured in the RBC formula.

The collateral in these accounts is maintained by a third party (typically a bank or other agent). The collateral agent maintains on behalf of the company detail asset listings of the collateral assets, and this data is the source for preparation of this schedule. The company should maintain such asset listings, at a minimum CUSIP, market value, book/adjusted carrying value, and maturity date.

The asset risk charges are derived from existing RBC factors for bonds, preferred and common stocks, other invested assets, and invested assets not otherwise classified (aggregate write-ins).

Specific Instructions for Application of the Formula


Off-balance sheet collateral included in General Interrogatories Part I, Lines 24.05 and 24.06 of the annual statement should agree with Line (4022), Column (1).

Lines (1) through (926) – Bonds – Bond factors described on page XR007, Fixed Income Assets – Bonds.

Line (4828) through (4633) – Preferred Stock – Preferred stock factors described on page XR009 – Equity Assets

Line (4735) – Common Stock – Common stock factors described on page XR009 – Equity Assets

Line (4836) – Real Estate and Property and Equipment Assets – Real Estate and Property and Equipment Assets factors described on page XR010 – Property & Equipment Assets

Line (4937) – Other Invested Assets – Other invested assets factor described on page XR007, Fixed Income Assets – Miscellaneous Assets.

Line (2038) – Mortgage Loans on Real Estate – Mortgage Loans on Real Estate factors described on page XR007, Fixed Income Assets – Miscellaneous Assets.

Line (3924) – Cash, Cash Equivalents and Short-Term Investments – Cash, Cash Equivalents and Short-Term Investments factors described on page XR007, Fixed Income Assets – Miscellaneous Assets.
FIXED INCOME ASSETS
XR007.1 AND XR007.2

The RBC requirement for fixed income assets is largely driven by the default risk on those assets. There are two major subcategories: Bonds and Miscellaneous. Bonds are obligations issued by business units, governmental units, and certain nonprofit units, having a fixed schedule for one or more future payments of money. This definition includes commercial paper, negotiable certificates of deposit, repurchase agreements, and equipment trust certificates. Miscellaneous fixed income assets are other assets with fixed repayments schedules, such as mortgages and collateral loans.

Bonds

The bond risk factors for investment grade bonds (NAIC Classes 1.A - 2.C) are based on cash flow modeling using historically adjusted default rates for each bond category. For each of 2,000 trials, annual economic conditions were generated for the ten-year modeling period. Each bond of a 400 bond portfolio was annually tested for default (based on a “roll of the dice”) where the default probability varies by designation category and that year’s economic environment. When a default takes place, the actual loss considers the expected principal loss by category, the time until the sale actually occurs, and the assumed tax consequences. Only default is recognized in the RBC factors because, under statutory accounting, bonds are generally carried at their amortized value on the statutory annual statement, so changes in the market value of the bonds following swings in interest rates do not, as a general rule, affect the capital and surplus of the regulated entities unless the bonds are actually sold. The accounting for reporting entities can be substantially different from other regulated entities, but the RBC formula continues to recognize only default risk. The default probabilities were based on historical data intended to reflect a complete cycle of favorable and unfavorable credit environments. The risk of default was measured over a 2-year time horizon, selected considering the duration of health assets and liabilities.

U.S. government bonds that are direct and guaranteed and backed by the full faith and credit of the U.S. government (including SVO Identified Funds that are determined by the SVO to be the equivalent of U.S. government guaranteed bonds or NAIC 01 bonds) receive a zero factor (see Annual Statement Instructions). There is no RBC requirement for bonds guaranteed by the full faith and credit of the United States because there is virtually no default risk associated with these securities.

The factors for NAIC Classes 3.A to 6 recognizes the factor for NAIC 06 bonds recognizes that the book/adjusted carrying value of these non-investment grade bonds reflects a loss of value upon default by being marked to market. These bond risk factors are based on the market value fluctuation for each of the NAIC classes compared to the market value fluctuation of stocks during the 2008-2009 financial crisis.

A bond portfolio adjustment has been incorporated into the bond factors based on a portfolio of 382 issuers.

The book/adjusted carrying value of all bonds and related fixed income investments should be reported in Column (1). The bonds are split into seven different risk classifications. These risk classifications are based on the NAIC designations assigned. For long-term bonds, these classifications are found on Lines 10.4 through 10.6 less the hybrid Lines 7.1 through 7.6 of Schedule D, Part 1A. Section (b) in the electronic only column of Schedule D, Part 1; short-term bonds will be found in the electronic only column of Schedule DA, Part 1 and the bonds reported as cash equivalents will be found in the electronic only column of Schedule E, Part 2 of the annual statement.[B11]

Enter the book/adjusted carrying value of the bonds, by NAIC designation, in Column (1). The RBC requirement will be automatically calculated in Column (2).
Miscellaneous Fixed Income Assets

The factor for cash is 0.3 percent. It is recognized that there is a small risk related to possible insolvency of the bank where cash deposits are held and this factor, equivalent to an unaffiliated NAIC 01 bond, reflects the short-term nature of this risk. The required risk-based capital for cash will not be less than zero, even if the company’s cash position is negative.

The Short-Term Investments to be included in this section are those short-term investments not reflected elsewhere in the formula. The 0.3 percent factor is equal to the factor for cash. The amount entered here should equal the total short-term investments found in Schedule DA, Part 1, Column 7, Line 839999 less bonds that are contained in Schedule D, Part IA, Section 4.

Collateral loans and mortgage loans are generally a small portion of the total portfolio value. A factor of 5 percent is consistent with other risk-based capital formulas studied by the working group.

The book adjusted carrying value of NAIC 01 and 02 Working Capital Finance Investments, Lines (2441) and (2542), should equal the Notes to Financial Statement, Lines 5M(01a) and 5M(01b), Column 3 of the annual statement.

Other Long-Term Invested Assets are those that are listed in Schedule BA and are somewhat more speculative and risky than most other investments. Therefore, a 20 percent factor is consistent with other risk-based capital formulas studied by the working group.

Low income housing tax credit investments are reported in Column (1) in accordance with SSAP No. 93 — Low Income Housing Tax Credit Property Investments.

Federal Guaranteed Low-Income Housing Tax Credit (LIHTC) investments are to be included in Line (2744). There must be an all-inclusive guarantee from an ARO-rated entity that guarantees the yield on the investment.

Federal Non-Guaranteed LIHTC investments with the following risk mitigation factors are to be included in Line (2845):

a) A level of leverage below 50 percent. For a LIHTC Fund, the level of leverage is measured at the fund level.
   b) There is a tax credit guarantee agreement from general partner or managing member. This agreement requires the general partner or managing member to reimburse investors for any shortfalls in tax credits due to errors of compliance, for the life of the partnership. For an LIHTC fund, a tax credit guarantee is required from the developers of the lower-tier LIHTC properties to the upper-tier partnership.

State Guaranteed LIHTC investments that at a minimum meet the federal requirements for guaranteed LIHTC investments are to be included in Line (2046).

State Non-Guaranteed LIHTC investments that at a minimum meet the federal requirements for non-guaranteed LIHTC investments are to be included on Line (3047).

All Other LIHTC investments, state and federal LIHTC investments that do not meet the requirements of Lines (2744) through (3047) would be reported on Line (4844).
EQUITY ASSETS
XR009

Unaffiliated Preferred Stocks
Experience data to develop preferred stock factors is not readily available; however, it is believed that preferred stocks are somewhat more likely to default than bonds. The loss on default would be somewhat higher than that experienced on bonds; however, formula factors are equal to bond factors.

The RBC requirements for unaffiliated preferred stocks and hybrids are based on the NAIC designation. Column (1) amounts are from Schedule D, Part 2, Section 1 not including affiliated preferred stock. The preferred stocks and hybrids must be broken out by asset designation (NAIC 01 through NAIC 06) and these individual groups are to be entered in the appropriate lines. The total amount of unaffiliated preferred stock and hybrids reported should equal annual statement Page 2, Column 3, Line 2.1, less any affiliated preferred stock in Schedule D Summary by Country, Column 1, Line 18. The total amount of hybrid securities reported should equal annual statement Schedule D, Part 1A, Section 1, Column 7, Line 7.7.

Unaffiliated Common Stock
Non-government money market mutual funds are more like cash than common stock, therefore it is appropriate to use the same factor as for cash. Federal Home Loan Bank Stock has characteristics more like a fixed income instrument rather than common stock. A 2.3 percent factor was chosen. The factor for other unaffiliated common stock is based on studies which indicate that a 10 percent to 12 percent factor is needed to provide capital to cover approximately 95 percent of the greatest losses in common stock over a one-year future period. The higher factor of 15 percent contained in the formula reflects the increased risk when testing a period in excess of one year. This factor assumes capital losses are unrealized and not subject to favorable tax treatment at the time of loss in market value.

ASSET CONCENTRATION
XR011

The purpose of the asset concentration calculation is to reflect the additional risk of high concentrations of certain types of assets in single exposures, termed “issuers.” An issuer is a single entity, such as IBM or the Ford Motor Company. When the reporting entity has a large portion of its asset portfolio concentrated in only a few issuers, there is a heightened risk of insolvency if one of those issuers should default. An issuer may be represented in the reporting entity’s investment portfolio by a single security designation, such as a large block of NAIC Designation Category 42–2.A bonds, or a combination of various securities, such as common stocks, preferred stocks, and bonds. The additional RBC for asset concentration is applied to the ten largest issuers.

Concentrated investments in certain types of assets are not expected to represent an additional risk over and above the general risk of the asset itself. Therefore, prior to determining the ten largest issuers, you should exclude those assets that are exempt from the asset concentration factor. Asset types that are excluded from the calculation include: NAIC 06 bonds and NAIC 06 preferred stock; affiliated common stock; affiliated preferred stock; affiliated bonds; property and equipment; U.S. government guaranteed bonds (including SVO Identified Funds that are determined by the SVO to be the equivalent of U.S. government guaranteed bonds or NAIC 01 bonds); NAIC 01 bonds and NAIC 01 preferred stock and hybrids; any other asset categories with risk-based capital factors less than 1 percent, and investment companies (mutual funds) and common trust funds that are diversified within the meaning of the federal Investment Company Act of 1940 [Section 5(b) (1)]. The proportionate share of individual securities within an investment company (mutual fund) or common trust fund are to be included in the determination of concentrated investments, subject to the exclusions identified.

With respect to investment companies (mutual funds) and common trust funds, the reporting entity is responsible for maintaining the appropriate documentation as evidence that such is diversified within the meaning of the federal Investment Company Act and providing this information upon request of the Commissioner, Director or Superintendent of the Department of Insurance. The reporting entity is also responsible for maintaining a listing of the individual securities and corresponding...
book/adjusted carrying values making up its investment companies (mutual funds) and common trust funds portfolio, in order to determine whether a concentration charge is necessary. This information should be provided to the Commissioner, Director or Superintendent upon request.

The assets that **ARE INCLUDED** in the calculation when determining the 10 largest issuers are as follows:

- NAIC Designation Category 2.A Unaffiliated Bonds
- NAIC Designation Category 2.B Unaffiliated Bonds
- NAIC Designation Category 2.C Unaffiliated Bonds
- NAIC Designation Category 3.A Unaffiliated Bonds
- NAIC Designation Category 3.B Unaffiliated Bonds
- NAIC Designation Category 3.C Unaffiliated Bonds
- NAIC Designation Category 4.A Unaffiliated Bonds
- NAIC Designation Category 4.B Unaffiliated Bonds
- NAIC Designation Category 4.C Unaffiliated Bonds
- NAIC Designation Category 5.A Unaffiliated Bonds
- NAIC Designation Category 5.B Unaffiliated Bonds
- NAIC Designation Category 5.C Unaffiliated Bonds
- NAIC 02 Unaffiliated Bonds
- NAIC 03 Unaffiliated Bonds
- NAIC 04 Unaffiliated Bonds
- NAIC 05 Unaffiliated Bonds
- Collateral Loans
- Mortgage Loans
- NAIC 02 Unaffiliated Preferred Stock
- NAIC 03 Unaffiliated Preferred Stock
- NAIC 04 Unaffiliated Preferred Stock
- NAIC 05 Unaffiliated Preferred Stock
- NAIC 02 Hybrids
- NAIC 03 Hybrids
- NAIC 04 Hybrids
- NAIC 05 Hybrids
- Other Long-Term Assets
- NAIC 02 Working Capital Finance Investments
- Federal Guaranteed Low Income Housing Tax Credits
- Federal Non-Guaranteed Low Income Housing Tax Credits
- State Guaranteed Low Income Housing Tax Credits
- State Non-Guaranteed Low Income Housing Tax Credits
- All Other Low Income Housing Tax Credits
- Unaffiliated Common Stock

The concentration factor basically doubles the risk-based capital factor (up to a maximum of 30 percent) for assets held in the 10 largest issuers. Since the risk-based capital of the assets included in the concentration factor has already been counted once in the basic formula, this factor itself only serves to add an additional risk-based capital requirement on these assets.
The name of each of the largest 10 issuers is entered at the top of the table and the appropriate statement amounts are entered in Column (2), Lines (1) through (262). Aggregate all similar asset types before entering the amount in Column (2). To determine the 10 largest issuers, first pool all of the assets subject to the concentration factor. From this pool, aggregate the various securities by issuer. The aggregate book/adjusted carrying values for the assets are computed, and the 10 largest are subject to the concentration factor. For example, an organization might own $10,000,000 in NAIC Designation Category 42.A bonds of IBM plus $5,000,000 of common stock. The total investment in that issuer is $15,000,000. If that is the largest issuer, then the identifier (“IBM Corporation”) would be entered in the space allowed for the first Issuer Name, and the $10,000,000 would be entered under the book/adjusted carrying value column for Line (1) (NAIC Designation Category 42.A unaffiliated bonds) and the $5,000,000 would be entered on Line (262) (unaffiliated common stock).

Replicated assets other than synthetically created indices should be included in the asset concentration calculation in the same manner as other assets.
July 12, 2019

Mr. Patrick McNaughton, Chair
Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Via electronic mail to Crystal Brown.

Re: Draft Bond Structure and Instructions

Dear Mr. McNaughton:

I am writing on behalf of UnitedHealth Group Incorporated. We appreciate the opportunity to comment on the Draft Bond Structure and Instructions that were exposed for comment by your Working Group on June 24, 2019.

From your remarks during the conference call on June 24, we understand that the focus of this exposure is the new structure for bond risk charges, and not the values of the risk factors themselves. Accordingly, we will simply note in passing that we continue to have concerns about the values of the factors, as expressed in our letter of October 4, 2018, addressed to you and the chair of the Investment Risk-Based Capital (E) Working Group.

With regard to the draft structure per se, and the accompanying instructions, we support the expansion of the bond risk factors to twenty-one categories from the current seven. Additionally, we would again refer you to our 10/4/18 comment letter — specifically, to the following paragraph.

Other asset classes,

As the Academy notes (page 13 of the report), there are other factors in the Health RBC formula that are based directly on the bond factors. They cite the factors for cash and preferred stock; the factor for receivables for securities is another example. We feel strongly that all such factors should be updated to be consistent with any new bond factors that are adopted.
That position has implications not only for the factors themselves, but also for the structure of the formula and the corresponding instructions. Therefore, we recommend the following.

1. In the instructions for Miscellaneous Fixed Income Assets on the second page of the exposure document, we recommend restoring the deleted language that linked the factor for cash to the factor for NAIC 01 bonds. We recognize that, now that the NAIC 01 designation will be split into three NAIC Designation Categories, the reference may become more complicated. Nonetheless, we believe that the linkage between the factors should be maintained, and that it should be appropriately documented in the instructions.

2. Likewise, in the instructions for Unaffiliated Preferred Stocks on the third page of the exposure document, we recommend restoring the deleted language that states that the preferred stock factors are equal to the bond factors for the corresponding categories. We note that the expanded system of NAIC Designation Categories has been proposed to apply to preferred stocks as well as bonds, and that therefore the necessary split of preferred stock holdings should be available.

3. In keeping with our recommendation #2 immediately preceding, we recommend that the list of preferred stock categories on the fifth page of the exposure document be expanded to reflect the NAIC Designation Categories. We point out that even if some other set of factors is ultimately selected for preferred stocks, those can be mapped to the NAIC Designation Categories; whereas, if the bond factors are used, those cannot be directly applied to the current seven-category structure.

4. Similarly, on the drafts of Page XR006 (the sixth page of the exposure document), Page XR009 (the tenth page of the exposure document), and Page XR011 (the eleventh page of the exposure document), the list of preferred stock categories should be expanded to reflect the NAIC Designation Categories.

We appreciate your consideration of our comments. We would be happy to discuss the matter with you further.

James R. Braue  
Director, Actuarial Services  
UnitedHealth Group

cc: Crystal Brown, NAIC  
Randi Reichel, UnitedHealth Group
November 13, 2018

Kevin Fry, Chair
Investment Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Via electronic mail to Jane Barr and Julie Garber.

Dear Mr. Fry:

We are writing today as a follow-up to our comment letter of October 4, 2018, and the discussion of that letter during the October 23, 2018, conference call of the Investment Risk-Based Capital Subgroup. In particular, we would like to expand our comments on the subject of including investment income in the calculation of the bond risk factors for the Health Risk-Based Capital formula.

During the call, a speaker suggested that incorporating investment income into the analysis would be contrary to the current system of regulating insurance entities’ capital flows. We believe that this comment arose from a misunderstanding of what our recommendation entailed, and although we tried to correct that misunderstanding during the conference call, we believe it will be useful to provide additional written comments on the subject.

It is certainly true that, because of entities’ ability to dividend out their earnings on a regular basis, it would not be appropriate to accumulate investment income over multiple years to offset losses in future years. However, that objection does not really apply to investment income (in this case, interest income) being earned contemporaneously with the losses. It is unlikely that an entity would dividend out all of its income over the course of the year, right up until December 31, and then suddenly discover that it had losses to offset. That does not mean that all of the investment income from that year would necessarily be available; but it seems reasonable to suppose that some part of it would be. Therefore, it does seem appropriate to include some reasonably conservative level of investment income in the analysis.

We understand that it would be difficult to modify the Academy’s models to reflect the investment income on a year-by-year basis. However, we believe that a relatively simple bottom-line adjustment could be made to the Academy’s proposed factors in order to reflect investment income. In the remainder of this letter, we will describe how such an adjustment could be constructed.
There are four elements of the adjustment to be considered: the portion of the annual investment income that should be considered available; the portion of the bonds that are generating income; the yield on the bonds; and the discount factor. Below, we will address each of these in turn.

Portion of annual investment income available.

In actuality, statutory limitations on ordinary dividends are typically based on prior-year income and surplus. Accordingly, an ordinary dividend should not be considered to include current-year investment income.

An entity can request an extraordinary dividend, which requires regulatory approval. Although the dividend request will usually include projections of year-end surplus and Authorized Control Level RBC, the regulators will also review the most recently filed financial statements. Therefore, unless the dividend is being requested very late in the year, the regulatory review will reflect at most one-half of the year’s investment income; and, if the dividend is being requested late in the year, probably a large portion of the losses on bonds will also be known, and taken into account in both the request and the review.

Accordingly, it seems reasonably but not excessively conservative to assume that 50% of the year’s investment income would be available to offset losses on bonds.

Ideally, this offset would be applied to losses on a year-by-year basis. However, to further simplify the calculation, and to add further conservatism, we can assume that all of the losses take place in a single year, and therefore only 50% of one year’s income is available. Since the modeling for the Health RBC bond factors used a two-year period, the conservatism introduced by this assumption, while significant, should be acceptable.

Portion of bonds that are generating income.

Not all of the bonds will actually be generating income during the year; some portion will be in default. Again, it is possible to make some reasonably conservative simplifying assumptions about the portion of bonds that are non-income-producing.

For investment-grade bonds, the Academy’s modeling for the bond factors indicates the proportion that is in default. Ideally, the year-by-year defaults would be examined to determine the portion of bonds that were income-producing. However, as a simplification, we can assume that all of the defaults take place in a single year. That is the maximum that could take place in a single year, and thus is a conservative assumption; also, it is consistent with the assumption stated above with regard to how many years of investment income should be considered.

Therefore, for example, if the Academy’s analysis produced a default factor of 5%, we would assume that only 95% of the bonds were producing income during that year. This is additionally conservative, as it assumes that the defaulting bonds are in default for the full year.
For speculative-grade bonds, the Academy’s factors were based on an analysis of market-value changes, rather than defaults. However, the Academy did publish the corresponding default-based factors in Table IV-1 of their report. Those default-based factors could be used in the same fashion as proposed above for investment-grade bonds.

We will note that the Academy’s bond factors are present values, and therefore could be considered to be understated for the purpose described here. However, in light of the two-year projection period used by the Academy, the understatement should be small, and should be more than compensated for by the conservatism introduced into this calculation elsewhere.

Yield on bonds.

Yield assumptions should be set separately for each credit rating category. Yields may vary significantly between the highest-rated and lowest-rated bonds.

The yields should be selected assuming a two-year maturity. In general, the bond portfolios of health entities have a somewhat longer average maturity than two years. However, since yields generally increase with maturity, using the two-year yield will introduce some additional conservatism. Also, the Academy’s selection of a two-year projection period was based on their analysis of liability duration; to the extent that assets are longer on average than liabilities, the additional income could be considered as compensation for the mismatch risk, and therefore not available for the present purpose.

The NAIC has performed substantial analysis, in connection with its Principle-Based Reserving activities, of how bond yields have historically varied by credit rating and maturity. The information that the NAIC has already collected for that purpose should be useful in determining appropriate yields for the calculation described here.

Discount factor.

The bond risk factors are calculated as a present value, and therefore the offset for investment income should be calculated in the same fashion. The discount rate should be the same as was used by the Academy for discounting the risk factors, as a matter of consistency. For purposes of conservatism, the discount should be applied assuming that the offset takes place at the end of the projection period (i.e., two years out), which would produce the maximum discount.

In conclusion.

The offset factor for each credit category would then be calculated as:

\[ 0.5 \times (1 - \text{default} \%) \times \text{yield} \% \times \text{(discount factor)} \]

The resulting offset factor would then be subtracted from the bond risk factor for the same credit category.
Obviously, many simplifying assumptions have been made in this approach, and it therefore is not altogether correct from a theoretical standpoint. However, we believe it provides a reasonable approximation of the proper offset. The simplifying assumptions tend to add significant conservatism to the approximation, which should make it more acceptable for purposes of RBC.

We will again note that ignoring investment income entirely in the determination of the bond factors introduces significant, and at this point unquantified, conservatism to the factors. If the Working Group chooses not to reflect investment income at all, then you should recognize that the formula will include this extra level of conservatism, and take that into account in any other decisions that you make.

We would be happy to discuss this matter further with your Working Group.

Sincerely,

James R. Braue
Director, Actuarial Services
UnitedHealth Group

cc: Jane Barr, NAIC
    Tim Deno, Co-Chair of the American Academy of Actuaries Joint P&C/Health Bond Factors Analysis Work Group
    Julie Garber, NAIC
    Randi Reichel, UnitedHealth Group
October 4, 2018

Kevin Fry, Chair
Investment Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO  64106-2197

Patrick McNaughton, Chair
Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO  64106-2197

Via electronic mail to Jane Barr and Julie Garber.

Dear Mr. Fry and Mr. McNaughton:

We are writing in regard to the report from the American Academy of Actuaries titled, “An Update to the Property & Casualty and Health Risk-Based Capital Bond Factors: Report to the NAIC Investment Risk-Based Capital (E) Working Group, Health Risk-Based Capital (E) Working Group, and Property and Casualty Risk-Based Capital (E) Working Group,” as exposed for comment by your Working Groups. UnitedHealth Group is one of the nation’s largest managed care and healthcare services companies, which administers and provides healthcare benefits serving individuals in all fifty states and the District of Columbia. We thank you for the opportunity to comment on the Academy’s report.

We begin with a comment regarding the treatment of investment income in the analysis. Beyond that, our comments are directed at three distinct areas addressed by the Academy’s report: investment-grade bonds; speculative-grade bonds; and other asset classes. All of our comments relate solely to the factors for Health Risk-Based Capital (RBC), although some of our comments may also be relevant to the comparable aspects of the analysis for Property and Casualty RBC.

**Treatment of investment income.**

Our first comment is relevant to both investment-grade bonds and speculative-grade bonds. We would like to raise a point that we cannot recall being addressed in previous discussions (and which we have not ourselves raised previously).
Investment income (i.e., bond coupon payments) was not reflected in the development of the bond risk factors for the Life RBC formula, except to a very limited extent. In their report of August 3, 2015, titled, “Model Construction and Development of RBC Factors for Fixed Income Securities for the NAIC’s Life Risk-Based Capital Formula,” the Academy explained the exclusion of most investment income as follows (on page 13): “The implicit assumption is that any profit from investments is fully distributed to policyholder dividends or used to absorb product or operational losses.” (The “profit from investments” referred to was previously described as “investment income (e.g., coupon income)

These considerations do not seem relevant to Health RBC. For companies subject to the Health RBC formula, generally very little of their business provides policyholder dividends (or retrospective rate credits) that involve investment income. (The Medical Loss Ratio rebate requirements for some business could be considered to be similar to policyholder dividends, but those rebates do not reflect investment income.) As to absorbing “product or operational losses,” we do not believe that the corresponding risk factors in the Health RBC formula were developed on the assumption that losses would be offset by investment income. If that latter understanding is correct, then neither reason that the Academy stated for exclusion of investment income in the Life analysis would be applicable to Health.

In light of that, it does seem appropriate to include investment income in the development of the bond risk factors for the Health RBC formula. Just as the formula would not reflect losses from insurance claims and operating expenses without also reflecting the insurance premium that is charged to fund those losses, likewise the formula should not reflect the losses from investments without reflecting the income from those investments. However, as the report being commented on does not describe a deviation from the Life default model in this respect, we must suppose that the proposed Health bond risk factors do not reflect investment income, except to the very limited extent permitted in the Life default model.

Accordingly, we request that your Working Groups consider whether investment income should be included, on some conservative basis, in the development of the bond factors for the Health RBC formula.

Investment-grade bonds.

For the most part, we agree with the Academy’s approach for investment-grade bonds. The assumptions made for purposes of the analysis seem reasonable (with the caveat about investment income discussed above), and the results of the analysis likewise do not present significant concerns, except in one area.

For the Aaa and Aa1 rating classes, the Academy’s analysis indicated risk factors of zero percent (at least, rounded to the nearest tenth of a percent). For reasons of conservatism, the Academy imposed a minimum risk factor of 0.1%, which is also the factor for the Aa2 rating class.

We understand and agree with the need for conservatism. However, we feel it is also necessary to reflect that the Aaa and Aa1 classes are indeed less risky than Aa2 (as borne out by the Academy’s analysis for longer bond durations). Therefore, while we agree that the factors
should be greater than zero, we also believe they should be lower than the factor for Aa2 bonds. That would not appear to be a problem from a mechanical standpoint, since the Health RBC formula already includes factors that are stated to the hundredth of a percent (e.g., the current factors for Working Capital Finance Investments).

We propose, therefore, that the factors for Aaa and Aa1 be graded down from the factor for Aa2; and as a matter of convenience, we suggest using the same proportions as represented by the Academy’s proposed factors for Property and Casualty RBC. Thus, the factor for Aaa would be $(0.2\% / 0.6\%) \times 0.1\% = 0.03\%$, and the factor for Aa1 would be $(0.4\% / 0.6\%) \times 0.1\% = 0.07\%$.

If, for the sake of consistency, your Working Groups wanted to round all of the bond factors to the nearest hundredth of a percent, that would be reasonable. However, we do not feel it is absolutely necessary.

**Speculative-grade bonds.**

The Academy has noted, in their report, many potential shortcomings of their analysis underlying the proposed bond risk factors for speculative-grade bonds. We do feel concern about several aspects of the analysis. However, given the limited amount of information available, we do not feel that there is a superior alternative. In particular, we do not feel that an analysis such as that presented in Appendix 3, using the standard deviations of S&P bond indices, provides an appropriate comparison. Standard deviation reflects favorable fluctuations as well as unfavorable ones, and the issue at hand is how the potential losses on speculative-grade bonds compare with the potential losses on common stock. Also, the Annual Statement data that the Academy used reflect that bonds are held at the lower of amortized cost and market value; this has a dampening effect on fluctuations in value, which is not reflected in the index data. Furthermore, as the Academy has noted, the composition of the bond indices is not necessarily representative of the bonds actually held by insurers. Therefore, we believe that an analysis based on the fluctuations in value of bonds held by insurers is preferable.

In keeping with that belief, the only adjustment that we would suggest to the analysis of speculative-grade bonds is the inclusion of investment income, as discussed above.

**Other asset classes.**

As the Academy notes (page 13 of the report), there are other factors in the Health RBC formula that are based directly on the bond factors. They cite the factors for cash and preferred stock; the factor for receivables for securities is another example. We feel strongly that all such factors should be updated to be consistent with any new bond factors that are adopted.

* * * * *

We look forward to discussing these matters with your Working Groups.
Sincerely,

James R. Braue
Director, Actuarial Services
UnitedHealth Group

cc: Jane Barr, NAIC
Julie Garber, NAIC
Randi Reichel, UnitedHealth Group
September 4, 2019

Patrick McNaughton
Chair, Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Re: Draft Bond Structure and Instructions

Dear Mr. McNaughton:

The American Academy of Actuaries\(^1\) Health Solvency Subcommittee is pleased to provide this response letter to the NAIC Health Risk-Based Capital (HRBC) Working Group. This letter is in response to the HRBC Working Group comment letters received on the exposure of the Draft Bond Structure and Instructions.

**United Health Group (UHG) sent two comment letters which comprised comments on:**

**Treatment of Investment Income**

Investment income is utilized in the development of the underwriting risk in the property and casualty (P&C) Risk-Based Capital Formula. Therefore it would be redundant to include as an offset to the default risk within the bond factor development. It is unclear whether the Health Risk-Based Capital Formula used a similar consideration in the development of the underwriting risk. The HRBC Working Group should consider the implications of investment income already included in the formula.

As stated in UHG’s second letter dated November 13, 2018, the bond factors would require a number of considerations and assumptions in order to accommodate the impact of investment income in the model. An alternative approach could be considered if determined appropriate.

**Investment-Grade Bonds**

As noted in the UHG comments, the Joint P&C/Health Bond Factors Analysis Work Group’s (PCHWG) report\(^2\) suggests a minimum risk factor of 0.1%, which UHG has stated it views as being too conservative. In considering the minimum risk charge, it’s important to recognize the risk charge associated with cash. If cash has a risk charge, then bonds should have a charge at

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\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

\(^2\) *An Update to the Property & Casualty and Health Risk-Based Capital Bond Factors*, Joint P&C/Health Bond Factors Analysis Work Group, July 30, 2018.
least as great. Related to bond risk, there may be other risks outside of the modeled risk of misuse or loss that should be taken into consideration.

Speculative-Grade Bonds

While the UHG comments expressed some general concerns with the approach, UHG also acknowledged that given the limited amount of information available, there was no superior alternative.

Other Asset Classes

UHG has stated it concurs with the PCHWG report on page 13—that all factors based upon bond factors should be updated.

America’s Health Insurance Plans (AHIP) provided comments on:

Speculative Grade—Size Adjustment

The AHIP comments surround the use of a bond size factor in the development of the speculative grade bond factors. It’s important to note that both life and P&C utilize a bond size adjustment factor on speculative-grade bond factors in their respective formulas. Therefore from a consistency standpoint, health incorporated a similar type of adjustment on the speculative-grade bond factors.

It’s important to note that footnote 74 in the PCHWG report acknowledged that the modeled approach was simplified and identified potential inconsistencies. However, the last sentence outlines why the approach was reasonable overall: “However, as the bond size factor is based on the total number of issuers (excluding US government issuers), rather than issuers by rating class, and as the proportion of [speculative-grade] bonds is not large for either life or P&C, we believe this approach is reasonable.”

If the HRBC Working Group decided to adjust the speculative-grade modeling to remove the size adjustment factor, then the investment-grade bonds would also need to be adjusted to account for a lower number of issuers on this asset class. This would lead to an increase in the proposed size adjustment and resulting factors.

*****

We appreciate the opportunity to provide these comments and would welcome the opportunity to speak with you regarding these comments in more detail and answer any questions you might have. If you have any questions or would like to discuss further, please contact David Linn, the Academy’s senior health policy analyst, at 202-223-8196 or linn@actuary.org.

Sincerely,

Tim Deno, MAAA, FSA
Chairperson, Health Solvency Subcommittee
American Academy of Actuaries
July 29, 2019

Mr. Patrick McNaughton
Chair, Health Risk-Based Capital Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

Re: Comments on Draft Bond Structure and Instructions

Dear Mr. McNaughton:

America’s Health Insurance Plans (AHIP) appreciates the opportunity to provide these comments on the request for comments on the proposed changes to the RBC calculations for bonds that include more categories and revised factors for both Investment Grade bonds (IG) and Speculative Grade bonds (SG). We would ask that the NAIC consider an alternative to the use of “speculative” for bonds in NAIC classes 3-5. Many bonds in these categories may have been purchased when they were rated as Investment Grade and have since had the rating lowered but are still in fully compliant status. A better term would be Higher Risk bonds.

The Academy has developed bond factors under two different approaches for Investment Grade bonds and Speculative Grade bonds.

For IG bonds, the model looked at the impact of bond default rates applied to an average portfolio. The HRBCWG is recommending an average bond size adjustment from the model’s assumption for portfolio size to the average for a Health insurer. It is based on statistical variations of a default/no-default modeling approach.

For SG bonds, the Academy developed factors based on the same model (since some of these factors are actually used for the LRBC formula) and modified them to 50% of the model value to reflect the different Statutory accounting rules for these bonds versus the assumptions in the model (held at amortized book value). The Academy recommended an alternative approach for SG Bonds. This alternative was a market value change approach and relied on the decrease in market value of bonds from 2007-2008.

However, the final factors for SG Bonds presented by the Academy included the same adjustment for portfolio size used for IG Bonds. We can find no basis for the assumption that the statistical fluctuation based on portfolio size from the default/no-default variation is appropriate for any presumed variation by portfolio size due to market value fluctuations. We continue to request that the WG seek review of this issue by the Academy.
AHIP Comments on HRBC Bond Structure and Instructions
July 24, 2019
Page 2

We do not have any comments with respect to the instructions as proposed.

We would be happy to address any questions the Working Group has with these comments.

Sincerely,

William C. Weller
Actuarial Consultant to AHIP

c/c: Crystal Brown, NAIC
    Candy Gallaher, AHIP
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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<td>Agenda Item #</td>
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<tr>
<td>TELEPHONE: 816-783-8146</td>
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<td>New Reporting Requirement [ ]</td>
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BLANK(S) TO WHICH PROPOSAL APPLIES

- [ ] ANNUAL STATEMENT
- [ ] QUARTERLY STATEMENT
- [ x ] INSTRUCTIONS
- [ ] CROSSCHECKS

- [ x ] Life, Accident & Health/Fraternity
- [ x ] Property/Casualty
- [ x ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)
- [ ] Title
- [ ] Other

Anticipated Effective Date:________________________

IDENTIFICATION OF ITEM(S) TO CHANGE

Revise the Health Annual Statement Test language

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of the change is to move those filers who write predominantly health business and file on the life blank to begin filing on the health blank.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:________________________

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018
Health Annual Statement

**GENERAL**

The annual statement is to be completed in accordance with the *Annual Statement Instructions and Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the health annual statement will be filed pursuant to such state’s filing requirements. The domiciliary state’s insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. **Health Statement Test:**

   If a reporting entity completes the health annual statement for the reporting year, the reporting entity must complete the Health Statement Test.

   The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. The purpose of this test is to identify a reporting entity writing predominantly health business (premium ratio of 90% or more) to file on a Health Statement and the associated Health RBC filing (if required). Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies.

   **Passing the Test:**

   A reporting entity is deemed to have passed the Health Statement Test if the values for the premium ratio in the Health Statement Test (General Interrogatories, Part 2) equal or exceed 90% for both the reporting and prior year.

   **Failing the Test:**

   Once the reporting entity has passed the health test and is currently filing on the Health Statement (Health RBC filing), the health test will be used to demonstrate that the insurer is still predominantly writing health business as defined above. If the premium ratio falls below 90% the company could still be viewed as writing predominantly health business and should continue to file on the Health Statement (and Health RBC Filing) but notify the domestic regulator as indicated below.

   **Variances from following these instructions:**

   If the reporting entity has consistently reported a premium ratio of 90% or greater and filed on the health blank but falls below the 90% premium ratio, the reporting entity shall apprise the domestic regulator if they fall below 90% and should advise of significant changes in their business at the time of their annual statement filing. This will allow the domestic regulator to work with the reporting entity to determine if the company should continue to complete the health annual statement and risk-based capital report or if the reporting entity should begin completing the life, accident and health and fraternal or property and casualty annual statement form and risk-based capital report. The domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which the Health Statement Test is submitted.
GENERAL INTERROGATORIES
PART 2 – HEALTH INTERROGATORIES

2. Health Test:

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<th>Prior Year Annual Statement Data</th>
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<td>2.1</td>
<td>Premium Numerator</td>
<td>Health Premium values listed in the Analysis of Operations by Line of Business (Gain and Loss Exhibit), Line 1, Column 2 through Column 9 (in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies).</td>
<td>Health Premium values listed in the Analysis of Operations by Line of Business (Gain and Loss Exhibit), Line 1, Column 2 through Column 9 (in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies).</td>
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<td>2.2</td>
<td>Premium Denominator</td>
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<td>Net Premium Income (Page 4, Line 2, Column 2) of the prior year’s annual statement.</td>
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<td>Premium Ratio</td>
<td>2.1/2.2</td>
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Life Annual Statement

GENERAL

The annual statement is to be completed in accordance with the Annual Statement Instructions and Accounting Practices and Procedures Manual except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the life, accident and health annual statement will be filed pursuant to such state’s filing requirements. The domiciliary state’s insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. Health Statement Test:

If a reporting entity is licensed as a life and health insurer and completes the life, accident and health annual statement for the reporting year, the reporting entity must complete the Health Statement Test.

The purpose of the Health Statement Test is to identify a reporting entity writing predominantly health lines of business (premium ratio of 90% or more), to move and file on a Health Statement and the associated Health RBC filing (if required). Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies.

Passing the Test:

A reporting entity is deemed to have passed the Health Statement Test if:

The values for the premium ratio in the Health Statement Test equal or exceed 90% for both the reporting and prior year

If a reporting entity completes the Life, Accident and Health annual statement for the reporting year and b) passes the Health Statement Test (as described above), the reporting entity must begin completing the health statement with the first quarter’s statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the life supplements for that year-end. (e.g. If the company passed the health test for year-end-2019 reporting, the company must begin filing the health blank with first quarter 2021).

Variances from following these instructions:

If the reporting entity has consistently reported a premium ratio of 90% or greater and filed on the health blank but falls below the 90% premium ratio, the reporting entity shall apprise the domestic regulator if they fall below 90% and should advise of significant changes in their business at the time of their annual statement filing. This will allow the domestic regulator to work with the reporting entity to determine if the company should continue to complete the health annual statement and risk-based capital report or if the reporting entity should begin completing the life, accident and health and fraternal or property and casualty annual statement form and risk-based capital report. The domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which the Health Statement Test is submitted.
GENERAL INTERROGATORIES

PART 2 – LIFE ACCIDENT AND HEALTH COMPANIES/FRATERNAL BENEFIT SOCIETIES INTERROGATORIES

2. Health Test:

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<th>Item</th>
<th>Description</th>
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<td>Premium Ratio</td>
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This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers compensation, accidental death and dismemberment policies and long-term care policies.

All reporting entities should file the test.

Premium information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.
Property/Casualty Annual Statement

GENERAL

The annual statement is to be completed in accordance with the Annual Statement Instructions and Accounting Practices and Procedures Manual except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the property and casualty annual statement will be filed pursuant to such state’s filing requirements. The domiciliary state’s insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. Health Statement Test:

   If a reporting entity is licensed as a property and casualty insurer and completes the property and casualty annual statement for the reporting year, the reporting entity must complete the Health Statement Test.

   The purpose of Health Statement Test is to identify a reporting entity writing predominantly health lines of business, to move and file on a Health Statement and the associated Health RBC filing (if required). Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies.

   Passing the Test:

   A reporting entity is deemed to have passed the Health Statement Test if:

   The values for the premium ratio in the Health Statement Test equal or exceed 90% for both the reporting and prior year

   If a reporting entity is a) completes the property and casualty annual statement for the reporting year and b) passes the Health Statement Test (as described above), the reporting entity must begin completing the health statement with the first quarter’s statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the property/casualty supplements for that year-end. (e.g. if the company passed the health test for YE-2019 reporting, the company must begin filing the health blank with first quarter 2021)

   Variances from following these instructions:

   If the reporting entity has consistently reported a premium ratio of 90% or greater and filed on the health blank but falls below the 90% premium ratio, the reporting entity shall apprise the domestic regulator if they fall below 90% and should advise of significant changes in their business at the time of their annual statement filing. This will allow the domestic regulator to work with the reporting entity to determine if the company should continue to complete the health annual statement and risk-based capital report or if the reporting entity should begin completing the life, accident and health and fraternal or property and casualty annual statement form and risk-based capital report. The domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which the Health Statement Test is submitted.
### GENERAL INTERROGATORIES

#### PART 2 – PROPERTY & CASUALTY INTERROGATORIES

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<td>2.3 Premium Ratio (2.1/2.2)</td>
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### PART 2 – PROPERTY AND CASUALTY INTERROGATORIES

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers compensation, accidental death and dismemberment policies and long-term care policies.

All reporting entities should file the test.

Premium information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.

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November 20, 2019

Mr. Patrick McNaughton
Chair, Health Risk-Based Capital (E) Working Group

Re: Health Test Exposure

Dear Mr. McNaughton:

The American Council of Life Insurers (ACLI)\(^1\) is pleased to submit the following comments regarding the exposed revisions to the health test.

ACLI is appreciative of the simplification of the health test from the prior requirements, but we have some concerns about the practical implications of the changes. The reduction in the premium threshold from 95% to 90% will increase the likelihood of companies to “bounce” back and forth between meeting the requirement and not, which may potentially create undue burden on the companies. ACLI is appreciative of the discretion granted by the commissioner in the “Variances from following these instructions” section, but note as constructed is a one-way test. ACLI would suggest strengthening this safe harbor to be a two-way test that gives greater discretion to the commissioner.

ACLI believes the premium threshold should be characterized as a “threshold”, rather than a passing/failing a test. We would suggest changing the sections from “Passing the Test” and “Failing the Test” to “Meeting the Test Threshold” and “Not Meeting the Test Threshold”.

ACLI is concerned that without greater clarification of the changes, it could create undue cost and effort for companies, which ultimately would create a worse outcome for consumers. There are considerable differences between the Health Blank and the Life Blank, and companies needing to switch between the two would need to develop expertise on how to properly complete them. Further, companies would need to license different software due to the change, which would cause additional cost. Insurance groups with multiple companies achieve efficiencies within the organization through consistency in reporting, with appropriate processes and controls and systems in place. From a regulator’s perspective, it may be difficult to properly assess the solvency position of the company due to swings in the RBC ratios were they to move from one set of RBC requirements to another.

We look forward to a discussion of these issues. Thank you.

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\(^1\) The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. 90 million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. Learn more at [www.acli.com](http://www.acli.com).
Sincerely,

[Signature]

cc Crystal Brown, NAIC
Steve Clayburn, ACLI
Jan Graeber, ACLI
Mike Monahan, ACLI
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met in Austin, TX, Dec. 7, 2019. The following Working Group members participated: Philip Barlow, Chair (DC); Steve Ostlund (AL); Eric Unger (CO); Carolyn Morgan (FL); Vincent Tsang (IL); Fred Andersen (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Puran Bheamsain (NY); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT). Also participating were: Mike Yanacheak (IA); and Peter Weber (OH).

1. **Adopted its Oct. 23 and Summer National Meeting Minutes**

Mr. Ostlund made a motion, seconded by Ms. Eom, to adopt the Working Group’s Oct. 23 (Attachment Three-A) and Aug. 3 (see NAIC Proceedings – Summer 2019, Capital Adequacy (E) Task Force, Attachment Three) minutes. The motion passed unanimously.

2. **Adopted the Longevity Risk (A/E) Subgroup’s Nov. 25, Nov. 4, Oct. 7, Sept. 30 and Sept. 18 Minutes**

Ms. Ahrens made a motion, seconded by Mr. Ostlund, to adopt the Longevity Risk (A/E) Subgroup’s Nov. 25 (Attachment Three-B), Nov. 4 (Attachment Three-C), Oct. 7 (Attachment Three-D), Sept. 30 (Attachment Three-E) and Sept. 18 (Attachment Three-F) minutes. The motion passed unanimously.

3. **Exposed the Longevity Risk (A/E) Subgroup’s Recommendation for Public Comment**

Ms. Ahrens said the Subgroup has been meeting to work on its recommendation for a longevity C-2 charge. She said the Subgroup’s memorandum (Attachment Three-G) to the Working Group provides an introduction with the general discussions that the Subgroup has had, provides its recommendation that the Working Group accept the factors proposed by the American Academy of Actuaries (Academy) Longevity Risk Task Force (Academy Task Force) (see NAIC Proceedings – Spring 2019, Capital Adequacy (E) Task Force, Attachment Five-D), and highlights the areas where the Subgroup did not reach full agreement. She said one of these areas is scope and, specifically, longevity reinsurance transactions (LRT) where there are still some complicated questions that need to be addressed. She said the Subgroup is recommending that the Working Group move forward with LRT scoped out for now with direction to the Subgroup to continue its study of LRT. She said the memorandum also addresses correlation and includes the Subgroup’s conclusion that correlation between longevity and mortality risk within the formula extends beyond the Subgroup’s charge. She said the memorandum includes as attachments the Academy Task Force’s original proposal, which is what the Subgroup’s recommendation is based upon (see NAIC Proceedings – Spring 2019, Capital Adequacy (E) Task Force, Attachment Five-D), the Academy Task Force’s update on correlation, which was presented to the Working Group at the Summer National Meeting (see NAIC Proceedings – Summer 2019, Capital Adequacy (E) Task Force, Attachment Three-H), and the actual proposal form with the risk-based capital (RBC) blank and instruction changes. She highlighted the fact that the blank and instruction changes being recommended do not include correlation (Attachment Three-H), but that the Academy Task Force also submitted an alternative presentation of the blank and instruction changes, which does include correlation (Attachment Three-I). Brian Bayerle (American Council of Life Insurers—ACLI) presented the ACLI’s comment letter (Attachment Three-J) suggesting that the Working Group include the Academy Task Force’s alternative, including correlation in any exposure.

The Working Group agreed with the Subgroup’s recommendation to scope out LRT for now with direction to the Subgroup to continue its work on this aspect. The Working Group also agreed to having consideration of correlation done by the Working Group. The Working Group agreed to expose the Subgroup’s recommended RBC blank and instructions changes, which do not include correlation, along with the Academy Task Force’s alternative, including correlation in order to get comments on both, for a public comment period ending Feb. 7, 2020.
4. Heard an Update from the Academy C2 Work Group

Chris Trost (Academy) said the Academy C2 Work Group’s charge is to review and, if appropriate, recommend changes to the life mortality RBC factors which, for the most part, have not been updated since they were originally developed. He said an update was given to the Working Group in June covering the assumptions and methods that were being used, and they have tried to incorporate the feedback that they got into their work. While the Work Group had presented some preliminary factors, based on that feedback and other constraints, he said the Work Group is not yet at a point to recommend factors; but he provided an update (Attachment Three-K) that includes that feedback’s impact on its work on each of the components of mortality risk. Mr. Barlow suggested scheduling a call specifically to discuss this before a final proposal is presented so Working Group member’s questions regarding some of the technical considerations can be addressed.

5. Received an Update on ESGs

Pat Allison (NAIC) said a request was made to NAIC staff during a July 16 joint conference call of the Working Group and the Life Actuarial (A) Task Force to develop a request for proposal (RFP) to find a vendor to provide an economic scenario generator (ESG) to replace the Academy’s ESG and be enhanced over time. She said work is continuing on the RFP, and the plan is for it to be a prescribed ESG for life and annuity reserves and capital involving VM-20, Requirements for Principle-Based Reserves for Life Products; VM-21, Requirements for Principle-Based Reserves for Variable Annuities; C3 Phase I; and C3 Phase II. She said the group drafting the RFP includes state insurance regulators, NAIC staff, the Academy, the ACLI, and industry subject-matter experts (SMEs); and it is working with a target completion date of the first quarter of 2020. She said there are a lot of steps after the RFP is issued, and the earliest implementation date would be 2022.

6. Discussed Comments Received on Life Growth Risk

Mr. Barlow said there were two comment letters received (Attachments Three-L and Three-M). Mr. Bayerle presented the ACLI’s comment letter and said the ACLI does not believe that there is a need for a life growth risk at this time, and he highlighted the two main points detailed in their comment letter: 1) state insurance regulators already have tools to assess life growth risk; and 2) rapid growth is less prevalent than in health or property/casualty (P/C) insurance. Mr. Barlow said he struggles with the same issue that the Operational Risk (E) Subgroup did in that there does not appear to be a good way to implement a growth risk charge for life insurance. He suggested tabling this issue until an actual approach to implementing it is presented or otherwise arises as something the Working Group needs to address. The Working Group agreed.

7. Discussed Other Matters

Ms. Hemphill detailed an issue with the new Variable Annuities Framework with regard to the phase in and smoothing. She said if there are voluntary reserves under the old framework, they will inappropriately reduce the C-3 RBC amount in the total asset requirement (TAR) under the new framework, even if there are no voluntary reserves being held under the new framework. She said there is a disconnect in that for the VM-21 reserve, the phase in is done as of Dec. 31, 2020. Doing a comparison between the old and the new frameworks while the C-3 phases in is based on a 2019 year-end calculation. She said there is a related issue with smoothing due to the treatment of voluntary reserves. She said she has discussed this with Mr. Bayerle, and there is agreement that this was an unintended piece of the language that was adopted, so they will be working on a way to address this. This can be addressed for 2020 on the capital side, but it is an issue to the extent that companies have voluntary reserves early adopted for 2019. Mr. Barlow noted that it is too late for the Working Group to change anything for 2019, but he suggested that the Working Group could issue some guidance on this issue and asked NAIC staff to assist in facilitating this.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call Oct. 23, 2019. The following Working Group members participated: Philip Barlow, Chair (DC); Steve Ostlund (AL); Perry Kupferman (CA); Deborah Batista (CO); Wanchin Chou (CT); Gilbert Moreau (FL); Bruce Sartain (IL); John Robinson and Fred Andersen (MN); William Leung (MO); Rhonda Ahrens (NE); Kevin Clarkson (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); and Mike Boerner (TX). Also participating was: Mike Yanacheak (IA).

1. Discussed the Comments Received on a Proposal to Update the RBC Charge for Unaffiliated Common Stock Supporting Long-Horizon Contractual Commitments

Mr. Barlow said the Working Group received several comment letters. He said there was an additional letter from Allstate, which is not included in the materials because it came in after the comment period. However, he said those comments can be raised as part of this discussion. He provided those submitting comment letters the opportunity to speak on their comments.

Mark Prindiville (Allstate) said Allstate submitted the original proposal, documentation of the underlying rationale, a 20-page example, a comment letter (Attachment Three-A1) and a response to the American Academy of Actuaries’ (Academy) comment letter, so Allstate’s views are well documented for the Working Group. He said the six guiding principles that form the foundation of the proposal that are listed on page three of Allstate’s comment letter. He made two points in response to the Academy’s comment letter. The first is whether the proposal should be implemented in the C-3 risk component as opposed to the C-1 component. Mr. Prindiville said this has been a discussion almost from the beginning. He agreed that there are reasons to support C-3 because there is a long horizon and a liability connection, so Allstate understands this position. However, he said by definition of the framework, this is a C-1 issue. C-1 covers the change in equity value, exclusively, while C-3 covers the risk of loss due to changes in interest rate levels and variable products. As a result, there is not any question, according to the current definition, this is a C-1 issue. He asked whether there should be a massive framework overhaul and move equity volatility to C-3 because of the long horizon and liability question. He said this would be complicated with which scenarios to use and how to do covariance. Mr. Prindiville said it would end up with the same issue, and it centers on that low-water mark. For short-term investing, that low-water mark is very important, but for a long-horizon product with the type of guardrails Allstate is proposing, he said this is much less relevant.

Mr. Prindiville said the second point is potential disconnect with the accounting because there are differing amounts of volatility modeled in risk-based capital (RBC) versus what may be included in statutory surplus and the capitalization ratio. He said there is not internal consistency currently and that the capitalization ratio amortization concept included in the proposal is an attempt to provide more consistency because the capitalization ratios would both be calibrated to seven-year horizons. He said Allstate does not believe accounting needs to change but that RBC is the modernization of statutory capital as a measurement of strength because statutory capital does not incorporate how risky a portfolio is or the recoverability of assets over longer horizons. What RBC measures is the claims paying ability of assets, which changes over the short run and the long run. Mr. Prindiville said that over the long run, if equities are used demonstrably, the claims paying ability is higher because the returns are much greater than those for bonds and much more able to support a long-term product.

Brian Bayerle (American Council of Life Insurers—ACLI) presented the ACLI’s comment letter (Attachment Three-A2). He said the ACLI’s comments are high-level and that they do not take an explicit position on the proposal. He said the ACLI appreciates the Working Group and other state insurance regulators having these discussions about how to improve retirement security. Obviously, the purpose of the RBC framework is to make sure companies are appropriately capitalized, and he said the ACLI would not be in favor of anything that would weaken that. Conceptually, he said the ACLI believes the Allstate proposal has appropriate guardrails, but in discussing any details, that main objective needs to be maintained. He said the ACLI’s comment letter addresses several technical issues but that the ACLI believes there are more discussions that could be had on this topic with other potential solutions.

Chris Trost (Academy) presented the Academy’s comment letter (Attachment Three-A3). With respect to the point made by Allstate about the inconsistency between the accounting and RBC, he said the Academy is concerned because the capital will be immediately impacted and fully reflected in the capital position on the statutory statement by reductions in the equity market, while RBC would be assuming some amortization. He said the Academy also commented that product-specific features tend
to be reflected in C-3 and not C-1. When looking at the product liabilities being considered here, the long-horizon contracts, he said there is really no aspect of those liability cash flows that would offset the loss. Mr. Barlow asked about the Academy’s point that product-specific investment choices are reflected in C-3 In the current RBC framework, Mr. Trost said there are certain specific places where liability characteristics are reflected, and those are with variable annuities and fixed annuities, where interest rates and assets are addressed. To reflect the common stock component in C-3, he said that would require redesign of the RBC framework where it would bring in equity performance for fixed annuities where it currently does not exist.

Mr. Andersen said he believes Allstate did a good job of presenting the history of stock market performance over the long-term but reiterated his concern that there needs to be an equal analysis of theory to prevent an unreasonable result where money can be borrowed at a low rate with a guarantee of a higher rate over time.

Mr. Carmello reiterated New York’s position that this proposal is a bad idea as it is not the time to be reducing RBC for equities. He noted that there was a 66% drop in equities in 2008 and 2009.

Mr. Barlow said this proposal would be a significant change to RBC and something requiring a lot of consideration. He said with other proposals in the past, the Working Group has referred them to the Academy for consideration, conducted field tests or asked NAIC staff to do some work. He asked Working Group members for any additional thoughts on the proposal and any input on how to move forward with the proposal. Ms. Ahrens said her initial thought is to agree with Mr. Andersen and suggested also that the Working Group should study this from more of a macro perspective beyond one company. She said the Working Group needs to keep in mind the concern Mr. Carmello raised about equities losing two-thirds of their value in recent history. She said there are a lot of questions to answer about whether this is a C-1 or C-3 risk. While she believes it is a C-3 risk, she said she does not fully agree that C-3 is not already set up in some ways to address something like this, citing C-3 Phase I cash-flow testing, which could potentially be leveraged to accommodate it. She said she believes there is a lot of discussion that needs to take place before the Working Group moves forward on something like this.

Mr. Sartain said this may be the same type of issue companies have with having reserves at too high a level and affecting pricing in that RBC charges that are too high can affect investment decisions. He said it seems indisputable that if you have a long-term liability, you are going to want to match that with some equities. He said this is probably true on the investment side, but the question is whether it fits into the RBC framework. If RBC is a regulatory tool, he asked how it is so critical for companies to make sure the RBC charges are not too conservative. He said rating agencies have their own capital models and that RBC is generally recognized as a blunt regulatory tool. He said it would be helpful to get the perspective of companies on that.

Mr. Barlow said he has had that same question for a long time. He said he was on a panel last year where there were quotes from analysts specifically referencing the RBC of a company and indicating that if that RBC fell below a certain percentage, it was time to be concerned. He said that certain percentage was not 200% but something significantly higher. He said while RBC is a tool with a single purpose to identify weakly capitalized companies, it seems this dynamic is a fact of life right now for the insurance industry. He said Allstate indicated to him that it is following a strategy of investing in equities for these liabilities, where interest rates and assets are addressed. To reflect the common stock component in C-3, he said that would require redesign of the RBC framework where it would bring in equity performance for fixed annuities where it currently does not exist.

Mr. Prindiville confirmed that Allstate has invested its block along the lines of what it believes is an optimal RBC charge because in its own economic capital framework, it has made the change that is being proposed. He said this was not easy and took several years of internal dialogue to get everyone comfortable with the underlying concepts and to ensure that all the right protections were in place so that Allstate will be able to withstand an untoward event in the markets. He said Allstate believes the concepts are more widely applicable and could be useful to the entire industry, which is why it has submitted the proposal. Mr. Robinson asked how long Allstate has been using this investment approach. Mr. Prindiville said about five years. In response to Mr. Andersen’s comment on theory, he said the last two pages in its comment letter are an attempt to provide the kind of theory being requested but that Allstate would be happy to engage further on this topic.

When considering whether equities are appropriate for immediate annuities, Mr. Trost said a portion of equities may be appropriate. However, he said he believes the real issue is that it is necessary to cover what the potential downside of the equities is, which is the short, concentrated event where losses can occur in a hurry. Mr. Sartain said it seems like the proposal covers this, at least in part, by having seven years of liquidity. He said the research would show that the longer the years extend, the more unlikely there would be that negative return on the equities. With equities, Mr. Trost said there is not the luxury of...
waiting for that entire seven-year period. He noted the example given of equities dropping rapidly by two-thirds. He said the issue is that this would be reflected in a much lower capital position in the statutory statements if they had a large portion of equities as opposed to if they did not invest in equities. He said it is a mismatch between how an insurance company’s capital is measured relative to its particular investment strategy. If there was a change in statutory accounting, whether or not it makes sense to hold them at something other than market value given their fluctuations, he said there would be a better consistency between the proposal and how statutory solvency would be measured.

Mr. Barlow agreed and said one of his concerns is a scenario where a company is insolvent but has a healthy RBC. He acknowledged that this would take an extraordinary set of circumstances but said it does happen occasionally. Mr. Prindiville said the capitalization ratio amortization part of the proposal is an attempt to mimic what the asset valuation reserve (AVR) does for statutory surplus. Mr. Yanacheak said he shares Mr. Barlow’s concern and said he believes that scenario definitely exists. He said it is a severe scenario, and while it may not be likely, severe scenarios are never regarded as likely. If it is a conditional tail expectation (CTE) type analysis, he said, when looking at tail events, he believes it might flip to likely, and that concerns him about this proposal. Mr. Barlow said there are some guardrails in the proposal that are good for what they do, but he is concerned that companies could use equities in a way that may not be appropriate for the liabilities they are backing and then, at the end of the year, trade to something for the purpose of RBC and then go back afterward. He said he does not yet have a clear view of what the next step is but suggested the Working Group could come up with additional questions. He asked Working Group members for their thoughts. Mr. Carmello suggested rejecting the proposal and moving on to other issues. He said RBC has been reduced for the last 20 years, and that is why the rating agencies’ multiples are up to four or five. Mr. Boerner said he has been struggling with what type of analysis would be useful right now, but he is not comfortable with the proposal at this point and said he would not oppose Mr. Carmello’s suggestion.

Mr. Carmello made a motion, seconded by Mr. Boerner, to reject the proposal. Mr. Andersen said he supports that for now but suggested a more independent and rigorous study as to what happens over a 30-year period would make this a discussion worth having again. The motion passed, with Illinois abstaining.

2. Exposed the Memorandum on Potential Further Work on Life Growth Operational Risk

The Working Group agreed to expose the memorandum from the Operational Risk (E) Subgroup for a 25-day public comment period ending Nov. 20. Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.

W:\National Meetings\2019\Fall\TF\CapAdequacy\LifeRBC\10_23_19 Call
September 20, 2019

VIA ELECTRONIC MAIL – dflemin@naic.org

Philip Barlow, Chair
Life Risk-Based Capital Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108

Re: Comments on Exposure of a Proposal to Update the RBC Charge for Unaffiliated Common Stock Supporting Long-Horizon Contractual Commitments

Dear Associate Commissioner Barlow, and members of the Life Risk-Based Capital Working Group:

We are writing on behalf of Allstate Life Insurance Company and its affiliated insurance companies (collectively, Allstate) regarding the Life Risk-Based Capital Working Group’s exposure of a proposal, sponsored by the Illinois Department of Insurance, to Update the Risk-Based Capital (RBC) Charge for Unaffiliated Common Stock Supporting Long-Horizon Contractual Commitments (Proposal). Allstate acknowledges the important work of the Life Risk-Based Capital Working Group (Working Group) and appreciates the significant contributions that Associate Commissioner Barlow, many state regulators, industry groups and peers have made in helping refine this Proposal. Feedback has consistently helped us to refine and strengthen the Proposal, and we welcome further dialogue once comments have been received.

Allstate is a multi-line insurance company with approximately $40 billion in annual revenues, 130 million policies in force, and $80 billion of assets under management, of which $9 billion backs structured settlement and immediate annuity policies. These commitments are long term in nature and fixed in all respects other than mortality. As is the case for pensions and endowments with similar obligations, equity investments can play an important role in the asset portfolio. Our research shows that an allocation to equity investments for products like these is likely to enable greater returns to policyholders while reducing the long-term solvency risk of the insurer. Such
investments diversify insurer portfolios and strengthen their long term financial ability to meet contractual guarantees.

Despite the expected benefits of holding equity investments for the long-term in a low interest rate environment, RBC charges for all insurance company investments are still tied to a short time horizon. The current C-1cs capital charge for unaffiliated common stock is 30% regardless of the underlying contractual obligations. As a result, insurers with business that includes long-term contractual obligations that are not subject to disintermediation risk often hold suboptimal economic portfolios that are too heavy on bonds and too light on equities. This investment mix reduces long-term investment performance and increases the risk to all stakeholders from extended periods of low interest rates. It also creates disincentives for the insurance industry to participate in solutions to long-term retirement needs such as pension buyouts and individual payout annuities.

Accordingly, this Proposal is to revise the life RBC framework to incorporate the existence of time diversification in equity markets. The amended life RBC calculation would allow eligible companies to voluntarily elect a C-1cs credit for unaffiliated common stock in the range of 15-20% pre-tax against the current 30% C-1cs capital charge specifically relating to equity investments backing long-term, contractual obligations not subject to disintermediation risk. An extensive set of guardrails will prevent an increase in risk to the insurance industry as a whole and mitigate insolvency risk at the company level.

Such guardrails include:

1. Equities must back reserves held for 7 years or more;
2. Reserves must not be subject to discretionary withdrawals which could shorten the time horizon;
3. An effective asset-liability strategy must be in place to mitigate short term liquidity risk;
4. A certification from a qualified Actuary is required to ensure documentation and transparency;
5. A management certification is required as to the company’s “intent and ability” to execute its investment strategy and live into the required guardrails;
6. Segmentation is required to separate long-duration assets and enhance transparency; and
7. Volatility associated with long horizon equities would be amortized into the Capitalization Ratio over a 7-year period.
Under this Proposal, we believe that insurers would be encouraged to follow sound, responsible investment policies that benefit consumers many years into the future, providing retirement security or a safe, reliable income stream for individuals with special needs.

Allstate believes strongly in a set of defining principles that form the foundation of this Proposal:

1. The RBC framework can be enhanced to encourage solutions that target the retirement security gap that exists for consumers;
2. Equity investments can help achieve the returns necessary to meet legacy obligations and improve the consumer value proposition for newly designed products;
3. Equities held for the long term demonstrate lower volatility and risk due to the benefit of time diversification;
4. Any credit for time diversification should be linked to company intent and ability to maintain equity exposure over the long term;
5. Companies taking such a credit must demonstrate compliance with guardrails designed to maintain the financial strength of companies and the industry; and
6. Payout annuities, with no exposure to disintermediation risk, are a simple and transparent test case to introduce a credit for time diversification.

To provide further context, we provide supplementary materials that relate the current Proposal to prior analysis, including a memorandum issued as part of the 2013 study by the NAIC Investments RBC Working Group. Through this lens, the Proposal can be seen as a logical extension of prior discussion. It evolves the RBC framework away from a rigid "one size fits all" approach to equities by linking the calibration interval to the expected duration of the investment. If a long horizon and requisite liquidity can be guaranteed, a "beginning to end" lens is more appropriate than application of a quarterly low watermark calculation.

As noted during the August 3rd Working Group meeting, Chairman Barlow outlined key questions to help guide the analysis and discussion of this Proposal by group members. Although Allstate has discussed and answered many of these questions in prior conversations with individual regulators, we now provide answers on the record for the benefit of all interested parties.
1. Allstate is focusing on the element of time diversification and urging that it be incorporated into the formula. Is C-1 the right place to accomplish that?

Following many conversations on this topic, Allstate continues to believe that the C-1 charge is the appropriate place to recognize time diversification of investment risk. The C-1 framework already recognizes other types of diversification - for example, diversification across issuers and industries. Diversification across time periods has a similarly powerful and beneficial impact on risk and is a logical addition in cases where it can be assured by demonstrating intent and ability to hold. The C-1 framework includes actuarial and management certifications to provide transparency and disclosure regarding this intent and ability.

Moreover, C-1 is the appropriate place according to the definitions and rules of the RBC framework itself. C-1 is defined and calibrated to cover the risk of asset default of principal and interest, or the risk of fluctuation in fair value. The latter part of this definition clearly encompasses equity risk, which varies significantly by horizon due to the existence of time diversification.

C-3, in contrast, is defined to cover the risk of loss due to changes in interest rate levels and changes in market levels associated with variable products. The volatility associated with equity investments backing immediate annuities and structured settlements is not in scope, as the products under discussion are not variable products.

Though equity volatility could in theory be moved to the C-3 calculation, this would represent a fundamental change to the overall framework, introducing a large number of complicated issues such as the scenarios to be used, the usage of “low watermark” adjustments, and the calibration of diversification assumptions across RBC categories. A more straightforward approach is to retain equity volatility within C-1 capital, but to consider it in the context of the investment horizon. Charges based on a short holding period are appropriate in cases where liquidity constraints exist. In contrast, where liquidity is not an issue and where a long holding period can be supported, time diversification reduces the impact of short-term volatility and reduces tail risk over the length of the holding period. Appropriate holding period requirements would be required in calculating C-1 charges to maintain the integrity and consistency of RBC category definitions.

The proposed C-1 adjustment modernizes the RBC framework while requiring full transparency and disclosure, and without the complexities associated with measuring risk in a C-3 context.

2. Is Allstate saying there is a risk of not holding equities?

The key consideration is the investment horizon. Over short time periods, stocks are generally acknowledged to be a higher risk investment than bonds. Over long time periods, in contrast, stocks benefit from compounding of returns and time diversification of risk. These two forces significantly increase the likelihood of a favorable outcome for stocks when compared to bonds.
Over this longer time period, the expected return of a diversified stock portfolio becomes much higher than that of a bond portfolio, due primarily to the compounding of returns. More importantly from a capital perspective, 95th percentile tail outcomes become more favorable for stocks than for bonds, due in large part to the impact of time diversification.

When considering the risk of not being able to make liability payments across the entire life of a long-tailed product line, a properly diversified stock portfolio represents a lower risk investment than a portfolio of bonds. Especially at times when interest rates are low for extended periods, stocks provide greater returns than fixed income securities and improve the insurer’s ability to meet obligations associated with long horizon liabilities.

3. **Should there be a change in NAIC accounting standards as well as the RBC formula?**

Allstate believes that NAIC accounting standards provide a sound and robust valuation of the capital of the company. RBC complements capital and measures the ability for the capital to meet policyholder obligations. Capitalization levels can only be evaluated in light of the company’s assets and liabilities. In cases where there is no disintermediation risk and liquidity is managed appropriately, liabilities due long into the future do not require immediate liquidation of balance sheet assets, and RBC charges should be adjusted to reflect the fact that short term price volatility is less important.

Though Allstate believes that a change in accounting standards is not necessary, proposed adjustments to the Capitalization Ratio would modernize it in a manner consistent with the incorporation of a time diversification credit for long horizon equity investments.

If equity C-1 charges are differentiated by time horizon as proposed, accounting and RBC frameworks will remain internally consistent to the extent that equity-related volatility is realized in a pattern that reflects the investment horizon used to calibrate the C-1 charges. In cases where C-1 charges are set to reflect a seven-year horizon, consistency suggests that equity gains and losses be amortized into the Capitalization Ratio over an identical seven-year period. Doing so equilibrates the expected volatility embedded in the C-1 charge to the realized volatility likely to flow through the Capitalization Ratio.

4. **The proposal assumes a diversified portfolio of equities. How can regulators be assured of that?**

Concentration risk is an important consideration that is not unique to this Proposal. Existing RBC charges assume a diversified portfolio of equities; adjustments and regulations are in place to guarantee diversified portfolios.

Single issuer concentration limits vary by state. In Illinois, for example, equity investments in a single issuer must be less than 3% of admitted assets. In addition, incremental capital charges are applied to large portfolio concentrations. “Top five” equity concentrations currently receive a 50% capital surcharge, effectively increasing the base C-1 charge from 30% to 45%. Finally,
beta adjustments increase required capital in cases where lack of diversification increases stock portfolio volatility above that of the market. These limits, penalties, and adjustments would all remain in place under the Proposal. Management certifications will continue to include statements of intent to follow all applicable statutes, including these revised requirements.

Reassessment of whether these protections are sufficient may be a worthy exercise, though it can be undertaken separately from the current Proposal.

From an audit perspective, Allstate agrees that a clear trail must be prepared showing that the assets receiving the credit are clearly intended to retire liabilities far into the future. Such assets should be segregated into company records with appropriate audit trails to the RBC workpapers.

5. How would reinsurance impact this change in the formula?

The credit is designed net of reinsurance. The equity assets identified for the credit will be demonstrated in the supporting memo of the actuarial certification to back long horizon liabilities.

6. How can we ensure the proposed change is limited to payout annuities/structured settlements?

Supplemental exhibits and certifications must be filed by companies opting for the credit, as framed by three interrogatories in the Blue Book presentation:

- Will the Risk-Based Capital Credit for Long Horizon Equity Investments Supplement Exhibits be filed with the state of domicile and the NAIC by March 1?

- Will the Actuarial Certification Related to the Risk-Based Capital Credit for Long Horizon Equity Investments be filed with the state of domicile and the NAIC by March 1?

- Will the Management Certification Related to the Risk-Based Capital Credit for Long Horizon Equity Investments be filed with the state of domicile and the NAIC by March 1?

A new supplement to Note 32 will show amounts applicable to the credit. As proposed, line 32.G.1 will include the liability related to the long horizon credit.

Finally, the equity assets identified for the credit will be demonstrated in the supporting memo of the actuarial certification to back only long horizon annuity liabilities.

7. Are there implications for PBR?

PBR, a reserve measurement framework, is separate from the RBC calculation. No implications are expected.
8. The NAIC is discussing the importance of retirement security. Could this proposal help with that? Should the NAIC take that into consideration?

Allstate believes that the changes proposed would provide social benefits in two ways. First, the Proposal enhances the ability of insurers to play an integral role in helping consumers to navigate challenges associated with saving for retirement. In an era of low interest rates, bond investments do not provide returns sufficient to meet the goals and needs of future retirees. Investment theory has consistently demonstrated that equites are a very important component of a diversified portfolio for investors with long time horizons. Allowing insurers to voluntarily elect this RBC credit allows them to diversify their investment risk and strengthen their long-term financial ability to meet the guarantees provided to customers. A supportive RBC framework would foster innovation within the life insurance industry and encourage companies to offer a wider array of products at attractive rates and terms that meet the retirement-oriented needs of consumers.

Our nation faces a second challenge in the form of its aging infrastructure. For many years, we have underinvested in this area and have fallen behind other countries, threatening our economic competitiveness. Infrastructure investments are long term in nature, and many are made in equity form. Because the characteristics of infrastructure investments align with the risk and return profile desired by long term investors, this Proposal would result in greater insurance industry participation in these investments. Notwithstanding this Proposal, if the NAIC is interested in encouraging infrastructure investments, capital requirements could be further reduced.

9. Should the proposal be limited to forward-looking investments and liabilities only, or can it be used for existing blocks of business?

Allstate believes that the Proposal should apply both to existing blocks and to new business. For existing blocks, which were generally written in economic regimes characterized by higher interest rates, appropriately-managed equity investments increase expected portfolio returns and reduce long term solvency risk. For new business, equity investment strategies enable insurers to offer higher returns that meet policyholder needs.

10. We have had a low interest rate environment for some time. What if interest rates go back up?

The principles of return compounding and time diversification are durable across time. They are not limited to a low interest rate environment. The data that backs our research goes all the way back to 1800. These two principles are apparent in all subsets of data that we have analyzed, including recent history.

The historical record clearly demonstrates that equities provide a long run return premium over bonds, observable across a wide variety of time periods, economic regimes, and geographic...
markets. Whether interest rates are low or high, we expect this premium to persist and to compound through time, making stock investments an attractive part of a long horizon portfolio.

In addition, equity returns are ultimately tied to corporate earnings growth in the economy. Cyclical volatility exists, related to short term growth cycles as well as changing investor sentiment and expectations for the future. However, this volatility is generally resolved across a longer-term horizon. This has been demonstrated in both high interest rate regimes (early 1980’s) and low interest rate regimes (the 2008 financial crisis and its aftermath).

Though durable, these principles are even more important in the existing environment, with bond yields well below guaranteed payment rates. Reinvestment risk associated with fixed income investments is acute. Making matters worse, many debt instruments have call or refinancing provisions that would delay expected benefits should yields to return to higher levels. Though borrowers may opt to refinance when rates fall, they tend to hold their loans when rates increase. Lower yielding bonds can be much “stickier” than their higher-yielding cousins. All told, the likelihood of bonds providing necessary returns for legacy structured settlement and payout blocks has declined significantly, making the equity alternative even more compelling than usual.

Regardless of interest rate conditions, we believe that the principles of return compounding and time diversification should be leveraged appropriately by long run investors. Time diversification and the proposed credit should be a permanent part of the RBC framework.

11. Time diversification has been demonstrated empirically, but is there corresponding theory to support the concept?

The previously cited connection of stock returns to corporate earnings growth is highly relevant. Popular models decompose stock returns into two underlying components: (1) current income (dividends) and (2) corporate earnings growth (which evolves into future dividends). Corporate earnings are cyclical in nature, tied to the much-studied business cycle. Periods of optimism, borrowing, capital investment, and earnings growth swing naturally to periods characterized by pessimism, deleveraging, and retrenchment. Stock returns will continue to traverse cyclical patterns, and the recovery parts of such cycles form the theoretical underpinning of time diversification.

Though derived and calibrated using empirical data, statistical theories regarding time diversification have also been advanced. Many risk models assume that returns across time periods are independent, demonstrating zero correlation between one period and the next. Under this assumption, cumulative risks associated with stock investments continue to grow with time, though at a decreasing rate as the horizon gets longer.

However, the historical record suggests that correlations are negative across time, particularly after a large directional change. All available information may be incorporated continuously into stock prices, but investors tend to overreact to news over short periods of time. According to this theory, negative returns in one period (a correction or bear market) are likely to be followed
by positive returns (recovery and the return of “animal spirits”). Mean-reverting behavior has long been a staple of interest rate risk modeling and forecasting, and similar concepts are being applied to stock returns by researchers and practitioners.

Academic and practitioner literature on this topic is deep, and we would be happy to provide examples to interested parties. One comprehensive reference is Jeremy Siegel’s book “Stocks for the Long Run” (fifth edition published in 2014 by McGraw-Hill).

12. Is long run equity investing a “money machine” that should not exist in principle?

This is a broad question that is not specific to stock markets. Historically, investors have earned “risk premia” in asset markets by bearing different types of risk. Versus a “safe” alternative such as Treasury bills, investors can earn expected profits by taking interest rate risk and investing in long term bonds. They can take credit risk and invest in corporate bonds, and they can take equity risk in the stock market. With the historical record as our guide, these investments should indeed be profitable over the long run, and the term “money machine” could be reasonably applied.

However, the reason that investors are compensated for taking these risks is the uncertainty and potential for short term loss. Interest rates could rise, borrowers could default, and equity markets could fall. Aversion to such losses creates the need for a premium paid on investments that involve greater risk and forms a foundation that provides attractive return opportunities for long run investors.

These short run risks are real and must be managed appropriately. Periods of steep short term loss and investor insolvency can be found across markets, including interest rates (the inflationary 1970’s), credit investments (the junk bond crisis), and equity risk (the recent financial crisis). In most cases of insolvency, liquidity was not available to allow the investor to weather the storm. An important part of our Proposal is to require demonstration of adequate short term liquidity that would forestall recognition of short term losses. At Allstate, we manage the payout annuity portfolio in two parts – (1) a laddered, high quality bond portfolio structured to provide seven years of liquidity to pay liability cash flows, and (2) an equity portfolio to leverage the powerful forces of return compounding and time diversification.
Allstate appreciates the opportunity to work with you and the members of the Life RBC Working Group to develop these proposed changes to RBC. Thank you very much for your consideration of these comments. Should you have any questions concerning the matters raised in this letter, please feel free to contact us.

Sincerely,

Theresa Resnick  
Vice President and Appointed Actuary  
Allstate Life & Retirement

Mark Prindiville  
Senior Vice President  
Data, Discovery, and Decision Science

cc: Dave Fleming, NAIC  
Kevin Fry, Deputy Director of Financial Corp. Regulation, Illinois Department of Insurance  
Mary Jane Fortin, President, Allstate Financial Businesses  
Bob Zeman, Government & Industry Relations, Allstate
The C-1 charge for equity investments was formally reconsidered by the Investment RBC Working Group in 2013.

An accompanying Memorandum was informed by rigorous analysis of historical stock market losses.

The S&P 500 was chosen as the representative public equity universe.

### 2013 IRBCWG Memorandum – Summary of Key Elements

<table>
<thead>
<tr>
<th>Element</th>
<th>Options Considered</th>
<th>Option Chosen</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historical Period</td>
<td>• 1926 – 2012&lt;br&gt;• 1946 – 2012&lt;br&gt;• 1960 – 2012&lt;br&gt;• 1982 – 2012</td>
<td>• 1946 - 2012</td>
<td>• The Great Depression and World War eras (as well as preceding periods) may not be representative of the modern era.&lt;br&gt;• Starting with the post-WW2 period, a longer data set is preferable in order to include more economic regimes.&lt;br&gt;• Usage of short data sets would make calibration volatile.</td>
</tr>
<tr>
<td>Horizon</td>
<td>• One Year&lt;br&gt;• Two Years&lt;br&gt;• Longer</td>
<td>• Two Years</td>
<td>• Usage of two years is more conservative than one year, and captures most of the maximum drawdown for a buy-and-hold investor.</td>
</tr>
<tr>
<td>Interval</td>
<td>• Worst Monthly&lt;br&gt;• Worst Quarterly&lt;br&gt;• Beginning to End</td>
<td>• Worst Quarterly</td>
<td>• Monthly intervals incorporate too much short term volatility.&lt;br&gt;• quarterly intervals align with statutory reporting.&lt;br&gt;• Pros and cons of &quot;Beginning to End&quot; are summarized on the next page.</td>
</tr>
<tr>
<td>Confidence Level</td>
<td>• 92nd&lt;br&gt;• 94th&lt;br&gt;• 95th</td>
<td>• 95th</td>
<td>• The 92nd and 94th percentiles offer consistency with other studies, but the 95th percentile is standard in the investment industry (roughly two standard deviations) and adds a measure of conservatism.</td>
</tr>
<tr>
<td>Beta</td>
<td>• Retain beta adjustments&lt;br&gt;• Eliminate beta adjustments</td>
<td>• Retain beta adjustments</td>
<td>• It is logical for more volatile, higher beta portfolios to receive a greater charge.&lt;br&gt;• Existing beta factors appear to appropriately differentiate insurer portfolios.</td>
</tr>
<tr>
<td>Private Equity</td>
<td>• Same charge as common stock&lt;br&gt;• Different charge</td>
<td>• Same charge as common stock</td>
<td>• Once historical private equity returns are adjusted for serial correlation, their annual standard deviation is comparable to that of the S&amp;P 500.</td>
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Recommendation: maintain 30% C-1 charge for common stock and schedule 8A private equity investments, retaining beta adjustments with an embedded cap and floor.
Connecting the 2013 Study to the Current Proposal

- On pages 4 and 11, the Memorandum notes that the equity C-1 charge would decrease if a longer horizon were applied
  - "When considering only endpoints, the risk-based capital requirement decreases as the time period increases." (page 4)
  - "... a longer period allows for time for the market to recover" (page 11)
- On page 12, the Memorandum quotes from a 1997 predecessor in debating the relevance of intermediate results, comparing “low watermark” and “beginning to end” approaches
  - "The original two-year holding period was used as being typical of the holding period for common stock”
  - In favor of beginning to end: “First, if an insurer has enough assets that it can meet cash flow requirements over the life of its obligations, the risk is solven on an economic basis even if it fails a solvency test at intermediate points. Second, even if one focuses on such intermediate results, there is no need to do so any more frequently than the company files its risk-based capital report.”
  - In favor of intermediate results: "... intermediate results are important, especially if the company is exposed to disintermediation risk.”
- Appendix 2 included a chart which graphically illustrated these considerations:

![Chart](image)

The chart included in Appendix 2 is based on data from 1960 to 2012 and uses 94th percentile results

These statements lay the foundation for the current proposal

The recommended 30% charge is appropriate to a two year horizon, but lower charges are reasonable when the holding period is longer than two years

By setting appropriate guardrails, the current proposal agrees with both sides in this debate; “beginning to end” is preferable in cases where there is no disintermediation risk (guardrail #2) and appropriate liquidity is demonstrated (guardrail #3); in addition, the proposal includes amortization of gains & losses into the Capitalization Ratio to reduce the potential for undercapitalization at intermediate points (guardrail #6)

This shorter data set excludes the 1950s, a period of general calm and low volatility

As such, the blue “intermediate result” approach suggests a capital charge above 30% at horizons of 20 months or greater

However, in its red “beginning to end” line, the chart affirms the central observation driving the current proposal; somewhere between five and seven years, equity market losses tend to flip to gains, even in tail scenarios
The Current Proposal as an Extension of the 2013 Study

- In 2013, the Investment RBC Working Group took a “one size fits all” approach to equity C-1 charges
  - It adopted a 30% charge for all equity holdings, regardless of product line and holding period
  - For a single, uniform charge to be applied in all cases, 30% was a reasonable outcome
- The current proposal modernizes the framework by adding nuance in dimensions foreseen by the 2013 Working Group
  - “One size fits all” is not appropriate to long investment horizons, where time diversification and compounding alter the landscape
  - Net of the proposed credit, a 15% charge is conservative and prudent, sufficient even in 99th percentile outcomes

Current Proposal – Summary of Key Elements

<table>
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<th>Option Chosen (Long Horizon Equities)</th>
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<tr>
<td>Confidence Level</td>
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**Recommendation:** Maintain 30% C-1 charge for most equity investments; reduce to 15% in cases where investments are intended for long horizons and align with specified guardrails.
September 20, 2019

Mr. Philip Barlow
Chair, Life Risk-Based Capital Working Group

Re: Risk-Based Capital Requirements for Long-Horizon Equity Investments Exposure

Dear Philip:

The American Council of Life Insurers (ACLI) is pleased to submit the following comments regarding the long-horizon equity investments proposal.

While not currently taking a position on this proposal, the ACLI supports solutions that enable consumers to purchase products they need to protect their financial and retirement security. Reducing the RBC charge for equities under certain circumstances could increase the availability of products and make those products more affordable. That said, companies must maintain appropriate capital levels to ensure that they can deliver on the promises they make.

ACLI supports continued discussion of the details associated with this proposal, and how this and similar approaches may benefit consumers. While this proposal only addresses payout annuities and structured settlements, we believe that the concepts could apply in other instances. If this proposal is pursued, ACLI also believes any such proposal should apply to all business, and not solely have a forward looking view. If solvency is appropriately measured and maintained, incentives can help achieve returns necessary to meet legacy obligations as well as improve consumer value for newly designed products.

Every capital framework introduces incentives and disincentives; this proposal addresses the disincentives in the RBC framework for companies to invest in equities. The concept behind the proposal is that well-capitalized companies would be able to weather the volatility of the assets held over the long term.

ACLI recognizes that, should this proposal be introduced into the RBC framework, appropriate guardrails would need to be established to maintain the financial strength of each company and the industry. Such guardrails may include requirements around the level of diversity of the portfolio and the minimum RBC ratio before the credit is allowed.

ACLI has identified technical aspects of this proposal that should be further discussed before proceeding. The proposal involves revisions to the RBC framework without explicit changes to the current accounting treatment of equities. Because equities are accounted for on a market value basis, an RBC

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1 The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. 90 million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. Learn more at [www.acli.com](http://www.acli.com).
ratio that amortizes equity losses will not reflect adverse equity impacts in the midst of a market downturn. Care needs to be taken if the NAIC does not intend to eventually revise the accounting treatment of equities to be on a book value basis, which aligns with the proposed concept.

We look forward to a discussion of these issues. Thank you.

Sincerely,

cc Dave Fleming, NAIC
September 20, 2019

Mr. Philip Barlow
Chair, Life Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Dear Philip,

The Life Capital Adequacy Committee (LCAC) of the American Academy of Actuaries’ (Academy) Life Practice Council is pleased to submit comments on the “Risk-Based Capital (RBC) Requirements for Long-Horizon Equity Investments” exposure. The exposure proposes a reduction in the RBC C-1 (asset risk) equity charge for a portion of equities that support long-duration payout contracts.

The LCAC does not support the reduction in the RBC C-1 equity charge for a portion of equities that back long-duration payout contracts for the following reasons:

1. Any consideration of product specific investment choices is reflected in C-3, not C-1. The C-1 component covers the risk of asset performance (e.g., default, change in equity value) as reported in statutory surplus.
2. The C-1 common stock equity charge is already reduced through the RBC covariance adjustment. For example, 2018 overall industry data shows about a 50% reduction.
3. The proposal only measures loss at the end of a stated period. RBC is designed to cover the capital requirement throughout a stated period consistent with a Greatest Present Value of Accumulated Deficiency (GPVAD) approach.
4. The proposed approach for determining total adjusted capital (TAC) in RBC (i.e., amortization of equity gains and losses) is inconsistent with how actual statutory capital is reported. As a result, the RBC amount calculated for the purposes of identifying weakly capitalized companies would not reflect the actual statutory solvency risk.
5. The potential statutory capital loss from equity risk would be based on asset performance only and would not be offset by the long-duration payout liabilities.

With those general comments in mind, the LCAC has drafted the following responses to the questions that were raised at the Life Risk-Based Capital Working Group meeting on Aug. 3:

1. Is time diversification something that should be reflected in RBC and if so, is it appropriately considered in the C-1 Risk category?

1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
Our comments reflect two possible aspects of “time diversification”:

One aspect is that time diversification occurs when different risks emerge more fully at different points in time, so the total amount needed to satisfy a risk measure at any one time is less than the sum of each separate risk measure across all time points in a projection. We believe this aspect of time diversification should be reflected in RBC. Under the current RBC framework:

- This phenomenon is directly considered in RBC covariance adjustments.
- This phenomenon is not directly considered in C-1 RBC because the risks are evaluated over different time horizons that are consistent with the typical cycle of each risk.
- This phenomenon is partially considered in C-3 testing, but only within each scenario, rather than across scenarios, because the GPVAD methodology takes results from potentially many different time horizons.

Another aspect is that time diversification occurs when the holding period for a stock increases and that results in a lower probability of losing money relative to the initial investment. However, equity investments like common stocks are held at market value, so any change in market value of a stock is immediately reflected in its statement value, and hence, immediately reflected in statutory capital. An entire stock portfolio, regardless of when it is acquired, is subject to the same mark-to-market risk. The RBC requirement is based on the GPVAD over the specified period, so RBC is determined to be sufficient both at the end of a specified period and at interim points as well. We believe this aspect of time diversification should not be reflected in RBC because it does not reduce mark-to-market risk.

2. *Is there an unrecognized solvency risk with payout annuities and structured settlements in this ongoing low interest rate environment and will a shift to equity investments to back those products alleviate that risk?*

There is not an unrecognized solvency risk with payout annuities and structured settlement options in the ongoing low-interest-rate environment. This risk is appropriately captured in RBC C-3 and asset adequacy testing. A shift to equities, while potentially leading to a higher expected return, would also increase mark-to-market risk (i.e., the risk of statutory losses from declines in market value of the common stocks) and would not decrease solvency risk.

3. *Should there be a complementary change to the accounting for the equities or is the proposal to modify the total adjusted capital (TAC) to smooth equity gains and losses sufficient?*

RBC is calibrated to identify potentially weakly capitalized companies. In order for the RBC ratio to operate as intended, the calculation needs to be on the same accounting basis as the reported statutory capital. Otherwise, the calculated capital amount will not be accurate for the statutory solvency risk. Therefore, if smoothing of TAC is done in the RBC calculation, the same change would need to be made to the accounting of statutory capital. This statutory change, if made, must also be reviewed for other impacts as well.

4. *The proposal assumes a diversified portfolio. How do we require an initial diversified portfolio backing the reserves and how do we allow reasonable trades in that portfolio while preventing inappropriate activity?*

To the extent that an individual insurer’s stock portfolio is more or less diversified than the diversification in the S&P 500 portfolio assumed in the proposal, a more sophisticated approach for measuring the relative diversification risk would need to be developed. For example, the
current LRBC formula adjusts the equity charge through a beta adjustment that measures the volatility of an individual stock relative to the S&P 500 index; the bond charges are adjusted based on the number of bond holdings in an insurer’s bond portfolio; and both bonds and stocks have a concentration factor requirement.

5. How might the use of reinsurance impact this proposal?

RBC should reflect the net risks that a company retains or assumes.

6. How do we ensure that this proposal is strictly limited to payout annuities and structured settlements?

An approach to accurately measure, monitor, and report which equity investments are allocated to payout annuities and structured settlements would need to be developed. It should be noted that other products like long-term care have similar characteristics as to payout annuities (i.e., longer liabilities with no immediate cash needs). Any adoption of a change to RBC should establish the rationale for the change as well as for excluding or including other product types.

7. Are there implications in this proposal for PBR or Asset Adequacy Analysis and if so, how should those be coordinated?

The proposal only addresses the calculation of RBC. The requirements for PBR and asset adequacy analysis would be unchanged. Any change in investment strategy that a company would choose as a result of this proposal would need to be reflected in its PBR and asset adequacy testing.

8. Retirement security is a big issue and a proposal that has the potential to put more money into the hands of retired people will help, but should that be a criterion that we consider in developing RBC?

The focus and purpose of RBC has always been a tool for regulators to identify weakly capitalized companies. Introducing other objectives would dilute that objective and introduce judgment and subjectivity in determining the capital requirement for risks.

9. Should this proposal be forward looking only? Given that there is no opportunity to adjust the payments for existing payout annuities and structured settlements is there a reason to allow it for existing contracts?

The issues that we have identified in the proposal are applicable to both new and existing contracts. In addition, RBC has not been designed to establish separate capital requirements by year of issue.

10. Does the proposal work for environments other than the current low-interest environment?

This proposal would introduce similar risks in different interest rate environments. The tradeoff of investing in equities is the prospect of higher expected returns but also greater risk of market value loss on a statutory basis. The capital requirements should appropriately reflect the higher level of risk. RBC factors and requirements are designed to measure risks accurately over most economic environments.
In addition to the questions that the Life Risk-Based Capital Working Group posed, we identified the following questions regarding this proposal that you may want to consider:

1. How does the analysis differ if periods other than seven years are used?
2. Would smoothed results also be used for insolvency impacts as to when state guaranty fund systems would be used?
3. Are equity dividends included, or just price movements?
4. How do the risk/return characteristics of this option compare with a variable payout annuity that has an allocation to variable and fixed funds?
5. How would federal income taxes be impacted?
6. Would the RBC covariance adjustment be appropriate in light of the proposed change?

If you have any questions on our comments, please contact Ian Trepanier, life policy analyst at the Academy (trepanier@actuary.org).

Sincerely,

Chris G. Trost, MAAA, FSA
Chairperson, Life Capital Adequacy Committee
American Academy of Actuaries
The Longevity Risk (A/E) Subgroup of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call Nov. 25, 2019. The following Subgroup members participated: Rhonda Ahrens, Chair (NE); Seong-min Eom (NJ); Bill Carmello (NY); and Peter Weber (OH). Also participating was Philip Barlow (DC).

1. Adopted its Recommendation to the Life Risk-Based Capital (E) Working Group on Longevity Risk

Ms. Ahrens said the Subgroup is considering adoption of the recommendation to the Life Risk-Based Capital (E) Working Group on new C-2 factors for longevity risk. She discussed the memorandum, which includes as attachments: 1) the American Academy of Actuaries (Academy) Longevity Risk Task Force’s proposal document, which was presented at the Spring National Meeting; 2) the Academy’s update on correlation, which was presented at the Summer National Meeting; and 3) the actual proposed changes to the risk-based capital (RBC) blank and instructions. She said this memorandum was also discussed during the Subgroup’s Nov. 4 conference call and now includes the edits that have been suggested. With respect to longevity reinsurance transactions (LRT), Ms. Ahrens said the issues that have been discussed by the Subgroup are highlighted in the third paragraph, with the following paragraph indicating that the Subgroup believes these transactions should ultimately be in scope of the proposal but that the Subgroup needs more time and guidance from the Working Group on this aspect. She said the issue of correlation is presented next explaining the discussions the Subgroup has had along with its recommendation that this is an issue to be considered by the Working Group.

Mr. Carmello suggested modifying the memorandum to indicate that a majority of the Subgroup members, as opposed to the Subgroup as a whole, supports scoping out LRT for now since he believes there is a way to have it included and it was not unanimous. He also suggested inclusion of the changes needed for the tax page and the authorized control level (ACL) page, LR030 and LR031, respectively, as part of the recommended RBC blank changes.

Ms. Eom expressed concern with the statement in the Academy’s proposal document concerning longevity reinsurance indicating that premium amounts excluded from statutory reserves should be netted against C-2 capital. She said she wants to make it clear that not everyone supports this. The Subgroup agreed to modify the paragraph on LRT to make clear that the need for further analysis is because the Subgroup did not reach a consensus, along with modifying the premium offset bullet point to reference a portion of future premiums, as opposed to all future premiums.

Mr. Carmello made a motion, seconded by Ms. Eom, to adopt as the recommendation to the Working Group the memorandum with the changes discussed along with the three attachments with pages showing the changes needed to LR030 and LR031 without correlation added. Brian Bayerle (American Council of Life Insurers—ACLI) said the Subgroup indicates in the memorandum that it has not taken a position on correlation and said the ACLI believes it would be better to advance the recommendation with versions of LR030 and LR031 with and without correlation and let the Working Group decide whether it wants to expose one or both of the versions. Mr. Barlow said he appreciates Mr. Bayerle’s comments and that he is not speaking for the Working Group, but it would be his preference that only one version rather than multiple versions be advanced to the Working Group. The motion passed unanimously.

2. Discussed the Academy’s Offer of Additional Assistance on Correlation

Ms. Ahrens said the Academy submitted a letter on the implementation of longevity C-2 with correlation that includes the RBC blanks changes that would be needed. With the Subgroup not taking a position on correlation, she said she believes this is something the Academy could direct to the Working Group. Paul Navratil (Academy) said the Academy is presenting this to make sure that the operational details are provided to facilitate the Working Group’s discussion of the issue. Mr. Barlow said he understands that the correlation aspect may fall outside of the specific consideration of longevity risk and is something that the Working Group can appropriately address.

Having no further business, the Longevity Risk (A/E) Subgroup adjourned.

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The Longevity Risk (A/E) Subgroup of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call Nov. 4, 2019. The following Subgroup members participated: Rhonda Ahrens, Chair (NE); Mike Yanacheak (IA); John Robinson (MN); Seong-min Eom (NJ); Bill Carmello (NY); and Peter Weber (OH).

1. Continued Discussion of the Academy’s Longevity Risk Task Force Proposal

Ms. Ahrens said a memorandum to the Life Risk-Based Capital (E) Working Group was drafted per the Subgroup’s discussion on Oct. 7 describing the Subgroup’s work on the proposed longevity risk C-2 charges. She said the memorandum outlines the Subgroup’s recommendation, which includes the proposal document along with the actual risk-based capital (RBC) blank and instruction changes, the discussions to date and the presentations from the American Academy of Actuaries (Academy) Longevity Risk Task Force. She said the memorandum also includes the Subgroup’s consideration of correlation explaining that the Subgroup believes that this aspect may not be in the Subgroup’s purview. Ms. Ahrens said the Subgroup has also discussed the scope of products to be included and, specifically, longevity reinsurance. She said state insurance regulators received some education on this during a regulator-to-regulator conference call held on Oct. 21 to discuss the similarities and differences to other longevity exposures in the life and fraternal annual statement that are included in the proposal’s scope. She said she believes it should be in scope but that the Subgroup seems to be divided on how a credit for this would be calculated or whether there should be a credit at all. Because there is more work to be done in this area, she believes that rather than holding up C-2 factors for other products, it should be scoped out for now and the additional work done possibly by a drafting group.

The Subgroup discussed edits to the memorandum, including adding detail to explain the issues with respect to longevity reinsurance, along with more clarity on those products that are within the scope of the proposal. Ms. Ahrens suggested: 1) having the suggested edits included; 2) having Subgroup members, the American Council of Life Insurers (ACLI) and the Academy review the updated memorandum; and 3) scheduling another conference call to consider adoption of the recommendation prior to the Fall National Meeting. The Subgroup agreed with this approach.

Having no further business, the Longevity Risk (A/E) Subgroup adjourned.
The Longevity Risk (A/E) Subgroup of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call Oct. 7, 2019. The following Subgroup members participated: Rhonda Ahrens, Chair (NE); Mike Yanacheak (IA); Seong-min Eom (NJ); Bill Carmello and Amanda Fenwick (NY); and Peter Weber (OH).

1. Continued Discussion of the Academy’s Longevity Risk Task Force Proposal

Ms. Ahrens said two remaining aspects of the American Academy of Actuaries (Academy) Longevity Risk Task Force’s proposal to incorporate a charge for longevity risk in the life and fraternal risk-based capital (RBC) formula are the covariance and the scope. With respect to scope, she said there may be a need to schedule a regulator-to-regulator conference call to provide some education on pension risk transfer (PRT) transactions. With respect to the covariance aspect, she asked whether this was actually part of the Task Force’s recommendation or whether it was an aspect it is highlighting for additional consideration.

Paul Navratil (Academy) said the proposal document, which was presented to the Life Risk-Based Capital (E) Working Group at the Spring National Meeting, presented the work done on the factors for longevity risk, but the recommendation was that in implementing the factors, covariance needed to be considered at the same time. He said the presentation at the Summer National Meeting provided more detail, but the summary was that the recommendation was for a correlation of -33% between longevity and mortality C-2. He said the key premise in the work when the factors for longevity risk were developed was to calibrate them to get to a 95th percentile, which entailed including consideration of both longevity risk and mortality risk.

Ms. Ahrens noted the presentation included other jurisdictions having correlations of -50% and -25%. She asked Subgroup members for their thoughts on what the Subgroup should present to the Life Risk-Based Capital (E) Working Group as part of the recommendation with respect to correlation. Ms. Fenwick reiterated New York’s opposition to including any correlation within C-2. When the Subgroup first started to look at longevity risk, she said it was to introduce a factor for longevity, and it is being watered down and made less conservative with the work looking at different assumptions on reserve levels and covariance. She said it is uncertain what is going to happen with longevity risk because it involves two different groups of people with life insurance versus annuities, and how this ultimately works out is an inexact science. Mr. Weber said that Ohio would probably favor some correlation. He said there may be some appeal in recommending something less than the -33%. He acknowledged that it is not an exact science but that 0% seems extreme so perhaps -25% as another jurisdiction is using may be appropriate. Ms. Ahrens noted concern expressed with the possibility of the overall C-2 component actually going down with the introduction of longevity risk and suggested a possible approach could be to require a floor of one of the two C-2 components on its own after application of any covariance adjustment. Mr. Yanacheak reiterated his belief that this is a Life Risk-Based Capital (E) Working Group-level discussion. He said he thinks the Subgroup has an obligation to point out this issue as it has been presented to the Subgroup that relates to the longevity risk and what the Subgroup is proposing. He said if the Working Group wants the Subgroup to do additional work, it can provide that guidance. Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI believes covariance is appropriate but would support consideration of this aspect going to the Working Group.

Ms. Ahrens suggested moving forward with recommending the Task Force’s Spring National Meeting proposal to Working Group along with a memorandum documenting: 1) the Subgroup’s considerations of the factors and the assumptions; 2) the actual RBC blank and instruction changes needed to implement the proposal; and 3) the Subgroup’s consideration of covariance with the consensus that the Subgroup believes this is an aspect that merits the Working Group’s consideration but that the Subgroup is willing to continue work on it with further direction. Mr. Yanacheak supported this approach. Mr. Bayerle said the ACLI supports the approach as well.

Having no further business, the Longevity Risk (A/E) Subgroup adjourned.

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The Longevity Risk (A/E) Subgroup of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call Sept. 30, 2019. The following Subgroup members participated: Rhonda Ahrens, Chair (NE); Mike Yanacheak (IA); Seong-min Eom (NJ); Bill Carmello (NY); and Peter Weber (OH). Also participating was: Vincent Tsang (IL).

1. Continued Discussion of the Academy’s Longevity Risk Task Force Proposal

The Subgroup continued its discussion of the requested sensitivities the American Academy of Actuaries (Academy) Longevity Risk Task Force provided in its Sept. 10 letter. Ms. Ahrens reminded the Subgroup that the Task Force’s proposal targets a 95th percentile total asset requirement (TAR) assuming an 85th percentile reserve. She said the Subgroup questioned whether this assumption could actually be made and what the factors would be at different assumed reserve levels that the Task force provided. Mr. Carmello reiterated his preference to go with the factors at the 75th percentile level without a covariance adjustment. Mr. Yanacheak said reserves are to cover moderately adverse events and that he believes the 85th percentile is close to a mean plus one standard deviation, so he is not opposed to going with the 85th percentile factors. Ms. Eom said she is also supportive of the 85th percentile since that is what is assumed for reserves in other product lines and, if there is a problem with the actual reserve level, the reserves can be addressed separately.

Ms. Ahrens said she agrees with using the 85th percentile. She noted a small study done with Nebraska companies that have payout products when she was new to the Subgroup. She said the study was not to determine what the current reserve formulation produces but rather to: 1) determine whether there was an issue with asset adequacy testing not working for these types of risks; and 2) verify that they were testing the longevity risk and that it was covered in the establishment of the moderately adverse condition coverage. She said there was also acknowledgement of the fact that there most likely was a lot of aggregation on the life sufficiency used to prevent additional asset adequacy reserves. At that time, she said she believes the Subgroup decided to focus on the risk-based capital (RBC) charge and that any insufficiencies in the reserves could be addressed separately. Mr. Weber said that is his recollection of the study; they were looking at things in aggregate and that there were certain sensitivities around it. He said he is supportive with using the 85th percentile.

Ms. Ahrens noted Mr. Carmello’s concerns with potential reserve inadequacies and asked him if he thought even using the 75th percentile would actually be the appropriate assumption. Mr. Carmello said the only positive about going with the 85th percentile is that state insurance regulators could start holding companies to it in examinations as another reason to increase reserves. For this product especially, he said he does not believe companies are very far from best estimates. He said he would pick the 60th percentile. Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI is supportive of using the 85th percentile and that the ACLI believes any concern with reserves not being at the appropriate level should be addressed separately.

Nancy Bennett (Academy) said that when RBC was developed, it was designed to establish minimum capital requirements and was built on the premise that reserves were adequate whether it was formulaic or formulaic plus any additional reserves established through cash flow testing. She said RBC was not intended to rectify any problems with reserves but rather to be built on top of that and that there was nothing specifically quantified about reserves in the development of individual RBC factors. Ms. Ahrens said her preference would be that the Subgroup recommend using the 85th percentile but explain that the Subgroup also looked at other levels and why as part of the recommendation. Mr. Yanacheak, Ms. Eom and Mr. Weber expressed support for this approach.

With respect to the sensitivity to the assumed average reserve per policy, Ms. Ahrens said she does not have an issue with the assumed average although she said she is surprised it was only 50,000 for payout-type products and questioned whether this might go up over time as insurers’ expertise with these products increased. Mr. Yanacheak said he does not have a concern with the 50,000 average assumption. Mr. Tsang noted the reduction in the factors as the size of the total reserve increases and the fact that the reductions get proportionally smaller with the increases. He questioned whether this would penalize smaller companies. Paul Navratil (Academy) said the two main risks considered were: 1) mortality improvement or trend risk, which is a risk that applies evenly to all sizes of business; and 2) estimation of base mortality or mortality level risk, which is much
higher on a small block of business. He said the grading down of the factors reflects the fact that level risk is much higher on a small block of business and then levels off as trend risk becomes the more dominant risk.

With respect to covariance, Ms. Ahrens said she has discussed the potential for the introduction of a covariance factor, which does not currently exist at Life Risk-Based Capital (E) Working Group meetings. She said there is a case to be made that diversification is a positive, and she asked for members’ thoughts. Mr. Carmello reiterated his opposition to this aspect. Mr. Yanacheak suggested this may be an issue for the Working Group to decide and expressed concern with the Subgroup potentially leading them astray if they have not specifically directed the Subgroup to address this aspect. Ms. Ahrens said she understands the theoretical justification for including this aspect but shares that concern. She suggested making the recommendation on factors and highlighting the potential for a correlation component along with alternatives for how it could be implemented, including limitations or guardrails that would address concerns about the introduction of an RBC charge potentially leading to decreased RBC.

Having no further business, the Longevity Risk (A/E) Subgroup adjourned.

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The Longevity Risk (A/E) Subgroup of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call Sept. 18, 2019. The following Subgroup members participated: Rhonda Ahrens, Chair (NE); Mike Yanacheak (IA); John Robinson (MN); Seong-min Eom (NJ); Bill Carmello and Amanda Fenwick (NY); and Peter Weber (OH).

1. Continued Discussion of the Academy’s Longevity Risk Task Force Proposal

Ms. Ahrens said the Subgroup discussed the comments received on the questions posed by the Subgroup as part of the exposure of the American Academy of Actuaries (Academy) Longevity Risk Task Force’s proposed approach for incorporating a risk charge into the life and fraternal risk-based capital (RBC) formula during its July 17 conference call. As part of that discussion, she said the Subgroup asked the Academy for some sensitivities around the assumed 85th percentile reserve level and the assumed average reserve per policy. Paul Navratil (Academy) presented the Academy’s responses (Attachment Three-F1).

With respect to what issues remained prior to being able to go forward with its recommendation, Ms. Ahrens said the correlation component is one. She said she has indicated to the Life Risk-Based Capital (E) Working Group that the Subgroup is focused on longevity and that it may be appropriate for the Working Group, where there is a larger audience, to decide whether there should be a correlation component within C-2. She said the Subgroup’s choices include simply adopting the Academy’s proposal and working with the Working Group on the next steps or also providing the Working Group with some alternatives along with the pros and cons of each.

Ms. Eom suggested that another issue is to limit the products to which the proposal will be specifically applicable. Ms. Ahrens agreed and said she believes the Subgroup may indicate that there may be other C-2 factors that need to be developed for products that are outside the scope of the proposal. The Subgroup discussed differences between various products and the possible need for a different approach for some, specifically longevity, reinsurance. Mr. Navratil indicated that this product was included in the Task Forces’ request in the field study, but there were not enough responses received from participating companies. Mr. Robinson asked if there was a maintenance recommendation as to how often the factors should be reviewed or updated. Mr. Navratil suggested that it might be more appropriate to look at that aspect in terms of things changing around product structure and the emergence and expectation of longevity risk as opposed to timeframe. Ms. Ahrens said she believes the Subgroup is in a position to recommend C-2 factors for longevity for year end 2020, and she suggested that the recommendation could include the Subgroup continuing to work on this product for the following year.

Ms. Ahrens asked Subgroup members for comments on the range of factors in the sensitivities presented with respect to the reserve level. Mr. Carmello acknowledged that the 85th percentile may be ideal, but it is not what the reality is and has been in that it is actually in the 60–65th percentile range for payout annuities; so the 75th percentile would be a compromise. Ms. Ahrens said the Subgroup has discussed in force versus business going forward and noted the complications of developing a factor that addresses both. She asked how this might tie into the discussion of a maintenance schedule and, specifically, how to address choosing a factor at the 75th percentile and then having reserves updated for business going forward. Mr. Carmello said that if the new mortality tables are more conservative than thought to be, it would be something that needed to be reviewed. The Subgroup discussed potential ways to identify the blocks of business in the information available in the annual statement.

Ms. Ahrens asked Subgroup members for comments on the range of factors in the sensitivities presented with respect to the reserve level. Mr. Carmello acknowledged that the 85th percentile may be ideal, but it is not what the reality is and has been in that it is actually in the 60–65th percentile range for payout annuities; so the 75th percentile would be a compromise. Ms. Ahrens said the Subgroup has discussed in force versus business going forward and noted the complications of developing a factor that addresses both. She asked how this might tie into the discussion of a maintenance schedule and, specifically, how to address choosing a factor at the 75th percentile and then having reserves updated for business going forward. Mr. Carmello said that if the new mortality tables are more conservative than thought to be, it would be something that needed to be reviewed. The Subgroup discussed potential ways to identify the blocks of business in the information available in the annual statement.

Ms. Ahrens said she believes the Subgroup needs to discuss three things during upcoming calls: 1) whether the Subgroup wants to recommend one of the longevity factor choices presented by the Academy, given the discussions on assumed reserve levels; 2) whether the Subgroup wants to make any adjustment to the assumed average reserve size; and 3) whether the Subgroup recommends a correlation component, which is part of the Academy’s proposal.

Having no further business, the Longevity Risk (A/E) Subgroup adjourned.
September 10, 2019

Ms. Rhonda Ahrens
Chair, Longevity Risk (A/E) Subgroup
National Association of Insurance Commissioners

Via email: Dave Fleming (dfleming@naic.org)

Re: Requested sensitivities to longevity risk-based capital (RBC) factors

Dear Rhonda,

On behalf of the Longevity Risk Task Force of the American Academy of Actuaries, I am providing additional assumption sensitivities to the proposed longevity C-2 risk factors as requested by the Longevity Risk Subgroup at the July 17, 2019, call.

1. Sensitivity to Assumed Reserve Level (85th percentile)

The proposed longevity C-2 factors we have suggested were calibrated to cover risk between a reserve level that was assumed to represent an 85th percentile outcome and a 95th percentile capital objective. The following are important to consider in setting the reserve level assumption for the purpose of calibrating risk-based capital factors:

- The appointed actuary is required to opine that aggregate reserves are adequate under moderately adverse conditions.
- Principle-based reserve requirements (e.g., VM-20 and VM-21) define prudent estimate assumptions at a conditional tail expectation (CTE) 70 level that is at least as adverse as the 85th percentile, although this is different from prescribing reserves at a specific level.
- The sufficiency of the overall reserve is the important result and key assumption in calibrating capital levels. It is not necessary or appropriate to consider the severity level of individual assumptions prescribed in statutory reserves—only whether aggregate reserve levels are appropriate.

---

1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
• RBC is based on the premise that reserves are adequate. If there are concerns that prescribed statutory reserve levels are insufficient, these are best addressed in reserve requirements directly.
• There should be consistency in assumed reserve levels across the RBC framework and any change to this fundamental RBC assumption should be applied consistently across risks rather than arbitrarily to longevity risk alone.

The sensitivities below show the impact to the RBC factor if the longevity stress were adjusted to represent the difference between reserves at different assumed levels of adequacy (85th, 80th, 75th) and the total asset requirement consistently calibrated to a 95th percentile outcome, as requested. Factors continue to be expressed as a percentage of statutory reserves as reported through the longevity risk field study (denominator is consistent across all sensitivities).

Providing these requested sensitivities does not imply that there is an actuarial basis for these alternatives or constitute any level of endorsement that they would be appropriate for use in calibrating risk-based capital factors.

<table>
<thead>
<tr>
<th>C-2 Longevity After-Tax Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Reserves</strong></td>
</tr>
<tr>
<td><strong>(in scope products)</strong></td>
</tr>
<tr>
<td>up to $250M</td>
</tr>
<tr>
<td>next $250M</td>
</tr>
<tr>
<td>next $500M</td>
</tr>
<tr>
<td>over $1B</td>
</tr>
</tbody>
</table>

2. Sensitivity to Assumed Average Reserve per Policy ($50k)

There was discussion at the July 17 Longevity Risk Subgroup call of the average reserve per policy assumption used to scale the factors on a dollar reserve basis rather than a life count basis.

We commented in our original proposal that the number of individual exposures is a better proxy for scaling longevity risk than the dollar size of reserves and would support such an approach if it is judged to be feasible to implement within RBC.

The preliminary factors we proposed are scaled to the dollar size of reserves, which is a simplification that more easily aligns to existing statutory reported values. In our view, $50,000 average reserve per policy is a reasonable assumption, though we do expect that this average reserve would vary significantly across companies and blocks of business.
The sensitivity below shows alternative scaling of the factors using different assumed reserve per policy values ($40k, $50k, $60k).

<table>
<thead>
<tr>
<th>Total Reserves (in scope products)</th>
<th>$40k/Policy</th>
<th>$50k/Policy</th>
<th>$60k/Policy</th>
<th>C-2 Longevity After-Tax Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>up to $200M</td>
<td></td>
<td></td>
<td></td>
<td>1.35%</td>
</tr>
<tr>
<td>next $200M</td>
<td></td>
<td></td>
<td></td>
<td>0.85%</td>
</tr>
<tr>
<td>next $400M</td>
<td></td>
<td></td>
<td></td>
<td>0.75%</td>
</tr>
<tr>
<td>over $800M</td>
<td></td>
<td></td>
<td></td>
<td>0.70%</td>
</tr>
</tbody>
</table>

*****

Should you have any questions or comments regarding this letter, please contact Ian Trepanier, life policy analyst at the Academy (trepanier@actuary.org).

Sincerely,

Paul Navratil, MAAA, FSA
Chairperson, Longevity Risk Task Force
American Academy of Actuaries
TO: Philip Barlow, Chair, Life Risk-Based Capital (E) Working Group

FROM: Rhonda Ahrens, Chair, Longevity Risk (A/E) Subgroup

DATE: November 25, 2019

RE: Recommendation for Incorporating an RBC Charge for Longevity Risk

The NAIC’s Longevity Risk (A/E) Subgroup was formed in 2016 with the charge to provide recommendations for recognizing longevity risk in statutory reserves and/or risk-based capital (RBC), as appropriate. The Subgroup has worked closely with the American Academy of Actuaries’ (Academy) Longevity Risk Task Force (Academy Task Force) over the ensuing three years to focus efforts on addressing RBC for longevity risk after determining that statutory reserves would be addressed through the work of other NAIC groups. After many discussions and considerable input from the Subgroup, the Academy Task Force conducted a field study in 2018. The intent of the field study was to quantify longevity risk coverage at an appropriate confidence level. The results of that field study were presented to the Life Risk-Based Capital (E) Working Group at the 2018 Summer National Meeting. Those results were used to produce a proposal for an RBC charge for longevity (the proposal) which was exposed for comment by the Subgroup, along with a list of questions on which the Subgroup requested input, on its March 5, 2019 conference call. The proposal was presented to the Working Group at the 2019 Spring National Meeting (see NAIC Proceedings – Spring 2019, Capital Adequacy (E) Task Force, Attachment Five-D). The comments and the responses to the Subgroup’s questions were discussed on its July 17, 2019 conference call.

The Subgroup wants the Working Group to be aware that special consideration was given to the proposal’s assumption of statutory reserves being at the 85th percentile. While differing views were expressed, the Subgroup’s consensus is that any deviation in reality from this assumption should be addressed as part of consideration of reserves and not as a factor in determining a capital charge. The Academy Task Force did produce potential factors that would address the gap if reserves were actually at the 75th or 80th percentile. Those factors are not included in the proposal being recommended as the Subgroup reached consensus on the after-tax factors as presented on page three of the proposal. These factors are then included on a pre-tax basis in the RBC instructions.

The Subgroup has also evaluated longevity reinsurance transactions (LRT), a reinsurance arrangement initially in scope for longevity C-2. LRT is a relatively new type of arrangement which involves the transfer of longevity risk associated with group annuities to a reinsurer and is discussed on slide nine of the proposal. While the Subgroup has held several discussions on LRT, because the Subgroup did not reach a consensus, we believe further analysis of the arrangement addressing key considerations is necessary for the Subgroup to issue a recommendation. These key considerations include:

- The basis for the factors – Statutory reserves may not be the appropriate basis to which the factor applies since reserves are generally zero at inception. The present value of future payout benefits using VM 22 criteria was discussed as a potential basis, however this would not be a statutory reporting item that could be pulled from the financial statement. The basis needs to be determined and the process for including it in the RBC pages needs to be established.
- Premium offset – Whether and how to allow a portion of future premiums due to the reinsurer under a reinsurance arrangement to offset the capital requirement resulting from applying the factor to the present value of benefits.
- Treatment for primary insurer – How capital would be reflected for a primary insurer that has reinsured longevity risk to a reinsurer.

The comments and responses to the Subgroup’s questions were discussed on its July 17, 2019 conference call.

The Subgroup wants the Working Group to be aware that special consideration was given to the proposal’s assumption of statutory reserves being at the 85th percentile. While differing views were expressed, the Subgroup’s consensus is that any deviation in reality from this assumption should be addressed as part of consideration of reserves and not as a factor in determining a capital charge. The Academy Task Force did produce potential factors that would address the gap if reserves were actually at the 75th or 80th percentile. Those factors are not included in the proposal being recommended as the Subgroup reached consensus on the after-tax factors as presented on page three of the proposal. These factors are then included on a pre-tax basis in the RBC instructions.

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- The basis for the factors – Statutory reserves may not be the appropriate basis to which the factor applies since reserves are generally zero at inception. The present value of future payout benefits using VM 22 criteria was discussed as a potential basis, however this would not be a statutory reporting item that could be pulled from the financial statement. The basis needs to be determined and the process for including it in the RBC pages needs to be established.
- Premium offset – Whether and how to allow a portion of future premiums due to the reinsurer under a reinsurance arrangement to offset the capital requirement resulting from applying the factor to the present value of benefits.
- Treatment for primary insurer – How capital would be reflected for a primary insurer that has reinsured longevity risk to a reinsurer.
The Subgroup recommends LRT arrangements should ultimately be included in scope for longevity C-2, however, additional time is needed in order to further review and consider these key issues. Therefore, for purposes of our current recommendations to the Working Group, a majority of the Subgroup supports scoping out LRT and seeks support on forming a drafting group to continue evaluation and development of a recommendation.

Another aspect the Subgroup discussed at length with differing viewpoints expressed was possible correlation between longevity and mortality risk. Correlation is an aspect that the Subgroup feels extends beyond our charges and is an issue for the Working Group to decide. The proposal includes the Academy Task Force’s recommendation that updated C-2 mortality factors and new C-2 longevity factors be implemented concurrently along with a covariance adjustment within C-2. Various correlation factors of 0%, -25% and -50% were included to demonstrate hypothetical company impacts related to implementation with or without correlation noting that additional work on coordinating and consideration of the proper level of covariance was needed. An update on this by the Academy Task Force was provided in a presentation to the Working Group at the 2019 Summer National Meeting (see NAIC Proceedings – Summer 2019, Capital Adequacy (E) Task Force, Attachment Three-H). The Subgroup believes the factors presented by the Academy Task Force may be reasonable but believes the Working Group is in a better position to consider this as it involves more than just the longevity component. As such, the Subgroup is only providing a recommendation for the factors as presented in slide three of the proposal, and is raising the topic of correlation for the entire Working Group to address.

The proposal, as produced and presented by the Academy Task Force (see NAIC Proceedings – Spring 2019, Capital Adequacy (E) Task Force, Attachment Five-D) and includes the Academy Task Force’s objectives and analysis approach along with the results of the field study and the calibration of the longevity factor. Proposal 2019-13-L (see NAIC Proceedings – Fall 2019, Capital Adequacy (E) Task Force, Attachment Three-H) presents the RBC blank and instruction changes necessary to implement the proposal.
Capital Adequacy (E) Task Force

RBC Proposal Form

[ ] Capital Adequacy (E) Task Force  [ ] Health RBC (E) Working Group  [ ] Life RBC (E) Working Group
[ ] Catastrophe Risk (E) Subgroup  [ ] Investment RBC (E) Working Group  [ ] Operational Risk (E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup  [ ] P/C RBC (E) Working Group  [x] Longevity Risk (A/E) Subgroup

DATE:  6/6/19

CONTACT PERSON: Dave Fleming
TELEPHONE:  816-783-8121
EMAIL ADDRESS: dfleming@naic.org
ON BEHALF OF: Longevity Risk (A/E) Subgroup
NAME: Rhonda Ahrens, Chair
TITLE: Chief Actuary
AFFILIATION: Nebraska Department of Insurance
ADDRESS: 1135 M Street, Suite 300
           Lincoln, NE 68501-2089

FOR NAIC USE ONLY
Agenda Item # 2019-13-L
Year 2019

DISPOSITION
[ ] ADOPTED
[ ] REJECTED
[ ] DEFERRED TO
[ ] REFERRED TO OTHER NAIC GROUP
[ X ] EXPOSED 11/4
[ ] OTHER (SPECIFY)

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED
[ ] Health RBC Blanks
[ ] Property/Casualty RBC Blanks  [ x ] Life and Fraternal RBC Instructions
[ ] Health RBC Instructions
[ ] Property/Casualty RBC Instructions  [ x ] Life and Fraternal RBC Blanks
[ ] OTHER

DESCRIPTION OF CHANGE(S)
This proposal creates a new schedule in the life and fraternal RBC formula along with the necessary instructions to incorporate a charge for longevity risk.

REASON OR JUSTIFICATION FOR CHANGE **
The Longevity Risk (A/E) Subgroup was charged with providing recommendations for recognizing longevity risk in statutory reserves and/or RBC, as appropriate. This represents the Subgroup’s recommendation as it applies to RBC.

Additional Staff Comments:
•  11-4-19: Proposal was exposed for comments (DBF)

** This section must be completed on all forms.

Revised 2-2019
LONGEVITY RISK
LRtbd

Basis of Factors

The factors chosen represent surplus needed to provide for claims in excess of reserves resulting from increased policyholder longevity calibrated to a 95th percentile level. For the purpose of this calibration aggregate reserves were assumed to provide for an 85th percentile outcome.

Longevity risk was considered over the entire lifetime of the policies since these annuity policies are generally not subject to repricing. Calibration of longevity risk considered both trend risk based on uncertainty in future population mortality improvements, as well as level or volatility risk which derives from misestimation of current population mortality rates or random fluctuations. Trend risk applies equally to all populations whereas level and volatility risk factors decrease with larger portfolios consistent with the law of large numbers.

Statutory reserve was chosen as the exposure base as a consistent measure of the economic exposure to increased longevity. Factors were also scaled by reserve level since number of insured policyholders is a less accessible measure of company specific volatility risk. Factors provided are pre-tax and were developed assuming a 21% tax adjustment would be subsequently applied.

Specific Instructions for Application of the Formula

Annual statement reference is for the total life contingent reserve for the products in scope. The scope includes annuity products with life contingent payments where benefits are to be distributed in the form of an annuity. It does not include annuity products that are not life contingent, or deferred annuity products where the policyholder has a right but not an obligation to annuitize. Line (3) for General Account Life Contingent Miscellaneous reserves is included in the event there are any reserves for products in scope reported on Exhibit 5 line 0799999, it is not meant to include cash flow testing reserves reported on this line. Included in scope are:

- Single Premium Immediate Annuities (SPIA) and other payout annuities in pay status
- Deferred Payout Annuities which will enter annuity pay status in the future upon annuitization
- Structured Settlements for annuitants with any life contingent benefits
- Group Annuities, such as those associated with pension liabilities with both immediate and deferred benefits

[additional instructions would be required if Longevity Reinsurance product remains in scope – placeholder pending decision on scope]

The total reserve exposure is then further broken down by size as in a tax table. This breakdown will not appear on the RBC filing software or on the printed copy, as the application of factors to reserves is completed automatically. The calculation is as follows:

<table>
<thead>
<tr>
<th>Line (5)</th>
<th>Life Contingent Annuity Reserves</th>
<th>(1) Statement Value</th>
<th>Factor</th>
<th>(2) RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 250 Million</td>
<td></td>
<td></td>
<td>X 0.0171 =</td>
<td></td>
</tr>
<tr>
<td>Next 250 Million</td>
<td></td>
<td></td>
<td>X 0.0108 =</td>
<td></td>
</tr>
<tr>
<td>Next 500 Million</td>
<td></td>
<td></td>
<td>X 0.0095 =</td>
<td></td>
</tr>
<tr>
<td>Over 1,000 Million</td>
<td></td>
<td></td>
<td>X 0.0089 =</td>
<td></td>
</tr>
<tr>
<td>Total Life Contingent Annuity Reserves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Longevity Risk

<table>
<thead>
<tr>
<th>Life Contingent Annuity Reserves</th>
<th>Annual Statement Source</th>
<th>Statement Value</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) General Account Life Contingent Annuity Reserves</td>
<td>Blue Book Exhibit 5 column 2 row 0299999, in part‡</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>(2) General Account Life Contingent Supplemental Contract Reserves</td>
<td>Blue Book Exhibit 5 column 2 row 0399999, in part‡</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>(3) General Account Life Contingent Miscellaneous Reserves</td>
<td>Blue Book Exhibit 5 column 2 row 0799999, in part‡</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>(4) Separate Account Life Contingent Annuity Reserves</td>
<td>Green Book Exhibit 3 column 2 row 0299999, in part‡</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>(5) Total Life Contingent Annuity Reserves</td>
<td>Lines (1) + (2) + (3) + (4)</td>
<td>X † =</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

† The tiered calculation is illustrated in the Longevity Risk section of the risk-based capital instructions.
‡ Include only the portion of reserves for products in scope per the instructions.

Denotes items that must be manually entered on the filing software.
### CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

<table>
<thead>
<tr>
<th>Source</th>
<th>RBC Amount</th>
<th>Tax Factor</th>
<th>RBC Tax Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>(134)</td>
<td>Long-Term Care</td>
<td>LR019 Health Premiums Column (2) Line (28) + LR023 Long-Term Care Column (4) Line (7)</td>
<td>X</td>
</tr>
<tr>
<td>(135)</td>
<td>Life Insurance C-2 Risk</td>
<td>LR025 Life Insurance Column (2) Line (8)</td>
<td></td>
</tr>
<tr>
<td>(136)</td>
<td>Group Insurance C-2 Risk</td>
<td>LR025 Life Insurance Column (2) Lines (20) and (21)</td>
<td></td>
</tr>
<tr>
<td>(136b)</td>
<td>Longevity C-2 Risk</td>
<td>LR024 Longevity Risk Column (2) Line (5)</td>
<td></td>
</tr>
<tr>
<td>(137)</td>
<td>Disability and Long-Term Care Health Claim Reserves</td>
<td>LR024 Health Claim Reserves Column (4) Line (9) + Line (15)</td>
<td></td>
</tr>
<tr>
<td>(138)</td>
<td>Premium Stabilization Credit</td>
<td>LR026 Premium Stabilization Reserves Column (2) Line (10)</td>
<td></td>
</tr>
<tr>
<td>(139)</td>
<td>Total C-2 Risk</td>
<td>Lines (133) + (134) + (135) + (136) + (136b) + (137) + (138)</td>
<td></td>
</tr>
<tr>
<td>(140)</td>
<td>Interest Rate Risk</td>
<td>LR027 Interest Rate Risk Column (3) Line (36)</td>
<td></td>
</tr>
<tr>
<td>(141)</td>
<td>Health Credit Risk</td>
<td>LR028 Health Credit Risk Column (2) Line (7)</td>
<td></td>
</tr>
<tr>
<td>(142)</td>
<td>Market Risk</td>
<td>LR027 Interest Rate Risk Column (3) Line (37)</td>
<td></td>
</tr>
<tr>
<td>(143)</td>
<td>Business Risk</td>
<td>LR029 Business Risk Column (2) Line (40)</td>
<td></td>
</tr>
<tr>
<td>(144)</td>
<td>Health Administrative Expenses</td>
<td>LR029 Business Risk Column (2) Line (57)</td>
<td></td>
</tr>
<tr>
<td>(145)</td>
<td>Total Tax Effect</td>
<td>Lines (109) + (120) + (139) + (140) + (141) + (142) + (143) + (144)</td>
<td></td>
</tr>
<tr>
<td>Insurance Risk (C-2)</td>
<td>Source</td>
<td>RBC Requirement</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>--------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>Individual and Industrial Life Insurance</td>
<td>LR025 Life Insurance Column (2) Line (8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group and Credit Life Insurance and FEGI/SGLI</td>
<td>LR025 Life Insurance Column (2) Lines (20) and (21)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Longevity Risk</td>
<td>LR024 Health Claim Reserves Column (4) Line (18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Health Insurance</td>
<td>LR026 Premium Stabilization Reserves Column (2) Line (10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (C-2) - Pre-Tax</td>
<td>Sum of Lines (43) through (46)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(C-2) Tax Effect</td>
<td>LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (139)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net (C-2) - Post-Tax</td>
<td>Line (47) - Line (48)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
November 22, 2019

Ms. Rhonda Ahrens  
Chair, Longevity Risk (A/E) Subgroup  
National Association of Insurance Commissioners

Via email: Dave Fleming (dfleming@naic.org)

Re: RBC Blank Implementation of Longevity C-2

Dear Rhonda,

On behalf of the Longevity Risk Task Force of the American Academy of Actuaries,¹ I am providing sample changes to risk-based capital (RBC) blanks to implement longevity C-2 factors to assist the Longevity Risk Subgroup.

Changes from the existing blanks are highlighted in yellow in the attached excel file.

- The LRbd tab was previously provided to calculate the pre-tax longevity C-2 amount based on the factors proposed by the LRTF.
- Changes to LR030 include longevity risk in the calculation of tax effect for C-2.
- Changes to LR031 include longevity risk in the calculation of Net C-2 Post-Tax.

It was necessary to add new lines to LR030 and LR031 for longevity risk. This was done in this sample by adding lines numbered with “b.” It may be preferable in a final version to renumber the entire calculation so that longevity risk uses a uniquely numbered line.

Correlation between longevity and mortality is included in the formulas suggested for implementation. The formula includes a TBD Correlation Factor which can be inserted into the formula pending a decision by Life RBC on correlation.

At your request we have also included an alternative formula (provided to the right in the exhibit) that includes a Guardrail Factor that could be used to limit the reduction from correlation. We do not believe this Guardrail Factor is needed as part of the implementation of longevity C-2. If correlation is implemented with the Guardrail Factor, we recommend that it be

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

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reviewed and phased out over time rather than become a permanent factor increasing the complexity of the RBC calculation.

*****

Should you have any questions or comments regarding this letter, please contact Ian Trepanier, life policy analyst at the Academy (trepanier@actuary.org).

Sincerely,

Paul Navratil, MAAA, FSA
Chairperson, Longevity Risk Task Force
American Academy of Actuaries
<table>
<thead>
<tr>
<th>Company Name</th>
<th>Source</th>
<th>(1) RBC Impact</th>
<th>Tax Factor</th>
<th>(2) RBC Tax Jeffrey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-Term Care</td>
<td>LR03 Long-Term Care Column (2) Line 19</td>
<td>Confidential when Completed</td>
<td>X 0.2000</td>
<td>0.2000</td>
</tr>
<tr>
<td>Life Insurance C3 Risk</td>
<td>LR03 Life Insurance Column (2) Line (8)</td>
<td>Confidential when Completed</td>
<td>X 0.7000</td>
<td>0.7000</td>
</tr>
<tr>
<td>Group Insurance C2 Risk</td>
<td>LR03 Group Insurance Column (2) Line (7)</td>
<td>Confidential when Completed</td>
<td>X 0.7000</td>
<td>0.7000</td>
</tr>
<tr>
<td>Annuity C3 Risk</td>
<td>LR03 Annuity Risk Column (2) Line (10)</td>
<td>Confidential when Completed</td>
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<td>0.2000</td>
</tr>
<tr>
<td>Disability and Long-Term Care Health Claims Reserves</td>
<td>LR03 Disability and Long-Term Care Health Claims Reserves Column (2) Line (23)</td>
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<td>X 0.2000</td>
<td>0.2000</td>
</tr>
<tr>
<td>Premium Refund/Lapse Credit</td>
<td>LR03 Premium Refund/Lapse Credit Column (2) Line (09)</td>
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<tr>
<td>Total</td>
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<td></td>
</tr>
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<td>Interest Rate Risk</td>
<td>LR03 Interest Rate Risk Column (1) Line (3)</td>
<td>Confidential when Completed</td>
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<td>0.2000</td>
</tr>
<tr>
<td>Market Risk</td>
<td>LR03 Market Risk Column (1) Line (5)</td>
<td>Confidential when Completed</td>
<td>X 0.2000</td>
<td>0.2000</td>
</tr>
<tr>
<td>Business Risk</td>
<td>LR03 Business Risk Column (1) Line (7)</td>
<td>Confidential when Completed</td>
<td>X 0.2000</td>
<td>0.2000</td>
</tr>
<tr>
<td>Health Administrative Expenses</td>
<td>LR03 Health Administrative Expenses Column (1) Line (17)</td>
<td>Confidential when Completed</td>
<td>X 0.0000</td>
<td>0.0000</td>
</tr>
<tr>
<td>Total Tax Effect</td>
<td>LR03 Total Tax Effect Column (1) Line (16)</td>
<td>Confidential when Completed</td>
<td></td>
<td></td>
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</table>

**Calculations:**

- LR03 Total Column (2) Line (148) = \((138) + (139) + (140) + (141) + (142) + (143) + (144))

**Alternate with Cannell Factor:**

- LR03 Total Column (2) Line (148) = \((138) + (139) + (140) + (141) + (142) + (143) + (144)) \times \text{Cannell Factor} \times 0.5068
<table>
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<tr>
<th>Company Name</th>
<th>Status</th>
<th>Confidential when Completed</th>
<th>NAIC Company Code</th>
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<tr>
<td>Insurance Risk (C-G)</td>
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<td></td>
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<tr>
<td>(43) Individual and Industrial Life Insurance</td>
<td>LR02 5L6-Income: Column (2) Line (5)</td>
<td></td>
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<tr>
<td>(46) General Credit Life Insurance and FG IS WL</td>
<td>LR02 5L6-Income: Column (2) Line (20) and (21)</td>
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<td>(48) Longevity Risk</td>
<td>LR06b Longevity Risk: Column (2) Line (5)</td>
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<td>(45) Total Health Insurance</td>
<td>LR02 4Health Claims Reserves: Column (4) Line (18)</td>
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<td>(46) Premium Stabilization Reserve Credit</td>
<td>LR02 4Premium Stabilization Reserves: Column (2) Line (10)</td>
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<td>(47) Total C-2: Pre-Tax</td>
<td>LR(40) - LR(40) - Square Root of (LR(40) - LR(40)) = 2 * (TBD Correlation Factor) * (LR(40) + LR(40)) = (LR(40))</td>
<td></td>
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<td>(48) C-2 Tax Effect</td>
<td>LR03HC decaluation of Tax Effect for Life and General Risk-Based Capital: Column (2) Line (1.59)</td>
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<td>(49) Net C-2: Post-Tax</td>
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<td>Interest Rate Risk (C-3a)</td>
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<td>(50) Total Interest Rate Risk: Pre-Tax</td>
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<td>(52) Net C-3a: Post-Tax</td>
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<td>(53) Total Health Credit Risk: Pre-Tax</td>
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<td>(55) Net C-3b: Post-Tax</td>
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<tr>
<td>Market Risk (C-3c)</td>
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<td>(56) Total Market Risk: Pre-Tax</td>
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<td>(58) Net C-3c: Post-Tax</td>
<td>Line (56) - Line (57)</td>
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</table>
November 26, 2019

Mr. Philip Barlow
Chair, NAIC Life Risk-Based Capital (E) Working Group

Re: Longevity Risk (A/E) Subgroup Recommendation for incorporating an RBC charge for longevity risk

Dear Philip:

The American Council of Life Insurers (ACLI)\(^1\) appreciates the opportunity to provide comments regarding the November 25\(^{th}\), 2019 Recommendation for incorporating an RBC charge for longevity risk (Recommendation) from Longevity Risk (A/E) Subgroup (Subgroup).

While ACLI believes the memorandum itself appropriately captures the deliberations and decisions made by the Subgroup, we are concerned about the removal of the formula reflecting the correlation adjustment between the C-2 mortality and longevity factors in LR030 and LR031. As the Recommendation makes clear, the Subgroup deemed it appropriate that any decision on the correlation adjustment be made by the Life Risk-Based Capital (E) Working Group (Working Group). However, the removal of the formula is equivalent to a +100% correlation between the factors, which is inconsistent with the Recommendation and the American Academy of Actuaries’ (Academy) proposal. ACLI strongly urges any exposure from the Working Group reflect the correlation factor in the formulas on LR030 and LR031. We note that the Academy recommended formula would work correctly regardless of the level of correlation that the Working Group ultimately decides.

The following table illustrates the formula using the examples of the Academy deck, and specifically that a +100% correlation factor is equivalent to the sum of the mortality and longevity risk charges. Formulaically, the C-2 risk is SQRT(C2a^2 + C2b^2 + 2*(Correlation Factor)*C2a*C2b):

<table>
<thead>
<tr>
<th>C2a Mortality/Other Insurance Risk</th>
<th>25.1</th>
<th>25.1</th>
<th>25.1</th>
<th>25.1</th>
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</thead>
<tbody>
<tr>
<td>C2b Longevity Insurance Risk</td>
<td>75.4</td>
<td>75.4</td>
<td>75.4</td>
<td>75.4</td>
</tr>
<tr>
<td>Correlation Factor</td>
<td>100%</td>
<td>0%</td>
<td>-25%</td>
<td>-33%</td>
</tr>
<tr>
<td>C-2 Insurance Risk</td>
<td>100.5</td>
<td>79.5</td>
<td>73.3</td>
<td>71.2</td>
</tr>
</tbody>
</table>

We appreciate the consideration of our comments in the Working Group’s exposure.

---

\(^1\) The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. 90 million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. Learn more at www.acli.com.
Sincerely,

[Signature]

cc Dave Fleming, NAIC
Attachment Three-K
Capital Adequacy (E) Task Force
12/8/19

Academy C-2 Mortality Work Group Update

Chris Trout, MAAA, FSA
Chairperson, C-2 Work Group
American Academy of Actuaries

Life Risk-Based Capital (E) Working Group [AE/01/69] – NAIC 2019 Fall National Meeting

C-2 Mortality Overall Approach

- C-2 requirement covers mortality risk at the 99th percentile and is net of risk covered in statutory reserves
- C-2 requirement includes mortality risks related to:
  - Volatility Risk – natural statistical deviations in experienced mortality
  - Level Risk – error in base mortality assumption
  - Trend Risk – adverse mortality trend
  - Catastrophe Risk – large temporary mortality increase from a severe event
- Evaluate mortality risks using Monte Carlo simulation
- Express capital requirement using a factor-based approach (e.g., factor applied to NAR)

Current C-2 Life Mortality Risk-Based Capital

<table>
<thead>
<tr>
<th>OAR</th>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>M400M</td>
<td>2.40</td>
<td>3.70</td>
</tr>
<tr>
<td>M400M</td>
<td>3.90</td>
<td>3.35</td>
</tr>
<tr>
<td>M400</td>
<td>1.57</td>
<td>0.87</td>
</tr>
<tr>
<td>M400</td>
<td>0.87</td>
<td>0.76</td>
</tr>
</tbody>
</table>

*Reflects updates due to tax reform.
Summary of Current Developments

- Preliminary analysis suggests a possible decrease in C-2 requirement, however more analysis needed
- Biggest reductions are due to exclusion of AIDS scenarios at early '90s estimates and improvement in mortality levels compared to what was expected in the original C-2 factors
- Some increase in trend and catastrophe components

Next Steps

- Additional analysis
  - Appropriate projection period
  - Differences between products
  - Size breakpoints; exposure base
  - Analysis of industry data; implication of “high” vs. “low” mortality company
  - Group Life
- Preliminary factor development completion targeted for 2020
- Provide LRBCWG call update in Q1/Q2

Questions?

Additional Questions, contact:
- Chris Trant, MA, FSA
  Chairperson, C-2 Work Group
- Ian Trepanier
  Life Policy Analyst
  American Academy of Actuaries
  trepanier@actuary.org

Appendix
### Risk Distribution Approach Comparison

<table>
<thead>
<tr>
<th>Risk</th>
<th>Distribution</th>
<th>Current Reserve Requirement</th>
<th>Revised Reserve Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level</td>
<td>Lognormal</td>
<td>Explicitly incorporate return</td>
<td>Lognormal, 1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Less convex pricing assumption</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Standard Deviation measures</td>
<td>2 Standard Deviation measures</td>
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<tr>
<td></td>
<td></td>
<td>Volatility factor for the 2 SDs</td>
<td>Volatility factor for the 2 SDs</td>
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<tr>
<td></td>
<td></td>
<td>Two independent components</td>
<td>Two independent components</td>
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<tr>
<td></td>
<td></td>
<td>Statistical correlation uncertainty model</td>
<td>Statistical correlation uncertainty model</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multivariate normal distribution</td>
<td>Multivariate normal distribution</td>
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<tr>
<td>Yard</td>
<td>Lognormal</td>
<td>2 Parameter LTV adjustment</td>
<td>2 Parameter LTV adjustment</td>
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<tr>
<td></td>
<td></td>
<td>2 Parameter LTV adjustment</td>
<td>2 Parameter LTV adjustment</td>
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<tr>
<td></td>
<td></td>
<td>Frequency estimate adjusted normal distribution</td>
<td>Frequency estimate adjusted normal distribution</td>
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<tr>
<td></td>
<td></td>
<td>2 Parameter LTV adjustment</td>
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<td>Frequency estimate adjusted normal distribution</td>
<td>Frequency estimate adjusted normal distribution</td>
</tr>
</tbody>
</table>

**Attachment Three-K**
Capital Adequacy (E) Task Force
12/8/19
Via email

- We are in favor of having a growth risk RBC charge for life insurers. There have been several insolvencies or near insolvencies over the years triggered in part by rapid growth including Executive Life and Mutual Benefit Life in the early 1990s. Many of these involved excessive sale of deferred annuities and/or GICs with high guaranteed interest rates. Even within the last five years, we have had to stop some insurers from selling deferred annuities with high guaranteed interest rates.

William B. Carmello, Jr., FSA, MAAA
Chief Life Actuary

New York State Department of Financial Services
One Commerce Plaza, Albany, NY 12257
November 20, 2019

Mr. Philip Barlow
Chair, Life Risk-Based Capital Working Group

Re: Life Growth Operational Risk Memorandum

Dear Philip:

The American Council of Life Insurers (ACLI)\(^1\) appreciates the opportunity to comment on the March 27th NAIC Operational Risk (E) Subgroup Memorandum “Potential Further Work on Life Growth Operational Risk” (Memorandum) on behalf of our member companies.

As previously articulated in comments and captured in the Memorandum, ACLI does not support the inclusion of a life growth risk charge to the Life RBC formula. Our main arguments against the need for a life growth risk charge are summarized as follows:

1) Regulators already have tools to assess life growth risk

The Life Trend Test already captures the impact of growth by testing if a similar amount of strain in the next year would lead to an RBC event. Under today’s RBC formula, fast-growing companies will indeed have corresponding fast-growing RBC requirements. Furthermore, if a company grows through acquisition, regulators must approve such transactions and have extensive access to information about both the acquiring company and the target company.

2) Rapid growth is less prevalent than in health or property/casualty insurance

The purpose of a growth risk charge is to measure the risk associated with rapid growth of a company’s book of business. In the health and property/casualty space, much of the business is renewed annually, and entire books of business may turn over in a few years. Rapid growth is likely a sign of mispricing that is not adequately captured in the pricing risk charge. For life insurance, the duration of the business is measured in years, and does not generally allow for frequent premium re-rating. As such, life books of business are generally stable over time. Further, the life insurance industry is fairly mature which limits aggregate growth. Rapid growth for a life insurer is more likely a sign of a reinsurance transaction or block acquisition, both of which would adequately be covered by the additional C-1, C-2, C-3, and C-4 charges that would occur when the business is added. Both the proposed methods for life growth risk charges may result in many companies being subject to a growth charge, which is not only counterintuitive, but not indicative of additional risk not already captured elsewhere.

\(^1\) The American Council of Life Insurers (ACLI) advocates on behalf of 290 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. 90 million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.
3) Appropriate measurement is difficult and application of a single year charge is inappropriate

Unlike in health or property/casualty insurance, a one-year measurement is not appropriate for life insurance due to the long duration of the business written. Were a life growth risk charge to be developed, it would likely need to look very different than the rest of the RBC framework, applicable for several years after the risk is first added to the life insurance company. The Memorandum acknowledges Method 1 (informational filing) was flawed and would not be an effective measurement of growth risk. Method 2 (enhanced add-on) creates an arbitrary threshold which is not risk sensitive and would create a “cliff effect”. Treating all companies below the threshold identically won’t give regulators reliable information about the riskiness of the various companies. For some companies, this has the potential to lead to an on-again, off-again application of this charge that would be difficult to plan for and would not add meaningful signal value to the company or its regulator.

While we agree that RBC is an integral part of the regulatory framework to address risk, we believe that an explicit life growth charge creates challenges. A question for regulators is whether an explicit life growth charge is necessary for the RBC calculation given that growth is implicitly captured elsewhere in the RBC framework; the absence of an explicit measure is not an indication that a risk is not being captured. Other regulatory risk frameworks have different purposes than RBC, so there is not an apples-to-apples comparison between frameworks. Finally, while we acknowledge that smaller companies may not be subject to the same regulatory tools as larger companies, the introduction of an additional life growth risk charge may introduce unwarranted volatility into the RBC ratio for smaller companies and thus make them less competitive in the marketplace.

We are available to discuss our positions on this topic at the convenience of working group members or other regulators.

Sincerely,

cc Dave Fleming, NAIC
Property and Casualty Risk-Based Capital (E) Working Group
Austin, Texas
December 8, 2019

The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met in Austin, TX, Dec. 8, 2019. The following Working Group members participated: Tom Botsko, Chair (OH); Sheila Travis (AL); Eric Unger (CO); Wanchin Chou (CT); Virginia Christy (FL); Judy Mottar (IL); Anna Krylova (NM); Lee Hill (SC); Miriam Fisk (TX); and Randy Milquet (WI). Also participating were: Patrick McNaughton and Steve Drutz (WA).

1. Adopted its Nov. 8 Minutes

Mr. Botsko said the Property and Casualty Risk-Based Capital (E) Working Group met Nov. 8 in joint session with the Catastrophe Risk (E) Subgroup and took the following action: 1) adopted the Subgroup’s Summer National Meeting minutes; 2) adopted the Working Group’s Summer National Meeting minutes; 3) adopted proposal 2019-11-P, which clarifies instructions regarding Lloyd’s of London and the 2019 reporting guideline; 4) adopted proposal 2019-12-P, which removes PR038 adjustment for reinsurance penalty; 5) exposed the 2019 catastrophe event lists; 6) heard updates from the American Academy of Actuaries (Academy) on reviewing the underwriting risk components; 7) discussed the appropriate factor of unrated uncollateralized recoverables; and 8) discussed the factor of using aggregate exceedance probability (AEP) basis vs. occurrence exceedance probability (OEP) basis.

Mr. Chou made a motion, seconded by Ms. Mottar, to adopt the Working Group and Subgroup’s Nov. 8 joint minutes (Attachment Four-A). The motion passed unanimously.

2. Adopted the Report of the Catastrophe Risk (E) Subgroup

Mr. Botsko said the Catastrophe Risk (E) Subgroup met Dec. 6 and took the following action: 1) adopted its Nov. 8 minutes; 2) adopted proposal 2019-14-CR (2019 Catastrophe Event Lists); 3) heard presentations from the Academy on: a) “Wildfire: Lessons Learned from the 2017-2018 Events”; and b) the Actuaries Climate Index (ACI); and 3) discussed the possibility of allowing additional third-party commercial vendor models.

Ms. Mottar made a motion, seconded by Ms. Travis, to adopt the report of the Catastrophe Risk (E) Subgroup (Attachment Four-B). The motion passed unanimously.

3. Exposed Proposal 2018-19-P (Vulnerable 6 or Unrated Risk Charge)

Mr. Botsko said the purpose of this proposal is to modify the instruction to reflect the factors for all uncollateralized reinsurance recoverable from unrated reinsurers be the same for authorized, unauthorized, certified and reciprocal reinsurance. He stated that the current 14% factors for uncollateralized reinsurance recoverable was based on Standard & Poor’s 500 index (S&P 500) asset risk factors for reinsurance credit risk plus a margin of 3% for other than credit risk. Also, the analysis the Working Group members performed earlier that confirmed that the factor changed between 10–30% would be minimally effective with respect to risk-based capital (RBC) action level changes for filers. Mr. Botsko recommended that the Working Group consider using the 14% in 2020 reporting. Then, the data will be re-evaluated annually until reaching any agreed-upon change to the factor.

Ralph Blanchard (Travelers) commented that unrated reinsurers should not be grouped with vulnerable companies.


4. Agreed to Refer its Working Agenda to the Capital Adequacy (E) Task Force

Mr. Botsko summarized the changes to the 2020 Property/Casualty (P/C) RBC working agenda: 1) removed “evaluate the proposed changes from the Investment Risk-Based Capital WG related to Bond changes in the P/C formula” in the new items section; and 2) added “evaluate the possibility of using the NAIC as centralized location for reinsurer designations” and...
“evaluate the possibility of allowing additional third-party models to calculate the catastrophe model losses” in the carry-over items and new items sections, respectively.

Mr. Milquet made a motion, seconded by Mr. Chou, to agree to refer the 2020 P/C RBC working agenda to the Capital Adequacy (E) Task Force for consideration (see NAIC Proceedings – Fall 2019, Capital Adequacy (E) Task Force, Attachment Five). The motion passed unanimously.

5. Discussed the Possibility of Using the NAIC as a Centralized Location for Reinsurer Designations

Mr. Botsko said based on the previous 2018 credit risk analysis, the Working Group identified a large amount of possible reporting errors on Schedule F, Part 3, such as incorrectly filed by: 1) wrongful categories; 2) pool status; and 3) overstated/understated reinsurer financial strength ratings. He stated that one of the possible solutions is using the NAIC as a centralized location for reinsurer designations. However, prioritization of the technology resources and obtaining the approval funds will be the biggest hurdle of this project. He anticipated that it would move faster if the industry is willing to assist with the funding portion.

Mr. Blanchard suggested that any such effort should focus on reinsurers with material volumes in Schedule F, Part 3, as this would reduce the cost.

Mr. Milquet commented that one of the options is to integrate the Jumpstart report to validate whether the items reported in the Schedule F are correct.

Scott Williamson (Reinsurance Association of America—RAA) said analysis indicated that many reinsurer designations reported in the Annual Statement Schedule F were understated. Using the NAIC as a centralized location will benefit the industry, as this will potentially reduce the R3 charges. He also stated regarding the issue of the resources and cost of this project, that he anticipated that it should be a straightforward process; and it should not be taking a long time to implement it.

Mr. Blanchard suggested that any effort should focus on reinsurers with material volumes in Schedule F, as this would reduce the cost. He also stated that reinsurers with small volumes below $100,000 are not significant, so it may not have an impact.

Mr. Botsko asked all the interested parties to consider: 1) whether building a centralized location for reinsurer designations will be a benefit to both state insurance regulators and the industry; and 2) the possibility of funding the project from the industry.

6. Discussed the Possible Treatment of the R3 Related to the Runoff and Captive Companies

Mr. Botsko said during the previous call and meeting, some companies asked the Working Group to consider different R3 treatment for run-off and captive companies. Mr. Blanchard said that there are two types of runoff companies; vulnerability runoff and others. As for captives, he believed that most of the balances are collateralized, so they should not create any RBC issues.

Mr. Williamson said identifying the run-off companies will be the biggest challenge for this issue.

Mr. Botsko asked all the interested parties to consider what the appropriate charges are for these groups of companies and provide thoughts to the Working Group during the upcoming conference call.

7. Discussed Other Matters

Mr. Botsko said the Mortgage Guaranty Insurance (E) Working Group is currently working with the consultant on the testing and finalization of a proposed risk-based mortgage guaranty capital model for monoline mortgage guaranty insurers. The Working Group will closely monitor the model development and discuss any potential impact to the P/C RBC formula.

Mr. Botsko also said the Restructuring Mechanisms (E) Subgroup is considering the need to make changes to the P/C RBC formula to better assess the minimum surplus requirements for companies in runoff. He stated that the Working Group will work closely with the Subgroup to address this issue.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group adjourned.
The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call Nov. 8, 2019, in joint session with the Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force. The following Working Group members participated: Tom Botsko, Chair (OH); Susan Bernard (CA); Mitchell Bronson (CO); Wanchin Chou (CT); Robert H. Lee (FL); Judy Mottar (IL); Sak-man Luk (NY); Anna Krylova (NM); Miriam Fisk (TX); and Randy Milquet (WI). The following Subgroup members participated: Tom Botsko, Chair (OH); Robert H. Lee, Vice Chair (FL); Susan Bernard (CA); Mitchell Bronson (CO); Wanchin Chou (CT); Judy Mottar (IL); Anna Krylova (NM); and Miriam Fisk (TX). Also participating were: Vincent Gosz (AZ); Julie Lederer (MO); and Steve Drutz (WA).

1. Adopted the Catastrophe Risk (E) Subgroup’s Summer National Meeting Minutes

Mr. Botsko said the Catastrophe Risk (E) Subgroup met Aug. 2 and took the following action: 1) heard a presentation from AIR Worldwide (AIR) on how the aggregate exceedance probability (AEP) and occurrence exceedance probability (OEP) curves are created based on the AIR modeling results; and 2) heard a presentation from Risk Management Solutions (RMS) on how the AEP and OEP are calculated and a comparison of the results.

Ms. Krylova made a motion, seconded by Ms. Mottar, to adopt the Subgroup’s Aug. 2 minutes (see NAIC Proceedings – Summer 2019, Capital Adequacy (E) Task Force, Attachment Four-B). The motion passed unanimously.

2. Adopted the Property and Casualty Risk-Based Capital (E) Working Group’s Summer National Meeting Minutes

Mr. Botsko said the Property and Casualty Risk-Based Capital (E) Working Group met Aug.4 and took the following action: 1) adopted its May 17 minutes; 2) adopted the report of the Catastrophe Risk (E) Subgroup; 3) adopted the Property/Casualty (P/C) Risk-Based Capital (RBC) newsletter; and 4) exposed proposal 2019-11-P, which clarifies to instructions regarding Lloyd’s of London and proposal 2019-12-P, which removes PR035 adjustment for reinsurance penalty.

Mr. Milquet made a motion, seconded by Mr. Luk, to adopt the Working Group’s Aug. 4 minutes (see NAIC Proceedings – Summer 2019, Capital Adequacy (E) Task Force, Attachment Four). The motion passed unanimously.

3. Adopted Proposal 2019-11-P (Clarification to Instructions Regarding Lloyd’s of London) and the 2019 Reporting Guideline

Mr. Botsko said upon review of 2018 Annual Statement Schedule F, Part 3 filings, it was observed that many filers reported reinsurance recoverable amounts due from Lloyd’s of London syndicates as NAIC 6 – unrated; therefore, they are subject to the highest R3 charge. He stated that the purpose of this proposal is to clarify that the reinsurance recoverable from individual syndicates of Lloyd’s of London that are covered under the Lloyd’s Central Fund may use the lowest financial strength group rating received from an approved rating agency.

Mr. Botsko said that because the deadline for the change of the 2019 RBC instructions has passed, a guideline for 2019 RBC reporting will be posted to the Working Group’s web page pending the proposal’s adoption by the Working Group. He also stated that the Working Group received no comments during the exposure period.

Mr. Chou made a motion, seconded by Mr. Milquet, to adopt the guidance for 2019 RBC reporting. The motion passed unanimously.

Mr. Milquet made a motion, seconded by Ms. Krylova, to adopt proposal 2019-11-P (see NAIC Proceedings – Fall 2019, Capital Adequacy (E) Task Force, Attachment Seven). The motion passed unanimously.
4. **Adopted Proposal 2019-12-P (Remove PR038 Adjustment for Reinsurance Penalty)**

Mr. Botsko said that because the computation of RBC charge for reinsurance recoverable has been moved to the Annual Statement Schedule F, Part 3 in 2018 reporting, the adjustment for reinsurance penalty for affiliates applicable to Schedule F in PR038 is no longer needed. He stated that the purpose of this proposal is to eliminate the adjustment for reinsurance penalty for affiliates applicable to Schedule F section in PR038. Mr. Botsko also said the Working Group received no comments during the exposure period.

Mr. Chou made a motion, seconded by Mr. Milquet, to adopt proposal 2019-12-P (*see NAIC Proceedings – Fall 2019, Capital Adequacy (E) Task Force, Attachment Eight*). The motion passed unanimously.

5. **Exposed the 2019 Catastrophe Event Lists**

Mr. Botsko said that in order to avoid double-counting the catastrophe losses in the RBC formula, the U.S. and non-U.S. catastrophe event lists provide a routine annual update for those catastrophe events that should be excluded from the R5 calculation.

The Working Group and the Subgroup agreed to expose the 2019 catastrophe event lists for a 14-day public comment period ending Nov. 22.

6. **Heard Updates from the Academy on Reviewing the Underwriting Risk Components**

Lauren Cavanaugh (American Academy of Actuaries—Academy) said a scope letter from the Academy that was provided in May listed three elements that the Academy is currently researching: 1) investment income adjustment (IIA); 2) loss concentration factor (LCF) and premium concentration factor (PCF); and 3) line of business (LOB) underwriting (UW) risk factors. She anticipated that the Academy will provide three reports to the Working Group for consideration in next year. The updated LOB UW risk factor report will be provided at the 2020 Spring National Meeting; the IIA report will be presented at the 2020 Summer National Meeting; and the LCF and PCF report will be discussed at the 2020 Fall National Meeting.

7. **Discussed the Appropriate Factor of Unrated Uncollateralized Recoverables**

Mr. Botsko said during the Summer National Meeting, the Working Group discussed an issue as to whether there should be a factor change for uncollateralized unrated reinsurance recoverable from captives, risk retention groups (RRGs), solvent run-off reinsurers, and fully collateralized/funds held/sidecars/cat bonds reinsurers.

Ralph Blanchard (Travelers) recommended that the Working Group consider a separate category for run-off companies in its groupings for the purpose of setting reinsurance recoverable RBC charges, as the charge should not be too high for the run-off companies. He also stated that the factors quoted from rating agencies appear to be selections rather than being purely data driven. Those selections appear to be excessively conservative for a solvency-regulated run-off company.

Scott Williamson (Reinsurance Association of America—RAA) said Mr. Luk presented an impact analysis of changing the R3 factor for uncollateralized unrated balances under a variety of options ranging from 10–30% at the Summer National Meeting. He said the analysis may be able to assist the state insurance regulators to determine what the appropriate factor should be.

Mr. Botsko urged the Working Group members and the interested parties to consider whether to: 1) consider a separate category for run-off companies; 2) make any change on the factors; and 3) phase-in any agreed upon change to the factor. Discussion will be continued at the Fall National Meeting.

8. **Discussed the Factor of Using AEP Basis vs. OEP Basis**

Mr. Botsko said that based on the RMS presentation at the Summer National Meeting, low frequency of earthquake peril leads to a small gap between the OEP and AEP factors, whereas a higher tendency for the clustering of hurricane peril leads to a slightly higher tendency on both factors. Also, the OEP to AEP factor for severe convective storms is higher than almost all other perils. In conclusion, the factors to adjust OEP to AEP depend on: 1) peril; 2) geographic scope; 3) portfolio composition; and 4) insurance structure.
Mr. Botsko asked all the interested parties to think about this issue and provide thoughts to the Subgroup at the Fall National Meeting.

9. **Discussed Other Matters**

Mr. Botsko said the Subgroup and the Working Group will meet at the Fall National Meeting to continue discussing all the outstanding items.

Mr. Chou said the Health Risk-Based Capital (E) Working Group is currently working on the changes in the health test. He said a referral would be sent to the Working Group in the near future.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group and the Catastrophe Risk (E) Subgroup adjourned.

W:\National Meetings\2019\Fall\TF\CapAdequacy\PCRBC\Att01 11-8propertyrcwg-catrisksgmin .doc
The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met in Austin, TX, Dec. 6, 2019. The following Subgroup members participated: Tom Botsko, Chair (OH); Virginia Christy, Vice Chair (FL); Rolf Kaumann (CO); Wanchin Chou and Qing He (CT); Judy Mottar (IL); Anna Krylova (NM); Andy Schallhorn (OK); Joe Cregan (SC); and Miriam Fisk (TX). Also participating was: Phil Vigliaturo (MN).

1. **Adopted its Nov. 8 Minutes**

   Mr. Botsko said the Catastrophe Risk (E) Subgroup met via conference call Nov. 8, 2019, in joint session with the Property and Casualty Risk-Based Capital (E) Working Group and took the following action: 1) adopted the Subgroup’s Summer National Meeting minutes; 2) adopted the Working Group’s Summer National Meeting minutes; 3) adopted proposal 2019-11-P, which clarifies the instruction regarding Lloyd’s of London and the 2019 reporting guideline; 4) adopted proposal 2019-12-P, which removes the PR038 adjustment for reinsurance penalty; 5) exposed the 2019 catastrophe event lists; 6) heard updates from the American Academy of Actuaries (Academy) on reviewing the underwriting risk components; 7) discussed the appropriate factor of unrated uncollateralized recoverables; and 8) discussed the factor of using aggregate exceedance probability AEP basis vs. occurrence exceedance probability (OEP) basis.

   Mr. Chou made a motion, seconded by Mr. Schallhorn, to adopt the Subgroup’s Nov. 8 minutes (see NAIC Proceedings – Fall 2019, Capital Adequacy (E) Task Force, Attachment Four-A). The motion passed unanimously.


   Mr. Botsko said, in order to avoid double-counting the catastrophe losses in the risk-based capital (RBC) formula, the U.S. and non-U.S. catastrophe event lists provide a routine annual update for those catastrophe events that should be excluded from the R5 calculation. He stated that the Subgroup exposed the list during the Nov. 8 conference call; no comments were received during the exposure period. Mr. Botsko also indicated that any additional events that occur between Nov. 1 and Dec. 31 will be exposed during the first week of January 2020. The Subgroup will either schedule a conference call or conduct an e-vote to consider adoption of the updated list.

   Mr. Kaumann made a motion, seconded by Mr. Chou, to adopt proposal 2019-14-CR (2019 Catastrophe Event Lists). The motion passed unanimously.

3. **Heard Presentations from the Academy on Wildfires and the ACI**

   Jeri Xu (Academy) said wildfires in California in 2017 and 2018 were among the largest and most costly on record. However, modeling of wildfire risk is very complex; acceptance and use of wildfire models by insurers and regulators is limited. She recommended the Subgroup: 1) study detailed claims from recent events to improve understanding of wildfire losses; 2) increase stakeholders’ confidence in wildfire modeling by increasing the transparency of model assumptions; and 3) establish generally accepted modeling standards for wildfire model review.

   Steve Jackson (Academy) said the Actuaries Climate Index (ACI) is an educational tool providing information about weather trends in the U.S. and Canada. It covers rainfall, temperature, dry spells, wind speed and sea level. He stated that the increase in average winter values is one factor driving the ACI’s five-year moving average to new highs.

   Mr. Botsko encouraged interested parties to review the materials the Academy provided and share their comments during an upcoming conference call.
4. **Discussed the Factor of Using AEP Basis vs. OEP Basis**

Mr. Botsko said, based on the Risk Management Solutions (RMS) presentation at the Summer National Meeting, the factors to adjust OEP to AEP depend on: 1) peril; 2) geographic scope; 3) portfolio composition; and 4) insurance structure.

Mr. Botsko asked all interested parties to think about this issue and provide thoughts to the Subgroup during an upcoming conference call.

5. **Discussed Modeling of Projected Losses**

Mr. Botsko said, based on the RBC instructions, the projected losses can be modeled using: 1) one of the five approved third-party commercial vendor catastrophe models; or 2) any internal models that have been granted permission by the domestic or lead state insurance regulators. He stated that recently, more and more commercial vendors have informed the Subgroup on the process to become one of the approved vendors.

Mr. Botsko asked all interested parties to think about the potential approaches and provide thoughts to the Subgroup during an upcoming conference call.

Having no further business, the Catastrophe Risk (E) Subgroup adjourned.
<table>
<thead>
<tr>
<th>#</th>
<th>Owner</th>
<th>2020 Priority</th>
<th>Expected Completion Date</th>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
<th>Date Added to Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Life RBC WG</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Make technical corrections to Life RBC instructions, blank and/or methods to provide for consistent treatment among asset types and among the various components of the RBC calculations for a single asset type.</td>
<td></td>
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<tr>
<td>2</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2019 or later</td>
<td>A. Evaluate the overall effectiveness of the C3 Phase 2 and AG 43 methodologies by conducting an in-depth analysis of the models, modeling assumptions, processes, supporting documentation and results of a sample of companies writing variable annuities with guarantees and to make recommendations to the Capital Adequacy Task Force or Life Actuarial Task Force on any changes to the methodologies to improve their overall effectiveness. B. Develop and recommend changes to C-3 Phase II and AG 43 that implement, for 2018 adoption, the Variable Annuities Capital and Reserve (E/A) Subgroup.</td>
<td>CATF</td>
<td>Being addressed by the Variable Annuities Capital and Reserve (E/A) Subgroup</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2019 or later</td>
<td>Provide recommendations for recognizing longevity risk in statutory reserves and/or RIC, as appropriate.</td>
<td>New Jersey</td>
<td>Being addressed by the Longevity (E/A) Subgroup</td>
<td></td>
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<tr>
<td>4</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2019 or later</td>
<td>Update the current C-3 Phase I or C-3 Phase II methodology to include indexed annuities.</td>
<td>AAA</td>
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<tr>
<td>5</td>
<td>Life RBC WG</td>
<td>2</td>
<td>2019 or later</td>
<td>Develop guidance, for inclusion in the proposed NAIC contingent deferred annuity (CDA) guidelines, for states as to how current regulations governing risk-based capital requirements, including C-3 Phase II, should be applied to contingent deferred annuities (CDAs). Recommend a process for reviewing capital adequacy for insurers issuing CDAs and prepare clarifying guidance, if necessary, due to different nomenclature then used with regard to CDAs. The development of this guidance does not preclude the Working Group from reviewing CDAs as part of any ongoing or future charges where applicable and is made with the understanding that this guidance could change as a result of such a review.</td>
<td>10/2/13 Referral from A Committee</td>
<td>It is important to consider the implications of work being done by the CDA and VA issues Working Groups to ensure consistency in addressing these changes. The Working Group is monitoring the progress of that work.</td>
<td></td>
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<tr>
<td>6</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2019</td>
<td>Review and evaluate company submissions for the RBC Shortfall schedule and corresponding adjustment to Total Adjusted Capital.</td>
<td></td>
<td></td>
<td>10/16/2015</td>
</tr>
<tr>
<td>7</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2019</td>
<td>Review and evaluate company submissions for the Primary Security Shortfall schedule and corresponding adjustment to Authorized Control Level.</td>
<td></td>
<td></td>
<td>10/16/2015</td>
</tr>
<tr>
<td>8</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2019</td>
<td>Continue consideration impacts and modifications necessary due to the Federal Tax Cuts and Jobs Act and develop guidance for users of RBC on those impacts.</td>
<td></td>
<td></td>
<td>3/24/2018</td>
</tr>
<tr>
<td>9</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2019</td>
<td>Determine if any adjustment is needed to the XXX/XXXX RBC Shortfall calculation to address surplus notes issued by captives.</td>
<td></td>
<td></td>
<td>11/1/17 Referral from the Reinsurance (E) Task Force</td>
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<tr>
<td>10</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2019</td>
<td>Address changes needed due to elimination of the Elateral annual statement blank.</td>
<td></td>
<td></td>
<td>9/1/2018</td>
</tr>
<tr>
<td>11</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2019</td>
<td>Determine if any adjustment is needed due to the changes made to the Life and Health Insurance Guaranty Association Model Act, Model #520.</td>
<td></td>
<td></td>
<td>9/1/2018</td>
</tr>
<tr>
<td>12</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2019</td>
<td>Determine if any adjustment is needed to the reinsurance credit risk in light of changes related to collateral and the changes made to the property RBC formula.</td>
<td></td>
<td></td>
<td>9/1/2018</td>
</tr>
<tr>
<td></td>
<td>Owner</td>
<td>Priority</td>
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<tr>
<td>13</td>
<td>Cat Risk SG</td>
<td>1</td>
<td>Year-end 2020</td>
<td>Continue development of RBC formula revisions to include a risk charge based on catastrophe model output:</td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td>a) Evaluate other catastrophe risks for possible inclusion in the charge:</td>
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<td></td>
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<td>- determine whether to recommend developing charges for any additional perils, and which perils or perils those should be.</td>
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<td>b) Evaluate the AEP vs OEP factors.</td>
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<tr>
<td>14</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>Year-end 2020 or later</td>
<td>Evaluate a) the current growth risk methodology whether it is adequately reflects both operational risk and underwriting risk; b) the premium and reserve based growth risk factors either as a stand-alone task or in conjunction with the ongoing underwriting risk factor review with consideration of the operational risk component of excessive growth; c) whether the application of the growth factors to NET proxies adequately accounts for growth risk that is ceded to reinsurers that do not trigger growth risk in their own right.</td>
<td>Refer from Operational Risk Subgroup</td>
<td>1) Sent a referral to the Academy on 6/14/18 conference call.</td>
<td>1/25/2018</td>
</tr>
<tr>
<td>15</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>Year-end 2020</td>
<td>Evaluate the impact to RBC on a) Pre-Tax vs. After Tax; b) Tax reform on Total Adjusted Capital</td>
<td></td>
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<td>1/25/2018</td>
</tr>
<tr>
<td>16</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>2020 Summer Meeting or later</td>
<td>Continue development of RBC formula revisions based on the Covered Agreement: a) consider eliminating the different treatment of uncollateralized reinsurance recoverable from authorized versus unauthorized, unrated reinsurers; b) consider whether the factor for uncollateralized, unrated reinsurers, runoff and captive companies should be adjusted; c) Evaluate the possibility of using NAIC as a centralized location for reinsurance designations.</td>
<td>12/5/19 - The WG exposed Proposal 2018-19-P (Vulnerable 6 or unrated risk charge) for a 45-day exposure period.</td>
<td></td>
<td>8/4/2018</td>
</tr>
<tr>
<td>17</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>Year-end 2021 or later</td>
<td>Evaluate the proposed changes from the Affiliated Investment Ad Hoc Group related to P&amp;C RBC Affiliated Investments.</td>
<td></td>
<td></td>
<td>6/10/2019</td>
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<tr>
<td>18</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>2021 Summer Meeting or later</td>
<td>Continue working with the Academy to review the methodology and revise the underwriting (Investment Income Adjustment, Loss Concentration, LOB UW risk) charges in the PRBC formula as appropriate.</td>
<td></td>
<td></td>
<td>6/10/2019</td>
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**New Items – P&C RBC**

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<th>Owner</th>
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<tr>
<td>19</td>
<td>Cat Risk SG</td>
<td>1</td>
<td>Year-end 2020 or later</td>
<td>Evaluate the possibility of allowing additional third party models to calculate the cat model losses.</td>
<td></td>
<td></td>
<td>12/6/2019</td>
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**Ongoing Items – Health RBC**
<table>
<thead>
<tr>
<th>2020 #</th>
<th>Owner</th>
<th>2020 Priority</th>
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<th>Date Added to Agenda</th>
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<tr>
<td>21</td>
<td>Health RBC WG</td>
<td>3</td>
<td>Year-end 2021 RBC or later</td>
<td>Discuss and monitor the development of federal level programs and actions and the potential impact of these changes to the HRBC formula: - Development of the state reinsurance programs; - Association Health Plans; - Cross-border sales</td>
<td>HRBCWG</td>
<td>Discuss and monitor the development of federal level programs and the potential impact on the HRBC formula.</td>
<td>1/11/2018</td>
</tr>
</tbody>
</table>

**Carry-Over Items Currently being Addressed – Health RBC**

| 22     | Health RBC WG | 3 | Year-End 2023 RBC or Later | Consider changes for stop-loss insurance or reinsurance. | AAA Report at Dec. 2006 Meeting | (Based on Academy report expected to be received at YE: 2016) 2016-17-CA. | 8/4/2018 |
| 23     | Health RBC WG | 2 | Year-End 2023 RBC or Later | Review the individual factors for each health care receivables line within the Credit Risk H3 component of the RBC formula. | HRBCWG | | 8/4/2018 |
| 24     | Health RBC WG | 1 | Year-end 2022 or later | Establish an Ad Hoc Group to review the Health Test and annual statement changes for reporting health business in the Life and P/C Blanks | HRBCWG | Evaluate the applicability of the current Health Test in the Annual Statement instructions in today's health insurance market. Discuss ways to gather additional information for health business reported in other blanks. | 8/4/2018 |
| 25     | Health RBC WG | 1 | Year-end 2020 RBC or later | Review the Managed Care Credit calculation in the Health RBC formula - specifically Category 2a and 2b. | HRBCWG | Review the Managed Care Category and the credit calculated, more specifically the credit calculated when moving from Category 0 & 1 to 2a & 2b. | 12/3/2018 |
| 26     | Health RBC WG | 1 | Year-end 2020 or later | Review referral letter from the Operational Risk (E) Subgroup on the excessive growth charge and the development of an Ad Hoc group to charge. | HRBCWG | Review if changes are required to the Health RBC Formula | 4/7/2019 |

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Ongoing Items – Task Force
<table>
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<tr>
<th>2020 #</th>
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<tbody>
<tr>
<td>27</td>
<td>CADTF</td>
<td>2</td>
<td>2018</td>
<td>Affiliated Investment Subsidiaries Referral Ad Hoc group formed Sept. 2016</td>
<td>Ad Hoc Group</td>
<td>Ad Hoc group will provide periodic updates on their progress.</td>
<td></td>
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<tr>
<td>28</td>
<td>CADTF</td>
<td>2</td>
<td>2020</td>
<td>Receivable for Securities factor</td>
<td></td>
<td></td>
<td>Consider evaluating the factor every 3 years. (2018, 2021, 2024 etc.)</td>
</tr>
<tr>
<td>29</td>
<td>CADTF</td>
<td>3</td>
<td>2020</td>
<td>NAIC Designation for Schedule D, Part 2 Section 2 - Common Stocks</td>
<td>Referral from SAPWG 8/13/2018</td>
<td>Exposed for a 30-day Comment period ending 11/8/2019</td>
<td>10/11/2018</td>
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<tr>
<td>30</td>
<td>CADTF</td>
<td>3</td>
<td>2020 or Later</td>
<td>Structured Notes</td>
<td>Referral from SAPWG April 16, 2019</td>
<td>Exposed for a 30-day Comment period ending 11/8/2019</td>
<td>8/4/2019</td>
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<tr>
<td>31</td>
<td>CADTF</td>
<td>3</td>
<td>2020</td>
<td>Comprehensive Fund Review for investments reported on Schedule D Pt 2 Sn2</td>
<td>Referral from VOSTF 9/21/2018</td>
<td>Discussed during Spring Mtg. NAIC staff to do analysis. Exposed for a 30-day comment period ending 11/8/19</td>
<td>11/16/2018</td>
</tr>
<tr>
<td>32</td>
<td>CADTF</td>
<td>2</td>
<td>2020 or Later</td>
<td>XXX/AXXX Captive Reinsurance RBC Shortfall</td>
<td>Referral from Reinsurance Task Force / RITF</td>
<td>Referred to Life RBC WG for consideration and comment</td>
<td>11/1/2017</td>
</tr>
<tr>
<td>33</td>
<td>CADTF</td>
<td>2</td>
<td>2020 or Later</td>
<td>Payout Annuities for RBC</td>
<td>Referral from Allstate and IL DOI</td>
<td>Referred to Life RBC WG for consideration and comment</td>
<td>3/25/2018</td>
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<tr>
<td>34</td>
<td>CADTF</td>
<td>2</td>
<td>2020 or Later</td>
<td>Guaranty Association Assessment Risk</td>
<td>Referral from Receivership and Insolvency (E) Task Force 5/1/2018</td>
<td>Referred to the Life RBC WG and Health RBC WG for consideration and comment</td>
<td>6/30/2018</td>
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</table>

**Carry-Over Items not Currently being Addressed – Task Force**

**New Items – Task Force**

**Carry-Over Items Currently being Addressed – Task Force**

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**Priority 1 – High priority**

**Priority 2 – Medium priority**

**Priority 3 – Low priority**
<table>
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<tr>
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<tr>
<td>35</td>
<td>Investment RBC WG</td>
<td>1</td>
<td>2020 or later</td>
<td>Carry-Over Items Currently being Addressed – Investment RBC</td>
<td>Rating Agency WG Referral March 2010</td>
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<td></td>
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<tr>
<td>36</td>
<td>Investment RBC WG</td>
<td>2</td>
<td>Year-End 2021</td>
<td>Consideration should be given to recalibrate the RBC formulae to require different levels of capital for municipal, corporate and structured securities.</td>
<td>Rating Agency WG Referral March 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Investment RBC WG</td>
<td>1</td>
<td>Year-End 2021</td>
<td>Ensure that the RBC formulae, for all business types, for common stock and bonds are consistent with respect to statistical safety levels, modeling assumptions, where appropriate.</td>
<td>CAaTF Consolidated with items #42, 43 and 44 from the 2015 Working Agenda</td>
<td></td>
<td>2/10/2015 8/17/2015</td>
</tr>
<tr>
<td>38</td>
<td>Investment RBC WG</td>
<td>2</td>
<td>Year-End 2021</td>
<td>Consider modifications for investment risk to capture more than credit risk to place less reliance on the rating agencies. Consider modifications to better identify liquidity and asset concentration.</td>
<td>CDS WG referrals</td>
<td></td>
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<tr>
<td>39</td>
<td>Investment RBC WG</td>
<td>2</td>
<td>Year-End 2021</td>
<td>The asset valuation reserve (AVR) establishes a reserve to offset potential credit-related investment losses on all invested asset categories. Similar to RBC,</td>
<td>Rating Agency WG Referral March</td>
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MEMORANDUM

TO: Commissioner David Altmaier (FL), Chair, Capital Adequacy (E) Task Force

FROM: Patrick McNaughton (WA), Chair, Health Risk-Based Capital (E) Working Group

DATE: October 21, 2019

RE: Recommendation Regarding Risk-Based Capital Charge for Guaranty Association Assessment Risk

On Sept. 21, 2018 the Health Risk-Based Capital (E) Working Group received a request from the Capital Adequacy (E) Task Force to review the referral letter regarding adopted amendments to the Life and Health Insurance Guaranty Association Model Act, Model #520. The referral outlined significant amendments to Model #520, including: 1) broadening the assessment base for long-term care insurance (LTCI) insolvencies to include both life and health insurers and splitting the assessment 50%/50% between the life and health insurers; 2) clarifying the guaranty associations’ coverage of LTCI; and 3) including health maintenance organizations (HMOs) as members of the guaranty association, similar to other health insurers. The referral letter requested that the Task Force consider if changes were warranted to the health RBC formula in light of the changes made to Model #520.

Based upon our review of existing Guaranty Fund Assessment Risk charge under the H4-Business Risk component, a charge of .5% is applied to direct earned premiums (as reported in Schedule T) in any state in which the reporting entity is subject to guaranty fund assessments. Based on the current instructions and reporting the Working Group does not believe that modifications to the Health Risk-Based Capital formula are required for the change to Model #520.

The recommendation above does not preclude the Working Group from potential changes to long-term care or the business risk component charge in the future.

If you have any questions regarding this memorandum, please contact me at PatM@oic.wa.gov or Crystal Brown (NAIC) at cbrown@naic.org.
## Capital Adequacy (E) Task Force

### RBC Proposal Form

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Eva Yeung</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE:</td>
<td>816-783-8407</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:eyeung@naic.org">eyeung@naic.org</a></td>
</tr>
<tr>
<td>NAME:</td>
<td>Tom Botsko</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Chair</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td>Ohio Department of Insurance</td>
</tr>
</tbody>
</table>
| ADDRESS:        | 50 W. Town Street, Third Floor – Suite 300  
                    Columbus, OH 43215 |

**DATE:** 8/5/2019

**FOR NAIC USE ONLY**

<table>
<thead>
<tr>
<th>Agenda Item #</th>
<th>2019-11-P</th>
</tr>
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<tr>
<td>Year</td>
<td>2020</td>
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**DISPOSITION**

- [ ] ADOPTED
- [ ] REJECTED
- [ ] DEFERRED TO
- [X] EXPOSED 8-4-19
- [ ] OTHER (SPECIFY) 

---

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

- [ ] Health RBC Blanks
- [ ] Property/Casualty RBC Blanks
- [ ] Life and Fraternal RBC Instructions
- [ ] Health RBC Instructions
- [X] Property/Casualty RBC Instructions
- [ ] Life and Fraternal RBC Blanks
- [ ] OTHER _________________________________

---

### DESCRIPTION OF CHANGE(S)

The proposed changes clarify the reinsurance recoverable from individual syndicates of Lloyds’ of London that are covered under the Lloyd’s Central Fund may utilize the lowest financial strength group rating received from an approved rating agency.

---

### REASON OR JUSTIFICATION FOR CHANGE **

Upon review of 2018 Schedule F Part 3 filings, it has been observed that many filers reported reinsurance recoverable amounts due from Lloyd’s of London Syndicates as being NAIC 6-Unrated; and therefore, subject to the highest credit risk charge.

---

### Additional Staff Comments:

8-3-19 The PCRBCWG exposed for comment until 9-3-19
11-8-19 This proposal has been adopted at the Joint Catastrophe Risk Subgroup and Property/Casualty Risk-Based Capital Working Group conference call on Nov. 8.

---

**This section must be completed on all forms.**

**Revised 2-2019**
Reinsurance Recoverables

The calculation of the credit risk charge for reinsurance recoverables is detailed in Schedule F Part 3 Columns 28 through 36 of the Property/Casualty Annual Statement. This calculation is performed at the transaction level and those results are then summed to determine the charge. Reinsurance balances receivable on reinsurance ceded to non-affiliated companies (excluding certain pools) and to alien affiliates are subject to the credit risk-based capital charge. The following types of cessions are exempt from this charge:

- Cessions to State Mandated Involuntary Pools and Associations or to Federal Insurance Programs.
- This category includes all federal insurance programs [e.g., National Flood Insurance Program (NFIP), Federal Crop Insurance Corporation (FCIC), etc., all state mandated residual market mechanisms and the National Council on Compensation Insurance (NCCI)].
- Cessions to U.S. Parents, Subsidiaries and Affiliates.

The categories above are automatically excluded from the data that is calculated in Schedule F Part 3 of the Annual Statement.

Since the Annual Statement requires the collectability of reinsurance balances be considered via the reinsurance penalty, the appropriate balances must be offset by any liability that has been established for this purpose. The amount from Page 3, Line 16 should be allocated to the appropriate (re)insurers listed on Schedule F. The total amount recoverable from reinsurers less any applicable reinsurance penalty is multiplied by 120% to stress the recoverable balance. The total of reinsurance payable and/or funds held amounts (not in excess of the stressed recoverable) are applied as offsets to arrive at the stressed net recoverable.

Since there are different reinsurance credit risk factors for collateralized and uncollateralized reinsurance recoverables, the stressed net recoverable should be offset by any available collateral, such as letters of credit, multiple beneficiary trusts, and single beneficiary trusts and other allowable offsets (not in excess of the stressed net recoverable). The collateralized amounts are derived from Schedule F Part 3 Column 32 and the uncollateralized amounts are derived from Column 33.

The risk-based capital for the various credits (including collateral offsets where applicable) taken for reinsurance may not be less than zero even if the amount reported or the amount net of offsets is negative.

The factor for reinsurance recoverables (paid and unpaid less any applicable reinsurance penalty) due from a particular reinsurer is determined based on that reinsurer’s financial strength rating assigned on a legal entity basis.

For the purpose of the credit risk-based capital charge, the equivalent rating category assigned will correspond to current financial strength rating received from an approved rating agency as outlined in the table below. Ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. If the reinsurer is unauthorized and does not have at least one financial strength rating, it should be assigned the “Vulnerable 6 or Unrated Unauthorized” equivalent rating. If the reinsurer is authorized and does not have at least one financial strength rating, it should be assigned the “Unrated Authorized Reinsurers” equivalent rating. Amounts recoverable from unrated voluntary pools should be assigned the “Secure 3” equivalent rating. An authorized association including incorporated and individual unincorporated underwriters or a member thereof [e.g. individual authorized syndicates of Lloyds of London that are backed by the Central Fund] may utilize the lowest financial strength group rating received from an approved rating agency. The table below shows the R3 reinsurance equivalent rating categories and corresponding factors for A.M. Best, Standard and Poor’s, Moody’s and Fitch ratings.
Proposed Guidance Statement:

Upon review of 2018 Schedule F Part 3 filings, it has been observed that many filers reported reinsurance recoverable amounts due from Lloyd’s of London Syndicates as being NAIC 6-Unrated; and therefore subject to the highest credit risk charge.

However, the RBC Instructions for PR012 - Credit Risk for Receivables provides that: “An authorized association including incorporated and individual unincorporated underwriters or a member thereof may utilize the lowest financial strength group rating received from an approved rating agency.” This instruction is applicable to reinsurance recoverable from individual syndicates of Lloyds’ of London that are covered under the Lloyd’s Central Fund; and are therefore eligible to be treated as rated for the purposes of PR012 and the R3 Credit Risk component of RBC. This treatment is consistent with the NAIC Credit for Reinsurance Model Law and Regulation concerning applicable NAIC ratings designations for the purpose of determining reduced collateral requirements.
Capital Adequacy (E) Task Force

RBC Proposal Form

[ ] Capital Adequacy (E) Task Force  [ ] Health RBC (E) Working Group  [ ] Life RBC (E) Working Group
[ ] Catastrophe Risk (E) Subgroup  [ ] Investment RBC (E) Working Group  [ ] Operational Risk (E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup  [ ] P/C RBC (E) Working Group  [ ] Longevity Risk (A/E) Subgroup

DATE: 4/11/19
FOR NAIC USE ONLY
Agenda Item # 2019-12-P
Year 2020

CONTACT PERSON: Eva Yeung
TELEPHONE: 816-783-8407
EMAIL ADDRESS: eyeung@naic.org
ON BEHALF OF: P/C RBC (E) Working Group
NAME: Tom Botsko
TITLE: Chair
AFFILIATION: Ohio Department of Insurance
ADDRESS: 50 West Town Street, Suite 300
Columbus, OH 43215

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED
[ ] Health RBC Blanks  [ x ] Property/Casualty RBC Blanks  [ ] Life and Fraternal RBC Instructions
[ ] Health RBC Instructions  [ ] Property/Casualty RBC Instructions  [ ] Life and Fraternal RBC Blanks
[ ] OTHER

DESCRIPTION OF CHANGE(S)

Eliminate PR038 Adjustment for Reinsurance Penalty for Affiliates Applicable to Schedule F.

REASON OR JUSTIFICATION FOR CHANGE **

As the computation of RBC charge for reinsurance recoverable has been moved to the Annual Statement Schedule F, Part 3 in 2018 reporting, the adjustment for Reinsurance Penalty for Affiliates Applicable to Schedule F in PR038 is no longer needed.

Additional Staff Comments:
8-4-19 The PCRBCWG exposed proposal 2019-12-P until 9-3-19.
11-8-19 This proposal has been adopted at the Joint Catastrophe Risk Subgroup and Property/Casualty Risk-Based Capital Working Group conference call on Nov. 8.

** This section must be completed on all forms. Revised 2-2019
### SCH F PT 3 REINSURANCE CREDIT AND MED TABULAR RESERVE MEDICAL TABULAR RESERVE DISCOUNT – RESERVES

#### Credit Risk for Receivables

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#### Underwriting Risk - Reserves

**Annual Statement Source:** Medical-Tabular-Reserve-Discount

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#### Underwriting Risk - Premiums

**Annual Statement Source:** STMTINCOME (page 4, col.1 in 4)

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Denotes items that must be manually entered on the filing software.
Capital Adequacy (E) Task Force
RBC Proposal Form

[ ] Capital Adequacy (E) Task Force  [ ] Health RBC (E) Working Group  [ ] Life RBC (E) Working Group
[ x ] Catastrophe Risk (E) Subgroup  [ ] Investment RBC (E) Working Group  [ ] Op Risk RBC (E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup  [ ] P/C RBC (E) Working Group  [ ] Stress Testing (E) Subgroup

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<tr>
<th>DATE: 11/8/2019</th>
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<tr>
<td>CONTACT PERSON: Eva Yeung</td>
<td>Agenda Item # 2019-14-CR</td>
</tr>
<tr>
<td>TELEPHONE: 816-783-8407</td>
<td>Year 2019</td>
</tr>
<tr>
<td>EMAIL ADDRESS: <a href="mailto:eveung@naic.org">eveung@naic.org</a></td>
<td>DISPOSITION</td>
</tr>
<tr>
<td>ON BEHALF OF: Catastrophe Risk (E) Subgroup</td>
<td>[ ] ADOPTED</td>
</tr>
<tr>
<td>NAME: Tom Botsko</td>
<td>[ ] REJECTED</td>
</tr>
<tr>
<td>TITLE: Chair</td>
<td>[ ] DEFERRED TO</td>
</tr>
<tr>
<td>AFFILIATION: Ohio Department of Insurance</td>
<td>[ ] REFERRED TO OTHER NAIC GROUP</td>
</tr>
<tr>
<td>ADDRESS: 50 West Town Street, Suite 300</td>
<td>[ x ] EXPOSED 11/8/19</td>
</tr>
<tr>
<td>Columbus, OH 43215</td>
<td>[ ] OTHER (SPECIFY)</td>
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IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

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[ ] Fraternal RBC Blanks  [ ] Health RBC Instructions  [ ] Property/Casualty RBC Instructions
[ ] Life RBC Blanks  [ ] Fraternal RBC Instructions  [ x ] OTHER __Cat Event Lists__

DESCRIPTION OF CHANGE(S)
2019 U.S. and non-U.S. Catastrophe Event Lists

REASON OR JUSTIFICATION FOR CHANGE **
New events were determined based on the sources from Swiss Re and Aon Benfield.

Additional Staff Comments:

11/8/19 The Catastrophe Risk SG exposed the proposal for 14 days public comment period ending 11/24/19.

** This section must be completed on all forms.  Revised 11-2013
<table>
<thead>
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<th>Name</th>
<th>Date</th>
<th>Location</th>
<th>Overall losses when occurred</th>
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<td>Tropical Storm</td>
<td>Hermine</td>
<td>2010</td>
<td></td>
<td>$120,000,000</td>
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<tr>
<td>Hurricane</td>
<td>Earl</td>
<td>2010</td>
<td></td>
<td>$45,000,000</td>
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<tr>
<td>Hurricane</td>
<td>Irene</td>
<td>2011</td>
<td></td>
<td>$4,300,000,000</td>
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<tr>
<td>Tropical Storm</td>
<td>Lee</td>
<td>2011</td>
<td></td>
<td>$315,000,000</td>
</tr>
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<td>Hurricane</td>
<td>Sandy</td>
<td>2012</td>
<td></td>
<td>$50,000,000,000</td>
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<tr>
<td>Hurricane</td>
<td>Isaac</td>
<td>2012</td>
<td></td>
<td>$970,000,000</td>
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<td>Tropical Storm</td>
<td>Debby</td>
<td>2012</td>
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<td>$105,000,000</td>
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<tr>
<td>Hurricane</td>
<td>Patricia</td>
<td>2015</td>
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<td>Hurricane</td>
<td>Joaquin</td>
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<td>Hurricane</td>
<td>Matthew</td>
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<td>Florida, North Carolina, South Carolina, Georgia and Virginia</td>
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<td>Jose</td>
<td>2017</td>
<td>East Coast of the United States</td>
<td>25+ million</td>
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<tr>
<td>Hurricane</td>
<td>Irma</td>
<td>2017</td>
<td>Eastern United States</td>
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<tr>
<td>Hurricane</td>
<td>Maria</td>
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<td>Hurricane</td>
<td>Nate</td>
<td>2017</td>
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<td>Lane</td>
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<td>Hawaii</td>
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<td>Barry</td>
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## Non U.S. List of Catastrophes For Use in Reporting Catastrophe Data in PR037 and PR100+

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<th>Event Type</th>
<th>Begin</th>
<th>End</th>
<th>Event</th>
<th>Country</th>
<th>Affected Area (Detail)</th>
<th>Munich Re NaCaTS Service Insured losses (in original values, US$m)</th>
<th>Swiss Re Sigma: Insured Loss Est US$m (mid point shown if range given) Mostly reflect total US and nonUS losses combined.</th>
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<td>04/04/2010</td>
<td>04/04/2010</td>
<td>Earthquake</td>
<td>Mexico</td>
<td>Baja California, Mexicali, Tijuana, Calexico</td>
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<tr>
<td>2010</td>
<td>Earthquake</td>
<td>27/02/2010</td>
<td>27/02/2010</td>
<td>Earthquake</td>
<td>Chile</td>
<td>Biobío, Concepción, Talcahuano, Concepción, Chillán, Del Maule, Talca, Curicó, Constitucion, Calera, Dera, Iloca, Peluhue, Parral, Metropolitana, Santiago, Valparaiso, Putaendo; La Araucania, Angol, Temuco; Del General Libertador Bernado O Higgins, Rancagua, Angol; Juan Fernandez Islands</td>
<td>8000</td>
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<td>02/09/2011</td>
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<td>Earthquake</td>
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<td>Japan</td>
<td>Honshu, Aomori, Tohoku; Miyagi, Sendai; Fukushima, Mito; Ibaraki; Tochigi, Utsunomiya; Iwate, Morikka; Yamagata, Chiba; Tokyo</td>
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<td>09/03/2011</td>
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<td>Earthquake</td>
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<td>12000</td>
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<td>02/02/2011</td>
<td>07/02/2011</td>
<td>Cyclone Yasi</td>
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<td>Event</td>
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<td>Insured losses (US$ million)</td>
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<td>Hurricane Patricia</td>
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<td>07/10/2015</td>
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<td>08/12/2015</td>
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<td>Typhoon</td>
<td>08/13/2015</td>
<td>08/30/2015</td>
<td>Typhoon Goni (Ineng)</td>
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<td>Severe Tropical Storm Elau</td>
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<td>12/03/15</td>
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<td>Typhoon Kogu (Lando)</td>
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<td>Typhoon Pabuk</td>
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<td>Typhoon Koppu</td>
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<td>Typhoon</td>
<td>Typhoon Goni</td>
<td>09/19/18</td>
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<td>Typhoon Yutu</td>
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<td>&gt; 25 million</td>
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Non U.S. List of Catastrophes For Use in Reporting Catastrophe Data in PR037 and PR100+

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<tr>
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<th>Event Type</th>
<th>Event Date 1</th>
<th>Event Date 2</th>
<th>Location(s)</th>
<th>NAICs</th>
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<td>08/03/16</td>
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<td>08/10/16</td>
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<td>08/23/16</td>
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<td>09/08/16</td>
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<td>10/22/16</td>
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<td>---------------------------------------------------------------------------</td>
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<td></td>
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</tr>
<tr>
<td>2018</td>
<td>Typhoon</td>
<td>08/23/18</td>
<td>08/25/18</td>
<td>Typhoon Soulik, Japan, South Korea, China and Russia, Haenam County, South Jeolla Province</td>
<td>&gt; 25 million</td>
<td></td>
<td></td>
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<tr>
<td>2018</td>
<td>Typhoon</td>
<td>09/04/18</td>
<td>09/05/18</td>
<td>Typhoon Jebi, Japan, Mariana Islands, Taiwan, Japan, Russian Far East and Arctic</td>
<td>&gt; 25 million</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>Earthquake</td>
<td>09/06/18</td>
<td>Earthquake, Japan, Hokkaido</td>
<td>&gt; 25 million</td>
<td></td>
<td></td>
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<tr>
<td>2018</td>
<td>Super Typhoon</td>
<td>09/15/18</td>
<td>09/18/18</td>
<td>Typhoon Mangkhut, N. Mariana Islands, Philippines, China and Hong Kong</td>
<td>&gt; 25 million</td>
<td></td>
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<tr>
<td>2018</td>
<td>Hurricane</td>
<td>09/23/18</td>
<td>Hurricane Leslie, Azores, Bermuda, Europe, Azores, Bermuda, Madeira, Iberian Peninsula, France</td>
<td>&gt; 25 million</td>
<td></td>
<td></td>
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<tr>
<td>2018</td>
<td>Hurricane</td>
<td>10/07/18</td>
<td>10/16/18</td>
<td>Hurricane Michael, Central American, Yucatan Peninsula, Cayman Islands, Cuba, Atlantic, Canada</td>
<td>&gt; 25 million</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>Cyclone</td>
<td>05/03/19</td>
<td>05/05/19</td>
<td>Cyclone Fanl, India, Bangladesh</td>
<td>&gt; 500 million</td>
<td></td>
<td></td>
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<tr>
<td>2019</td>
<td>Earthquake</td>
<td>06/17/19</td>
<td>Earthquake, China</td>
<td>&gt; 25 million</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2019</td>
<td>Tropical Storm</td>
<td>08/01/19</td>
<td>08/08/19</td>
<td>Tropical Storm Wilma, China, Vietnam</td>
<td>&gt; 25 million</td>
<td></td>
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<tr>
<td>2019</td>
<td>Typhoon</td>
<td>08/09/19</td>
<td>08/11/19</td>
<td>Typhoon Lekima, China</td>
<td>&gt; 455 million</td>
<td></td>
<td></td>
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<tr>
<td>2019</td>
<td>Typhoon</td>
<td>08/15/19</td>
<td>08/16/19</td>
<td>Typhoon Krosa, Japan</td>
<td>&gt; 25 million</td>
<td></td>
<td></td>
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<tr>
<td>2019</td>
<td>Hurricane</td>
<td>08/31/19</td>
<td>09/07/19</td>
<td>Hurricane Dorian, Caribbean, Bahamas, Canada</td>
<td>&gt; 1 billion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>Typhoon</td>
<td>09/05/19</td>
<td>09/08/19</td>
<td>Typhoon Lingling, Japan, China, Korea</td>
<td>&gt; 5.78 billion</td>
<td></td>
<td></td>
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<tr>
<td>2019</td>
<td>Typhoon</td>
<td>09/08/19</td>
<td>09/09/19</td>
<td>Typhoon Faxai, Japan</td>
<td>&gt; 7 billion</td>
<td></td>
<td></td>
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<tr>
<td>2019</td>
<td>Hurricane</td>
<td>09/19/19</td>
<td>09/22/19</td>
<td>Hurricane Humberto, Bermuda</td>
<td>&gt; 25+ million</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Munich Re’s NAT CAT Service, Swiss Re Sigma and Aon Benfield
Risk-Based Capital Preamble

History of Risk-Based Capital by the NAIC

A. Background

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

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

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

4. In 1992, the NAIC adopted the life risk-based capital (RBC) formula with an implementation date of year-end 1993. The formula was developed for specific regulatory needs. Four major categories were identified for the life formula: Asset Risk, Insurance Risk, Interest Rate Risk and All other Business Risk. The property and casualty and health formulas were implemented in 1994 and 1998, respectively. The focus of these formulas is Asset Risk, Underwriting Risk, Credit Risk and Business Risk (Health).

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

6. The mission of the Capital Adequacy (E) Task Force CADTF was to determine the minimum amount of capital an insurer should be required to hold to avoid triggering various specific regulatory actions. The risk-based capital (RBC) formula largely consists of a series of risk factors that are applied to selected assets, liabilities or other specific company financial data to establish the minimum capital threshold levels generally needed to bear the risk arising from that item.

37. To carry out the mission, the Capital Adequacy (E) Task Force CADTF was charged with carrying out the following initiatives:

- Evaluate emerging "risk" issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
Preamble

- Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
- Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the revised NAIC Accounting Practices and Procedures Manual (AP&P Manual) and the NAIC Valuation Manual to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives.

The Risk-based Capital (RBC) forecasting and instructions were developed and are now maintained in accordance with the mission of the Capital Adequacy (E) Task Force (CADTF) as a method of measuring the minimum threshold amount of capital appropriate for an insurance company to support its overall business operations in consideration of avoid capital specific regulatory requirements based on its size and risk profile.

B. Purpose of Risk-Based Capital

The purpose of risk-based capital (RBC) is to identify potentially weakly capitalized companies. This facilitates regulatory actions that in most cases ensure policyholders will receive the benefits promised without relying on a guaranty association or taxpayer funds. Consequently, the RBC formula calculates capital level trigger points that enable regulatory intervention in the operation of such companies. The minimum capital (RBC levels) an insurer needs to operate its business and insurers should seek to maintain capital above the RBC levels.

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

Comparison of an insurer’s TAC to any RBC level is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under the provisions of Risk-Based Capital (RBC) for Insurers Model Act (#312) or Risk-Based Capital (RBC) for Health Organizations Model Act (#315) (Model Laws), the making, publishing, disseminating, circulation or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in a form of a notice, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any insurer or of any component derived in the calculation by any insurer is prohibited.

C. History of Risk-Based Capital

From the inception of insurance regulation in the middle 1900s, the limitation of insurance company insolvency risk has been a major goal of the regulatory process. The requirement of adequate capital has been a major tool in limiting insolvency costs throughout the history of insurance regulation. Initially, the states enacted statutes requiring a specified minimum amount of capital and surplus for an insurance company to enter the business or to remain in business.

In 1992, the NAIC adopted the life-risk-based-capital formula with an implementation date of year-end 1993. The formula was developed for specific regulatory needs. Four major categories were identified for the life formula: Asset Risk, Insurance Risk, Interest Rate Risk, and All other Business Risk. The property and casualty and health formulas were implemented in 1994 and 1998, respectively. The focus of these formulas is Asset Risk, Underwriting Risk, Credit Risk and Business Risk (Health).
10. The total risk-based capital needed by an insurer to avoid being taken into conservatorship is the Authorized Control Level Risk-Based Capital, which is 50 percent of the sum of the risk-based capital for the categories, adjusted for covariance. The covariance adjustment is meant to take into account that problems in all risk categories are not likely to occur at the same time.

**BC. Objectives of Risk-Based Capital Reports**

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

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

There are several RBC Levels with different levels of anticipated additional regulatory oversight following the reporting of an RBC Event. Company Action Level (CAL) has the least amount of additional regulatory oversight as it envisions the company providing to its regulator a plan of action to increase capital or reduce risk or otherwise satisfy the regulator of the adequacy of its capital. The Regulatory Action Level (RAL) is the next higher level where the regulator is more directly involved in the development of the plan of action. The Authorized Control Level (ACL) anticipates an even higher amount of regulatory action in implementing the plan of action.

**CD. Critical Concepts of Risk-Based Capital**

**¶113.** Fixed minimum capital requirements have been largely based on the judgement of the drafters of statutes and varied widely among the states. Those fixed minimum capital and surplus requirement have served to protect the public reasonably well for over a century. Beginning in the 1960’s rapidly rising inflation brought rapidly rising interest rates.

**¶114.** Over the years, various financial models have been developed to try to measure the “right” amount of capital that an insurance company should hold. Risk-based capital seeks to modify the risk profile of all insurance companies to the point where they all have an equal probability of insolvency. "No single formula or ratio can give a complete picture of a company’s operations, let alone the operation of an entire industry. However, a properly designed formula will help in the early identification of companies with inadequate capital levels and allow corrective action to begin sooner. This should ultimately lower the number of company failures and reduce the cost of any failures that may occur.”

**¶115.** Because the NAIC formula develops a minimum threshold levels of capitalization rather than a target level, it is impractical to use the RBC formula to compare the minimum RBC level Ratio developed by one insurance company to the minimum level RBC Ratio developed by another. Comparisons of amounts that exceed the minimum threshold standards do not provide a definitive assessment of their relative financial strength. For this reason, the Model Law prohibits insurance companies, their agents and others involved in the business of insurance using the company’s RBC results to compare competitors.

**¶116.** The principal focus of solvency measurement is determination of financial condition through analysis of the financial statements and risk-based capital. However, protection of the policyholders can

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1 Page 6- Report of the Industry Advisory Committee to the Life Risk-Based Capital (E) Working Group (11/17/91)
only be maintained through continued monitoring of the financial condition of the insurance enterprise. Operating performance is another indicator of an enterprise’s ability to maintain itself as a going concern.

4E16. The Capital Adequacy Task Force (CADTF) and its RBC Working Groups are charged with evaluating refinements to the existing NAIC risk-based capital formula and considering improvements and revisions to the various RBC blanks to 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity (when it is determined to be necessary); and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified.

4E17. The Capital Adequacy (E) Task Force (CADTF) and its RBC Working groups will monitor and evaluate changes to the Annual Statement Blanks and Purposes and Procedure Manual of the NAIC Investment Analysis Office to determine if assets or specifically investments evaluated by the Security Valuation Office are relevant to the Risk-Based Capital formula in determining the minimum threshold capital and surplus for all insurance companies or whether reporting available to the regulator as a more appropriate means to addressing the risk. The Task Force will consider different methods of determining whether a particular risk should be added as a new risk to be studied and selected for a change to the applicable RBC formula, but due consideration will be given to the materiality of the risk to the industry as well as the very specific purpose of the RBC formulas to develop regulatory minimum threshold capital levels.
September 9, 2019 - sent electronically -

Commissioner Dave Altmaier, CATF Chair
and Ms. Jane Barr, NAIC Company Licensing and RBC Manager
National Association of Insurance Commissioners
701 Hall of the States
444 North Capitol Street, N.W.
Washington, D.C. 20001-1509

Re: AHIP’s Comments on the August 2019 exposure of a Risk-Based Capital (RBC) Preamble

Dear Commissioner Altmaier and Ms. Barr:

America’s Health Insurance Plans (AHIP) appreciates the opportunity to provide these comments on the RBC Preamble exposed at the August 2019 Summer National NAIC Meeting.

As AHIP noted in comments to the previous draft, we believe that a preamble is a positive addition to the RBC Framework and are supportive of adding one. We thank the Task Force for their receptiveness to comments on the previous draft. We believe the new version contains many improvements, however there are a few remaining areas where we believe small changes are needed in order to clarify the intent of RBC. These areas are as follows: (Note that we have also included a mark-up of the exposed preamble with the suggested wording changes):

Paragraph 3 - The last sentence seems to imply that RBC was/is needed because of rising interest rates and inflation. However, we think that was not the rationale. From the very beginning the concerns were with companies’ capital and variation in risk, as well as size of the company. Therefore, we recommend suggesting adding in place of the paragraph’s last sentence the following:

‘However, they fail to recognize variations in risk between broad categories of key elements of insurance, nor do they recognize differences in the amount of capital appropriate for the size of various insurers.’

Paragraph 6 – we suggest avoiding the use of the term “minimum capital” anywhere in the Preamble. The original purpose of RBC is not intended to set minimums, but rather specifies four threshold amounts or trigger points for varying types of regulatory oversight (see the comments on paragraph 12). Since the RBC formulas do not address all company issues (e.g. expansion into new areas, concentration of risk, etc.), the trigger points are for IDENTIFICATION and potential specific actions not minimums (like the state statutory requirements).
AHIP Comments on Risk-Based Capital (RBC) Preamble
August 26, 2019
Page 2

Paragraph 7 - The third bullet should also note the need to monitor the NAIC Valuation Manual as changes to reserves may well impact the risks (up or down) to the company's capital and surplus.

Paragraph 8 – We again suggest replacement of the word “minimum” with “threshold”. In addition, support for a company’s business operations goes well beyond RBC including future plans and potential needs to maintain certain business financial ratings. These are addressed by ORSA not by RBC. Hence, we have suggested alternate wording.

Paragraph 9 - The ending of this paragraph appears to say the all companies identified as "potentially weakly capitalized companies" are indeed weakly capitalized. That has been shown to not always be the case, as many companies have shown their regulators how the RBC components mis-identify them. We would recommend changing the ending to "in the operation of such companies."

In Paragraph 12 - We believe that the Preamble should not be silent on one of its most important elements - the use of multiple thresholds to identify issues and address them with less regulatory action. We recommend including the following additional paragraphs which outline the structure of the RBC Events approach.

“To support this role, the RBC Reports identify potentially weakly capitalized companies in that each insurer must report situations where the actual Total Adjusted Capital is below a threshold amount for any of the several RBC Levels. This is known as an RBC Event and reporting is mandatory. The state regulatory response is likely to be unique to each insurer as each insurer’s risk profile will have some differences from the average risk profile used to develop the RBC Formula factors and calculations.

There are several RBC Levels with different levels of anticipated additional regulatory oversight following the reporting of an RBC Event. Company Action Level (CAL) has the least amount of additional regulatory oversight as it envisions the company providing to its regulator a plan of action to increase capital or reduce risk or otherwise satisfy the regulator of the adequacy of its capital. The Regulatory Action Level (RAL) is the next higher level where the regulator is more directly involved in the development of the plan of action. The Authorized Control Level (ACL) anticipates an even higher amount of regulatory action in implementing the plan of action.”

In Paragraph 14 - We recommend the use of “RBC Ratio” and “threshold” rather than “minimum level” and “minimum” in this paragraph.

In Paragraph 17 - We recommend replacing “minimum” with “threshold” in this paragraph.
AHIP Comments on Risk-Based Capital (RBC) Preamble
August 26, 2019
Page 3

We thank you for your consideration of these comments and would be happy to address any questions the Task Force may have.

Sincerely,

Candy Gallaher, Senior Advisor – Policy and Government Affairs
America’s Health Insurance Plans
cgallaher@ahip.org

cc: William Weller, Omega Squared – Consultant to AHIP
    Ray Nelson, TriPlus Services – Consultant to AHIP
Risk-Based Capital
Preamble

History of Risk-Based Capital by the NAIC

A. Background

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

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

3. Fixed minimum capital requirements were largely based on the judgement of the drafters of statutes and varied widely among the states. Those fixed minimum capital and surplus requirement have served to protect the public reasonably well for over a century. Beginning in the 1960’s rapidly rising inflation brought rapidly rising interest rates. However, they fail to recognize variations in risk between broad categories of key elements of insurance, nor do they recognize differences in the amount of capital appropriate for the size of various insurers.

4. In 1992, the NAIC adopted the life risk-based capital (RBC) formula with an implementation date of year-end 1993. The formula was developed for specific regulatory needs. Four major categories were identified for the life formula: Asset Risk, Insurance Risk, Interest Rate Risk and All other Business Risk. The property and casualty and health formulas were implemented in 1994 and 1998, respectively. The focus of these formulas is Asset Risk, Underwriting Risk, Credit Risk and Business Risk (Health).

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6. The mission of the Capital Adequacy (E) Task Force CADTF was to determine the minimum amount of capital an insurer should be required to hold to avoid triggering various specific regulatory actions. The risk-based capital (RBC) formula largely consists of a series of risk factors that are applied to selected assets, liabilities or other specific company financial data to establish the minimum capital threshold levels generally needed to bear the risk arising from that item.

32. To carry out the mission, the Capital Adequacy (E) Task Force CADTF was charged with carrying out the following initiatives:

- Evaluate emerging "risk" issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
- Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
Preamble

- Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the revised NAIC Accounting Practices and Procedures Manual (AP&P Manual) and the NAIC Valuation Manual to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives.

48. The Risk-based Capital—RBC forecasting and instructions were developed and are now maintained in accordance with the mission of the Capital Adequacy (E) Task Force (CADTF) as a method of measuring the minimum threshold amount of capital appropriate for an insurance company to avoid capital specific regulatory requirements based on support its overall business operations in consideration of its size and risk profile.

B. Purpose of Risk-Based Capital

59. The purpose of risk-based capital—RBC is to identify potentially weakly capitalized companies. This facilitates regulatory actions that in most cases ensure policyholders will receive the benefits promised without relying on a guaranty association or taxpayer funds. Consequently, the RBC formula calculates capital level trigger points that enable regulatory intervention in the operation of such weakly capitalized companies. Determine the minimum capital (RBC levels) an insurer needs to operate its business and insurers should seek to maintain capital above the RBC levels.

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

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C. History of Risk-Based Capital

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

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Preamble

**BC. Objectives of Risk-Based Capital Reports**

**4412.** The primary responsibility of each state insurance department is to regulate insurance companies in accordance with state laws with an emphasis on solvency for the protection of policyholders. The ultimate objective of solvency regulation is to ensure that policyholder, contract holder and other legal obligations are met when they come due and that companies maintain capital and surplus at all times and in such forms as required by statute, to provide an adequate margin of safety.

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**CQ. Critical Concepts of Risk-Based Capital**

12. Fixed minimum capital requirements have been largely based on the judgement of the drafters of statutes and varied widely among the states. Those fixed minimum capital and surplus requirements have served to protect the public reasonably well for over a century. Beginning in the 1960’s rapidly rising inflation brought rapidly rising interest rates.

1213. Over the years, various financial models have been developed to try to measure the “right” amount of capital that an insurance company should hold. Risk-based capital seeks to modify the risk profile of all insurance companies to the point where they all have an equal probability of insolvency. No single formula or ratio can give a complete picture of a company’s operations, let alone the operation of an entire industry. However, a properly designed formula will help in the early identification of companies with inadequate capital levels and allow corrective action to begin sooner. This should ultimately lower the number of company failures and reduce the cost of any failures that may occur."

14. Because the NAIC formula develops a minimum threshold levels of capitalization rather than a target level, it is impractical to use the RBC formula to compare the RBC Rationminimum RBC level developed by one insurance company to the RBC Ration minimum level developed by another. Comparisons of amounts that exceed the thresholdminimum standards do not provide a definitive assessment of their relative financial strength. For this reason, the Model Law prohibits insurance companies, their agents and others involved in the business of insurance using the company’s RBC results to compare competitors.

15. The principal focus of solvency measurement is determination of financial condition through analysis of the financial statements and risk-based capital. However, protection of the policyholders can only be maintained through continual monitoring of the financial condition of the insurance enterprise. Operating performance is another indicator of an enterprise’s ability to maintain itself as a going concern.

16. The Capital Adequacy Task Force (CADTF) and its RBC Working Groups are charged with evaluating refinements to the existing NAIC risk-based capital formula and considering improvements and revisions to the various RBC blanks to 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity (when it is determined to be necessary); and 2) oversee the development of
Preamble

additional reporting formats within the existing RBC blanks as needs are identified

1217. The Capital Adequacy (E) Task Force CADTF and its RBC Working groups will monitor and evaluate changes to the Annual Statement Blanks and Purposes and Procedure Manual of the NAIC Investment Analysis Office to determine if assets or specifically investments evaluated by the Security Valuation Office are relevant to the Risk-Based Capital formula in determining the threshold\text{minimum} capital and surplus for all insurance companies or whether reporting available to the regulator as a more appropriate means to addressing the risk. The Task Force will consider different methods of determining whether a particular risk should be added as a new risk to be studied and selected for a change to the applicable RBC formula, but due consideration will be given to the materiality of the risk to the industry as well as the very specific purpose of the RBC formulas to develop regulatory threshold\text{minimum} capital levels.

\footnotesize{\textsuperscript{1}Page 6- Report of the Industry Advisory Committee to the Life Risk-Based Capital (E) Working Group (11/17/91)}
To: Commissioner David Altmaier, Chair of the Capital Adequacy (E) Task Force  
Kevin Fry, Chair of the Valuation of Securities (E) Task Force  
Jake Garn, Chair of the Blanks (E) Working Group

From: Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group

Date: August 13, 2018

Re: NAIC Designations for Schedule D, Part 2 – Section 2 – Common Stocks

The purpose of this referral is to communicate the Statutory Accounting Principles (E) Working Group’s support for the consideration of reporting revisions to permit NAIC designations for SEC registered funds (mutual funds, closed end funds and unit investment trusts), in scope of SSAP No. 30—Unaffiliated Common Stock (reported on Schedule D, Part 2 – Section 2 – Common Stock (D-2-2)), if determined appropriate based on the underlying holdings of the fund. (It is presumed that such NAIC designations would only be permitted for SEC registered funds that are comprised of bond or qualifying preferred stock investments.)

This referral was developed in response to requests to move equity investments that have underlying bond investments from the scope of SSAP No. 30 to the scope of SSAP No. 26R—Bonds in order to obtain more appropriate risk-based capital (RBC) charges. In reviewing the request, the Statutory Accounting Principles (E) Working Group has concluded against moving these equity investments to SSAP No. 26R for the following reasons:

- SEC registered funds in scope of SSAP No. 30 are not bonds, and do not represent a creditor relationship whereby there is a fixed schedule for one or more future payments.

- The long-term bond schedule (Schedule D-1) is not conducive to the reporting of funds, and questions often arise on the proper completion of Schedule D-1 for the limited equity investments already captured in scope of SSAP No. 26R. (For example, several columns on Schedule D-1 are not applicable for funds including interest rate, par value, maturity date, etc.)

- Existing guidance that allows SVO-Identified ETFs to be reported in scope of SSAP No. 26R, on Schedule D-1, has historically resulted with inconsistent reporting for similar investments. Companies may not identify that they have investments permitted for reporting on Schedule D-1 and continue to report these investments on Schedule D-2-2, or companies may infer the limited SSAP No. 26R provisions to additional investments that do not qualify for Schedule D-1 reporting.

- The desire for equity investments to be within scope of SSAP No. 26R is driven by RBC charges and not the investment structure or the measurement method for the investment.

Although the Statutory Accounting Principles (E) Working Group supports the consideration of revisions to permit NAIC designations on Schedule D-2-2, the Statutory Accounting Principles (E) Working Group defers to each of the identified groups in determining whether it is appropriate and feasible to incorporate these revisions. The ability to report NAIC designations on Schedule D-2-2 would require revisions that would include, at a minimum, the following assessments:


2. Valuation of Securities (E) Task Force – Consider and establish a methodology for reviewing equity investments with underlying bond investments and in determining the appropriate NAIC designation.
3. Capital Adequacy (E) Task Force – Consider and determine the extent, if any, the reported NAIC designation for the SEC registered investment should be factored into the RBC calculation.

Although the Statutory Accounting Principles (E) Working Group has previously communicated that they do not plan to entertain future requests to reclassify investments to be in scope of a different SSAP when the key driver is an RBC charge, this issue was raised as part of the Statutory Accounting Principles (E) Working Group’s current project to review SSAP No. 30 under the investment classification project. Going forward, if future requests are received, the Working Group intends to direct inquirers to the appropriate NAIC group for RBC assessment.

A referral response is not expected, as there will be no statutory accounting impact regardless of the ultimate decision. As noted, the Statutory Accounting Principles (E) Working Group has previously concluded against moving these equity investments from the scope of SSAP No. 30 to SSAP No. 26R.

Please contact NAIC staff of the Statutory Accounting Principles (E) Working Group with any questions.

Cc: Julie Gann, Robin Marcotte, Fatima Sediqzad, Jake Stultz, Charles A. Theriault, Robert Carcano, Mary Caswell, Calvin Ferguson, Jane Barr, Lou Felice

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To: Commissioner Altmaier, Chair of the Capital Adequacy (E) Task Force
   Kevin Fry, Chair of the Valuation of Securities (E) Task Force

From: Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group

Date: November 27, 2018

Re: Foreign Mutual Funds

During the Fall National Meeting, the Statutory Accounting Principles (E) Working Group exposed agenda item 2018-34 proposing to explicitly include registered foreign mutual funds in scope of SSAP No. 30R—Unaffiliated Common Stock. (The revisions explicitly exclude other foreign funds from the scope of the SSAP.) This agenda item was developed pursuant to an industry request in response to substantive revisions to SSAP No. 30R. Although industry supported adopting the substantive revisions, it was identified that foreign mutual funds have previously been captured in scope of SSAP No. 30 (under the generic scope reference of “mutual funds”). The industry comments identified that the substantive revisions to include SEC-registered open-end funds (mutual funds), closed-end funds and unit-investment trusts in scope of SSAP No. 30R, perhaps inadvertently excluded foreign mutual funds. Consistent with industry’s request, the substantive revisions to SSAP No. 30R were adopted during the Fall National Meeting (under agenda item 2017-32), and the Working Group exposed proposed revisions to consider foreign mutual funds in scope.

Although there is a general assessment that foreign mutual funds should be treated similarly to foreign common stock, (which are in scope of SSAP No. 30R), the Statutory Accounting Principles (E) Working Group directed referrals to the Valuation of Securities (E) Task Force and the Capital Adequacy (E) Task Force to inquire on the exposure and solicit input. Specifically, comments were requested on the following questions:

1) Should only certain jurisdictions be permitted to have their registered mutual funds included as common stock? (For example, UK, Hong Kong, Canadian, etc.)

2) Should Canadian registered mutual funds continue to be considered “domestic securities” in accordance with the current annual statement instructions? (Under current annual statement instructions, Canadian securities are considered domestic securities.) Would the classification of Canadian mutual funds as “domestic” securities result with an inappropriate assessment that they represent U.S. SEC registered funds? If reported as domestic securities, should a new code or other reporting mechanism be established to identify Canadian mutual funds on Schedule D-2-2?

3) Should all foreign mutual funds be captured in the Supplemental Investment Risk Interrogatory as foreign investments? For example, question 4.01 of the Interrogatory asks whether foreign investments are less than 2.5% of total admitted assets. If an entity has more than 2.5% in foreign investments, then additional information on the foreign securities is required. The ultimate question is whether an investment in a registered foreign mutual fund should be captured in determining whether the foreign threshold percentage is met. If included in the total, then the issue is whether the subsequent foreign investment Integratory questions should be answered in accordance with the country that registered the fund, without a look-through to the underlying origin of the investments held in the foreign mutual fund. (The subsequent questions ask for the foreign investment exposure by the NAIC sovereign designation.) The risk is that allocating a foreign mutual fund to the registration country may not provide accurate information on the actual exposure of the investments within the fund, particularly if the registered foreign fund is made up of investments from other countries.
• For example, SEC-registered mutual funds could be “global funds,” meaning they invest primarily in foreign companies with investments also in U.S. companies, or “international funds,” meaning that they invest in companies outside of the United States. Other SEC-Registered funds include “regional or country funds,” which invest primarily in a particular region or country, or “international index funds,” which seek to track the results of a particular foreign market or international index.

4) Should there be clarification that only U.S. SEC registered mutual funds are permitted to be identified as “diversified” and excluded from the Asset Concentration Factor section of the risk-based capital filing, or should all funds that are diversified in accordance with the SEC Investment Company Act of 1940 be excluded from this factor?

• The current interrogatory asks whether there are diversified mutual funds reported on Schedule D-2-2 (diversified according to the SEC Investment Company Act of 1940, Section 5(b)(1)). Technically, this current question does not restrict the reporting to SEC registered mutual funds. As such, it is uncertain whether foreign mutual funds that meet the diversification requirements of the 1940 Act are permitted to be reported in this Interrogatory.

• It has been communicated that certain Exchange Traded Funds (ETFs), although not registered as mutual funds, are diversified in accordance with the Investment Company Act of 1940, Section 5(b)(1). The question is whether these funds should be captured in the general interrogatory for exclusion from the asset concentration factor for RBC purposes. (If these funds should be captured in the GI, then a subsequent revisions will likely be proposed to clarify what is permitted to be reported.)

Thank you for your attention to this referral. If possible, a response would be preferred by Feb 15, 2019 to correspond with the Statutory Accounting Principles (E) Working Group exposure deadline. Consideration of comments received is planned to occur during the 2019 Spring National Meeting.

Please contact NAIC staff of the Statutory Accounting Principles (E) Working Group with any questions.

Cc: Charles A. Therriault, Robert Carcano, Jane Barr, Julie Gann, Robin Marcotte, Jake Stultz and Fatima Sediqzad

Attachment: Agenda Item 2018-34

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MEMORANDUM

TO:        David Altmair, Chair, Capital Adequacy (E) Task Force
FROM:     Kevin Fry, Chair, Valuation of Securities (E) Task Force
CC:        Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
           Robert Carcano, NAIC Consultant
RE:       Referral to the Capital Adequacy (E) Task Force – Request for Assignment of Risk-Based Capital (RBC) Charges for Funds That Predominantly Hold Bonds
DATE:     May 10, 2019

1. **Introduction** – The Valuation of Securities (E) Task Force requests that the Capital Adequacy (E) Task Force consider formally integrating the comprehensive instructions for mutual funds recently adopted for the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) into the NAIC RBC framework. The mutual funds for which integration is sought: 1) are issued by investment companies registered with and regulated by the U.S. Securities and Exchange Commission (SEC); 2) whose offering is registered with the SEC; 3) whose published investment objective is to invest solely in bonds or solely in preferred stock; 4) are all within scope of the *Accounting Practices and Procedures Manual* (AP&P Manual); 5) cannot be purchased and reported as filing exempt (FE) on the basis of a nationally recognized statistical rating organization (NRSRO) credit rating; and 6) are subject to a *pre-purchase review and identification procedure* performed by the SVO.¹

2. **Background** – The primary financial solvency tool of the Valuation of Securities (E) Task Force is a number of related analytical methodologies for the quantification of non-payment risk. These tools have often been used to identify and facilitate investments that provide insurers a needed return at a lower non-payment risk. The Task Force first recognized that bond mutual funds could be structured to perform much better than equity in 1991. Over the next (almost) 30 years, the Task Force developed specific narrow exceptions where the SVO could analyze the cash flow from these specific bond fund types and determine if there would be lower non-payment risk than that associated with shares of common stock. Two Task Force exceptions adopted prior to the adoption of the AP&P Manual and one adopted afterward sought to characterize shares of such funds as being “bond-like” and were accommodated by including them as in scope of *Statement of Statutory Accounting Principles SSAP No. 26R—Bonds*. Over time, it became increasingly clear that the reporting of non-bond instruments in a framework developed for bonds produces reporting problems that can be avoided if it is recognized that the intent is to provide regulatory treatment consistent with credit risk.

¹ The Valuation of Securities (E) Task Force’s procedure permits the sponsor of a fund or an insurer to request an SVO assessment of a fund to determine if it meets requirements imposed by the Task Force for more appropriate treatment and if the fund is in scope of the AP&P Manual. If the fund is eligible, the SVO adds the name of the fund to the relevant list with a **preliminary** NAIC designation. The various lists are published. If an insurance company buys a fund on a list, it files that security with the SVO for an official NAIC designation. The SVO assigns an official NAIC designation and enters the security and designation into NAIC systems only after it confirms that nothing has changed since its initial assessment.
Since 2013, the SVO has expressed concern that it was frequently presented with bond mutual funds it could not designate, solely because they were not issued by an investment company operating as open-end management companies (the only company in scope of SSAP No. 30R—Unaffiliated Common Stock). Significant staff resources were being expended by the SVO and the NAIC Financial Regulatory Services (FRS) Division to manage the situation. In 2017, the SVO and the FRS Division asked the Task Force for permission to draft a clarifying amendment to the P&P Manual, explaining that mutual funds should not be filed with the SVO unless they strictly comply with the rules in the P&P Manual and AP&P Manual. The SVO staff also cautioned that the lack of a comprehensive approach to this asset class posed a significant risk to state insurance regulation because credit rating organizations were assigning credit ratings to funds that insurers could use to report fund shares as bonds under the FE rule. Therefore, the SVO urged the Task Force to consider modernizing the rules for bond mutual funds. On Sept. 27, 2017, the Task Force directed NAIC staff to develop a comprehensive proposal to ensure consistent treatment for investments in funds that only hold bond portfolios across all the schedules. About the same time, the Statutory Accounting Principles (E) Working Group announced a project to expand the scope of SSAP No. 30R to bring in scope funds issued by closed-end management companies and unit investment trusts. Subsequently, and in partial response to the Task Force’s fund initiative, the Working Group and the Blanks (E) Working Group expressed support for adding a column to Schedule D, Part 2, Section 2 that would permit funds designated by the SVO (and only funds designated by the SVO) to be reported on that schedule, but with an NAIC designation that could, in turn, align with an RBC factor to be determined by the Capital Adequacy (E) Task Force.

3. Referral – The Valuation of Securities (E) Task Force received and considered 18 comment letters: 15 in support and three opposed. The letters in support emphasized that the continued designation of bond funds assists financial solvency objectives of all insurers, but it is especially important for small and medium-size insurers, who face significant challenges and incur significant costs when purchasing individual bonds.

One letter opposed to the instructions argued that C-1 for bonds is based on default which bonds held by a fund will never experience because fund managers have an incentive to sell any bond that is downgraded. (The commenter’s observation that bonds in a portfolio would be sold before the default would seem to the SVO staff to be a positive attribute and in alignment with financial solvency objectives.) The point of this commenter was that funds are more likely to experience losses attributable to credit deterioration than to default, with the conclusion being that funds are not a proper subject for RBC. A second comment letter agreed that the current C-1 treatment for funds could be refined, but expressed concern that adopting a credit rating methodology could trigger materially lower, and potentially inadequate, life RBC charges without proper consideration of the risks to statutory surplus. Both of these arguments interpose highly technical arguments that not only ignore that the NAIC, through the Task Force and the SVO, have been assessing the cash flow and risk characteristics of bond funds for almost 30 years, but also ignores that the Task Force intentionally made a policy decision to use NAIC designations as a proxy to represent those risk characteristics of bond funds. They also ignore that while RBC factors are derived from an assessment of corporate bond defaults, they are applied to municipal and structured securities, as well as many other instruments that are not corporate bonds and do not have the cash flow or default risk characteristics of corporate bonds. The proposed continued use of the RBC framework for bond mutual funds is a similar recognition of the need to use available tools to provide workable (if imperfect) solutions to real-world challenges. Concerns expressed in a third comment letter were factually clarified in a number of public discussions, and the factual clarifications are summarized below for your convenience.2

2 The comprehensive instructions do not expand bond treatment or permit funds not in scope of the SSAPs. The proposal expands the existing framework to funds issued by investment companies organized as closed-end management companies and unit investments trusts. This was done to recognize that such U.S. Securities and Exchange Commission (SEC)-regulated funds may be identical to those issued by open-end management companies and to align the SVO framework with the AP&P Manual SSAPs, which bring these entities in scope of SSAP No. 30R as common stock reported on Schedule D, Part 2, Section 2. Investments in SVO-verified money market funds would still be reported as cash equivalents under SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments without a designation. SVO-identified bond exchange-traded funds (ETFs) would still be reported as bonds under SSAP No. 26R with an SVO-assigned NAIC designation, as has been the case since 2006. Investments in ETFs not captured on an SVO listing would continue to be reported as common stock under SSAP No. 30R without an NAIC designation. Private funds would still be reported as joint ventures under SSAP No. 46—Joint Ventures, Partnerships and Limited Liability Companies captured on
The Task Force requests that the Capital Adequacy (E) Task Force consider attributing the bond RBC factors to all bond and preferred stock funds. This approach is easy to implement and consistent with past NAIC practice; including both the role of the Valuation of Securities (E) Task Force in identifying the risks in securities and the practical approach expressed in the administration of the RBC framework, which is based on default characteristics of corporate bonds but applied to many other instruments with risk and default characteristics unlike those of corporate bonds. The recommended approach is sought for an NAIC activity successfully conducted for almost 30 years and for an asset class that is heavily regulated, has been successful for 85 years in many differing economic environments and provides potentially significant efficiencies to insurers.

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Schedule BA, and annual financial statement instructions will continue to permit life and fraternal companies to report an NAIC designation for fixed-income investments.
MEMORANDUM

To: David Altmaier, Chair, Capital Adequacy (E) Task Force

From: Kevin Fry, Chair, Valuation of Securities (E) Task Force

Cc: Robert Carcano, Senior Counsel, NAIC Investment Analysis Office
Julie Gann, Senior Manager, NAIC Financial Regulatory Services Division

Date: September 21, 2018

Re: Referral to the Capital Adequacy Task Force - Comprehensive Fund Proposal

1. **Introduction** – In mid-2017, the SVO and FRS asked for an instruction to draft guidance for the *Purpose and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to clarify eligibility of fund investments for assignment of NAIC Designations. The SVO explained that many funds are excluded from designation eligibility but are structurally identical to those permitted under the P&P Manual and the Accounting Practices and Procedures Manual (AP&PM). On Sept. 27, 2017, the Valuation of Securities (E) Task Force (VOS TF) directed NAIC staff to develop a comprehensive proposal to ensure consistent treatment for investments that involved funds that invest in bond portfolios.

2. **Background** – The VOS TF has permitted more appropriate treatment to funds that invest in bonds and possess other defined characteristics since 1991, as summarized below:

   - **1991** – Money market mutual funds that hold short-term U.S. Treasuries - exempted from reserve.¹
   - **1992** – Funds holding U.S. direct and full faith and credit obligations - exempted from reserving
   - **1992** – Funds holding high quality corporate bonds & U.S. Government obligations - reserve as NAIC 1 bonds².
   - **1995** – Short-term bond funds - holding high quality corporate & U.S./GSO obligations) - Schedule D; market value & reserved as bonds for AVR and RBC³.
   - **2003** – Exchange Traded Funds that held bonds – report as bonds.⁴
   - **2005** – BA assets with fixed income characteristics can be assigned NAIC Designations.⁵
   - **2017** – SVO authorized to assign NAIC Designations to private Schedule BA funds, joint ventures or partnership interests if underlying investments are fixed-income like to align with Annual Reporting Instruction.⁶

Significant efforts have also been made to align guidance in the P&P Manual and the AP&PM for this investment, as summarized below:

- Investments in money market mutual funds are reported as cash equivalents under SSAP No. 2R without an NAIC Designation.
- SVO-Identified Bond ETFs are reported as bonds under SSAP No. 26R with an NAIC designation as assigned by the SVO.
- SVO-Identified Preferred Stock ETFs are reported as preferred stock under SSAP No. 32 with an NAIC designation as assigned by the SVO.

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¹ NAIC Proceedings 1991 Vol I-A pages 505, 520, 531
² NAIC Proceedings, 1993 Vol 1B, page 770; and Nov. 9, 1992 minutes of the IMR/AVR Study Group
³ NAIC Proceedings, 1995 2Q, pages 419, 437, 467 – 472
⁴ NAIC Proceedings 2003 1Q, page 730; 2003 2Q, pages 810 - 813; 4Q page, 1859
⁶ See the minutes of the Valuation of Securities (E) Task Force conference call held November 13, 2017
Investments in ETFs (not captured on an SVO listing) are reported as common stock under SSAP No. 30 without an NAIC designation.

SVO-Identified Bond Mutual Funds are reported under SSAP No. 26R with an NAIC 1 designation.

All other mutual funds (regardless of what they hold, if they are not on an SVO listing) are reported under SSAP No. 30 without an NAIC designation.

Under a current initiative related to a review of SSAP No. 30 the SAP WG is considering whether all investments in a registered investment company should be captured in scope of SSAP No. 30. (This would expand the current reference to “mutual funds” to also include closed-end funds and unit investment trusts within scope of SSAP No. 30.) (A related initiative is discussed in this footnote.)

Guidance for non-SEC registered funds is not explicit within the AP&PM, but industry has reported such investments as joint ventures pursuant to SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies. These investments are captured on Schedule BA, with an NAIC designation permissible for fixed-income investments held by life and fraternal companies.

The Comprehensive Fund Proposal would unify guidance for all fund investments in a new section in the P&P Manual. All existing procedures for fund investments developed by the VOS TF since 1991 would be retained. The proposal would expand existing policy to funds issued by an investment company that is a closed end fund or a unit investment trust type registered with and regulated by the U.S. SEC. This tracks the SAPWG’s proposed expansion of SSAP No. 30 discussed above and the blanks initiative discussed in footnote 7. The policy that fund investments are not eligible for filing exemption would be extended to the new fund procedure and to private (Schedule BA) funds. Analytical definitions, criteria, methodology and instructions are modernized. Greater detail on analytics provides enhanced transparency to insurers.

3. **Referral** – The VOS TF refers to the CAD TF a recommendation that it conduct a comprehensive review of all funds (as described above) that can be assigned NAIC Designations by the SVO and consider how those NAIC Designations should be included into the RBC calculation; specifically, for the CAD TF to consider what RBC changes they would like to make once NAIC Designations are added to Schedule D-2-2. Currently, bond ETFs and private funds receive different RBC treatment than other similarly structured funds. Equalizing the RBC treatment for assets with similar credit risk, represented by the SVO assigned NAIC Designation, when joined with the proposed changes in the P&P Manual and those made in the AP&PM over the last several years would provide a consistent and uniform NAIC process consistent with regulatory needs for an asset that has experienced significant evolution since 1991.

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7 In furtherance of its consideration of SSAP No. 30, on August 15, 2018, the SAP WG sent a referral to the Capital Adequacy (E) Task Force, Valuation of Securities (E) Task Force and the Blanks (E) Working Group noting support for the consideration of revisions to permit NAIC designations on Schedule D-2-2 – Common Stock. As detailed within that referral, the SAPWG defers to each of the noted groups in determining whether it is appropriate and feasible to incorporate the revisions.

8 In each of the above assignments, if the SVO confirms that criteria and characteristics specified by the VOS TF are met, it places the name of the fund on a published list. An insurer can purchase any fund on the list and then files the fund shares with the SVO for an NAIC Designation. If the criteria and characteristics have not changed in the interim, the SVO assigns an NAIC Designation to the fund and annually reviews the Designation.
EXAMINATION OVERSIGHT (E) TASK FORCE

Examination Oversight (E) Task Force Dec. 8, 2019, Minutes ................................................................. 10-686
Examination Oversight (E) Task Force Sept. 13, 2019, Minutes (Attachment One) .................................. 10-689
  Referral from the Risk-Focused Surveillance (E) Working Group Regarding Guidance
  in the Financial Analysis Handbook Relating to Salary Compensation (Attachment Two-A) .............. 10-693
  Referral from the Group Solvency Issues (E) Working Group Regarding Guidance
  in the Financial Analysis Handbook Relating to Analysis Documentation Standards
  for Insurers that are Part of a Large Insurance Group (Attachment Two-B) ........................................ 10-695
Financial Analysis Research and Development (E) Working Group Exposure
  Draft to Change Life IRIS Ratios No. 4, 10 and 12 (Attachment Two-C) ............................................. 10-707
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IT Examination (E) Working Group Sept. 26, 2019, Minutes (Attachment Four) ...................................... 10-722
  Revisions to Guidance in the Financial Condition Examiners Handbook; Section III, General
  Examination Considerations, and Exhibit C, IT Review Standards Summary Memorandum
  (Attachment Four-A) ......................................................................................................................... 10-723
  Financial Examiners Handbook (E) Technical Group Sept. 12, 2019, Minutes
  (Attachment Five-A) ......................................................................................................................... 10-740
  Revisions to Guidance in the Financial Condition Examiners Handbook Related to Salary
  Range Guidelines and C-Level Interviews (Attachment Five-A1) ..................................................... 10-743
  Revisions to Guidance in the Financial Condition Examiners Handbook Related to Troubled
  Insurance Companies, Exhibit V – Overarching Prospective Risk Assessment, and
  Exhibit AA – Summary Review Memorandum (Attachment Five-B) ............................................. 10-752
Revisions to Guidance in the Financial Condition Examiners Handbook Related to Management
  Letters (Attachment Six) .................................................................................................................. 10-767

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The Examination Oversight (E) Task Force met in Austin, TX, Dec. 8, 2019. The following Task Force members participated: Jillian Froment, Chair, represented by Dwight Radel (OH); Allen W. Kerr, Vice Chair, represented by Mel Anderson (AR); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridling represented by Sheila Travis (AL); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Kathy Belfi and William Arfanis (CT); Stephen C. Taylor represented by N. Kevin Brown (DC); Trinidad Navarro represented by Ryllynn Brown (DE); Colin M. Hayashida represented by Andrew Kurata (HI); Doug Ommen represented by Carrie Mears (IA); Dean L. Cameron represented by Nathan Faragher (ID); Stephen W. Robertson represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Nancy G. Atkins represented by Sandy Batts (KY); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by James A. McCarthy (MA); Anita G. Fox represented by Judy Weaver (MI); SteveKelley represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by John Rehagen and Shannon Schmoeger (MO); Jon Godfread represented by Matt Fischer (ND); Bruce R. Ramge represented by Justin Schrader and Lindsay Crawford (NE); Marlene Caride represented by Diane Sherman (NJ); John G. Franchini represented by Lea Geckler (NM); Glen Mulready represented by Eli Snowbarger (OK); Larry Deiter represented by Johanna Nickelson (SD); Kent Sullivan represented by Ignatius Wheeler and Shawn Frederick (TX); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); Tregenza A. Roach represented by Glendina Matthew (VI); Mike Kreidler represented by Patrick McNaughton (WA); Mark Afable represented by Amy Malm (WI); and Jeff Rude represented by Linda Johnson (WY).

1. **Adopted its Sept. 13 and Summer National Meeting Minutes**

Ms. Weaver made a motion, seconded by Ms. Malm, to adopt the Task Force’s Sept. 13 (Attachment One) and Aug. 4 (see NAIC Proceedings – Summer 2019, Examination Oversight (E) Task Force) minutes. The motion passed unanimously.

2. **Adopted the Reports of its Working Groups**

   a. **Electronic Workpaper (E) Working Group**

The Electronic Workpaper (E) Working Group met Dec. 3 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings, to continue discussions in evaluating replacement options for TeamMate AM, which will be reaching its end of life in 2023.

   b. **Financial Analysis Solvency Tools (E) Working Group**

The Financial Analysis Solvency Tools (E) Working Group met Sept. 4 to discuss changes to the Financial Analysis Handbook (Handbook) and Insurance Regulatory Information System (IRIS) for 2019 annual financial statement filings. The following proposals were adopted via an e-vote that concluded Oct. 15:

   1. Combined two quantitative procedures under property/casualty (P/C) reserving, where the materiality procedure and the related quantitative benchmark procedure were combined under one procedure.
   2. Exposed enhanced regulatory guidance to the Handbook related to parental guarantees and troubled insurance companies that resulted from referrals from the Financial Analysis (E) Working Group.
   3. Adopted Handbook guidance on salary compensation that was drafted by the Risk-Focused Surveillance (E) Working Group and exposed at the 2018 Fall National Meeting.
   4. Adopted previously exposed guidance updates to the Handbook related to intercompany pooling, which was referred by the Group Solvency Issues (E) Working Group.
   5. Adopted previously exposed changes to the life IRIS for 2020 annual financial statement filings due to blank changes.

At the close of the Sept. 4 meeting, the Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
c. **Financial Examiners Coordination (E) Working Group**

The Financial Examiners Coordination (E) Working Group met Aug. 5 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to receive reports on exam coordination efforts from selected states.

d. **IT Examination (E) Working Group**

Mr. McNaughton said the IT Examination (E) Working Group met Sept. 26 to adopt revisions on the following topics:

1. Information technology (IT) review conclusions – Revisions are intended to clarify the scope of the IT review and the way examiners should respond to IT review findings.
2. Use of third-party work – Revisions are intended to clarify the ways that third-party work can be evaluated and used during an exam’s IT review.
3. Cybersecurity self-assessment tools – Revisions allow state insurance regulators to incorporate the results of a company’s completed self-assessment. Additionally, a drafting group developed a mapping between IT exam guidance and the cybersecurity self-assessment tool developed by the Financial Services Sector Coordinating Council (FSSCC) to facilitate state insurance regulator use of the information contained within the tool.

Mr. Eft made a motion, seconded by Mr. Wheeler, to adopt the reports from the Electronic Workpaper (E) Working Group; the Financial Analysis Solvency Tools (E) Working Group, including its Sept. 4 (Attachment Two) and Oct. 15 (Attachment Three) minutes; the Financial Examiners Coordination (E) Working Group; and the IT Examination (E) Working Group, including its Sept. 26 minutes (Attachment Four).

e. **Financial Examiners Handbook (E) Technical Group**

Mr. Schrader said the Financial Examiners Handbook (E) Technical Group met Nov. 14 and Sept. 12 to adopt revisions on the following topics:

1. Troubled Companies – Revisions incorporate insights from the Troubled Insurance Company Handbook on the following topics: priority ratings guidance, communication expectations for companies that are troubled or potentially troubled, and pre-receivership considerations.
2. Management Letters – Revisions clarify which level of the management a letter should be addressed to and the level of information that should be included therein.
3. Exhibit V (Prospective Risk Assessment) – Revisions encourage enhanced testing of overarching prospective risks and better facilitate the communication of examination results with the financial analysts.
4. Exhibit AA (Summary Review Memorandum) – Revisions add guidance for determining the level of concern and overall trend for a particular risk component.
5. C-level Interviews – Revisions address the order in which C-level interviews should be conducted and provide a new interview template for interviewing a chief marketing officer (CMO).
6. Regulator Compensation – Revisions include a description of commonly held roles and responsibilities for commonly held regulatory positions and suggest salary ranges for examiners and analysts based on the results of a state insurance regulator compensation study.

Before the Task Force meeting, Joseph Zolecki (Blue Cross and Blue Shield Association—BCBSA) submitted a comment on behalf of interested parties, suggesting an amendment to the management letter revisions, which Susan Bernard (CA), chair of the Technical Group, accepted as a friendly amendment. The revisions would clarify that the judgements made by state insurance regulators regarding management letters would be based on the new guidance that the Technical Group agreed to add on its conference calls.

Ms. Weaver and Ms. Belfi asked about the intent of the revisions. Mr. Zolecki said they were to clearly link the discretion that the state insurance regulators have to the new revisions added, which detail some of the factors state insurance regulators may consider in issuing management letters.

Mr. Schrader and Mr. Romero commented that the new revisions would likely not materially affect the issuance of management letters.
Tom Finnell (America’s Health Insurance Plans—AHIP) offered an updated amendment, which would replace the use of the words “based on” with “considering.”

Ms. Belfi made a motion, seconded by Ms. Weaver, to adopt the Financial Examiners Technical Group’s report as amended during the Task Force meeting, including its Nov. 14 minutes (Attachment Five) and the revisions to the *Financial Condition Examiners Handbook* (Attachment Six).

3. **Heard an Update on LIBOR**

The Task Force received an update from Michele Lee Wong (NAIC) that provided an update to state insurance regulators, noting that the use of the London Inter-bank Offered Rate (LIBOR) as a reference rate within U.S. financial markets would be changing soon. The NAIC’s Capital Markets Bureau (CMB) will be providing a further state insurance regulator-only update to clarify the implications to U.S. state insurance regulators.

4. **Heard an Update on Jumpstart Reports**

The Task Force received an update from Mr. Romero regarding state insurance regulator-only work that had taken place to update the NAIC’s Jumpstart reports. That work was completed at the end of 2019, and Mr. Romero noted that further state insurance regulator-only communication would be sent with information on the nature of the changes made.

Having no further business, the Examination Oversight (E) Task Force adjourned into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to receive reports on exams open past 22 months.
The Examination Oversight (E) Task Force conducted an e-vote that concluded Sept. 13, 2019. The following Task Force members participated: Jillian Froment, Chair, represented by Dwight Radel (OH); Allen W. Kerr, Vice Chair, represented by Mel Anderson (AR); Jim L. Ridling represented by Richard Ford (AL); Ricardo Lara represented by Susan Bernard (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by William Arfanis (CT); Trinidad Navarro represented by Rylvonn Brown (DE); Colin M. Hayashida represented by Tian Xiao (HI); Doug Ommen represented by Jim Armstrong (IA); Stephen W. Robertson represented by Roy Eft (IN); Nancy G. Atkins represented by Sandra Batts (KY); Anita G. Fox represented by Judy Weaver (MI); Steve Kelley represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by Shannon Schmoeger (MO); Jon Godfread represented by Matt Fischer (ND); Bruce R. Ramge represented by Lindsay Crawford (NE); John Elias represented by Doug Bartlett (NH); Marlene Caride represented by Steve Kerner (NJ); Glen Mulready represented by Joel Sander (OK); Larry Deiter represented by Johanna Nickelson (SD); Kent Sullivan represented by Ignatius Wheeler (TX); Todd E. Kiser represented by Jake Garn (UT); Tregenza A. Roach represented by Gwendolyn Brady (VI); Mike Kreidler represented by Patrick McNaughton (WA); Mark Afable represented by Amy Malm (WI); and Jeff Rude represented by Linda Johnson (WY).

1. **Adopted its 2020 Proposed Charges**

The Task Force conducted an e-vote to consider adoption of its 2020 proposed charges (*see NAIC Proceedings – Fall 2019, Financial Condition (E) Committee, Attachment One-A*). New in 2020, the groups reporting to the Task Force will have updated charges as follows:

- The Electronic Workpaper (E) Working Group was asked to ensure its review of regulator needs includes consideration of both hosting and software needs, as well as considers needs of the broader regulatory community.
- The Financial Analysis Solvency Tools (E) Working Group and the Financial Examiners Handbook (E) Technical Group had a charge related to their principle-based reserving (PBR) work removed. A broad charge asking that the groups work with the Life Actuarial (A) Task Force on PBR remains.

The motion passed unanimously.

Having no further business, the Examination Oversight (E) Task Force adjourned.
The Financial Analysis Solvency Tools (E) Working Group of the Examination Oversight (E) Task Force met via conference call Sept. 4, 2019. The following Working Group members participated: Judy Weaver, Chair (MI); Patricia Gosselin, Vice Chair represented by Douglas Bartlett (NH); Sheila Travis (AL); Scott Persten and Kurt Regner (AZ); Emma Hirschhorn (CA); Kathy Belfi and Lynn Reed (CT); N. Kevin Brown (DC); Eric Moser (IL); Roy Eft (IN); James Matheson (NY); Dwight Radel and Tim Biler (OH); Ryan Keeling (OR); Kimberly Rankin (PA); Jack Broccoli (RI); Amy Garcia (TX); and Kristin Forsberg (WI).


Ms. Weaver said an NAIC staff proposal was received to expose revisions to certain benchmarks and guidance in the Financial Analysis Handbook. She called on NAIC staff to summarize the proposed revisions.

Bree Wilson (NAIC) summarized a proposal to eliminate two questions from the annual property/casualty (P/C) reserving repository because of the lack of a materiality threshold and because the subsequent questions address both the metric and materiality threshold. She said eliminating these questions prevents the repositories from flagging the same exposure multiple times.

Ms. Wilson said other proposed revisions resulted from NAIC staff’s review of benchmarks across all analysis tools and that the proposed revisions are to sync-up the benchmarks in certain Financial Analysis Handbook procedures where differences were noted.

Ms. Wilson also summarized the proposed revisions to the P/C Statement of Actuarial Opinion Worksheet to align with changes in the current instructions.

Hearing no objections, Ms. Weaver said the proposals would be exposed for a 30-day public comment period ending Oct. 4.


Ms. Weaver said the Financial Analysis (E) Working Group sent two referrals to add enhanced regulatory guidance to the Financial Analysis Handbook related to parental guarantees and troubled insurance companies for the Working Group’s consideration.

Regarding parental guarantees, Ms. Weaver said that referral stems from the Financial Analysis (E) Working Group’s observation of situations where such agreements were not honored or fulfilled.

Ms. Weaver said the troubled insurance company referral was to consider adding new guidance in the Financial Analysis Handbook on communication expectations of troubled or potentially troubled insurers and pre-receivership considerations. She said this proposal resulted from recent revisions made to the Troubled Insurance Company Handbook.

Ms. Weaver called on NAIC staff to summarize the proposed updates to the Financial Analysis Handbook related to these referrals.

Rodney Good (NAIC) summarized the additional guidance in the Financial Analysis Handbook related to parental guarantees and capital maintenance agreements. He said that NAIC staff propose the additional guidance to be added to the analyst reference guide for strategic risk. The added guidance outlines certain considerations for the analyst in assessing current and prospective risks related to such agreements. For example, he said that in addition to reviewing and understanding the terms of the agreement, the guidance includes: 1) assessing the financial background of the entity providing the commitment; 2) obtaining additional information from the insurer, such as contingency plans if the agreement is not honored; and 3) for the
analyst to review the holding company analysis for additional insight into the parent company or ultimate controlling person, specifically the financial condition and in determining if there are liquidity concerns.

Regarding the troubled insurance company referral, Mr. Good summarized NAIC staff’s proposal to include the additional guidance under the Department Organization and Communication section of the Financial Analysis Handbook. Mr. Good said that this consists of a new section for Considerations for Troubled Insurance Companies. He said that, the associated guidance is a condensed version of what is included in the Troubled Insurance Company Handbook, which is a regulator-only resource. The proposed guidance in the Financial Analysis Handbook includes communication of troubled or potentially troubled companies within the department and with other states and/or other parties, as needed.

Hearing no objections, Ms. Weaver said the enhanced regulatory guidance to the Financial Analysis Handbook would be exposed for a 30-day public comment period ending Oct. 4.

3. **Adopted a Referral from the Risk-Focused Surveillance (E) Working Group**

Ms. Weaver said the third agenda item is to consider adoption of salary compensation guidance drafted by the Risk-Focused Surveillance (E) Working Group in the 2020 Financial Analysis Handbook. She called on NAIC staff to summarize the referral and updates to the handbook.

Mr. Good said the salary compensation guidance was drafted by the Risk-Focused Surveillance (E) Working Group and exposed at the 2018 Fall National Meeting for a 45-day comment period ending Jan. 18, 2019. No comments were received. As such, the guidance was referred to Financial Analysis Solvency Tools (E) Working Group and the Financial Examiners Handbook (E) Technical Group for consideration of adoption. The proposed guidance in the Financial Analysis Handbook reflects the final draft and is ready for consideration of adoption.

Ms. Rankin made a motion, seconded by Mr. Regner, to adopt the guidance in the 2020 Financial Analysis Handbook. The motion passed unanimously (Attachment Two-A).

4. **Adopted a Referral from the Group Solvency Issues (E) Working Group**

Ms. Weaver said that no comments were received on the previously exposed updates to the 2020 Financial Analysis Handbook related to analysis documentation standards for insurers that are part of a large insurance group, which resulted from a referral received from the Group Solvency Issues (E) Working Group. She called on NAIC staff to provide a brief overview of the referral.

Ralph Villegas (NAIC) said that these referrals were jointly exposed in June for a public comment period ending July 12. He said there was one comment letter received from Wisconsin to address how to efficiently document analysis of pooled insurance groups, as well as information on the insurance group when the ultimate controlling person of the group is an insurance entity, and additional information that would be expected from the non-lead state.


5. **Adopted its July 25 Minutes**

Ms. Weaver said the Working Group met on July 25 to expose revisions to the life Insurance Regulatory Information System (IRIS) Ratio 4, Adequacy of Investment Income; Ratio 10, Change in Product Mix; and Ratio 12, Change in Reserving for a 30-day public comment period ending Aug. 26.

Mr. Regner made a motion, seconded by Ms. Garcia, to adopt the Working Group’s July 25 minutes (See NAIC Proceedings – 2019 Summer, Examination Oversight (E) Task Force, Attachment One). The motion passed unanimously.

6. **Adopted Revisions to the Life IRIS**

Ms. Weaver said the next agenda item is to hear comments received from the exposed IRIS revisions and consider adoption of those changes. She called on NAIC staff to summarize the comments and revisions.
Kelly Hill (NAIC) said comments were received from the American Council of Life Insurers (ACLI), with the first two comments relating to the mortality risk column that was added by the Blanks (E) Working Group to the analysis by line of business table. She said that NAIC staff agreed that these elements should be included; therefore, the elements were added to IRIS (2A). Ms. Hill said the third comment was to include group credit life in the credit life element for Ratio 10. She agreed that these elements should be considered and revised the proposed changes to IRIS accordingly.

Mr. Regner made a motion, seconded by Mr. Broccoli, to adopt the IRIS revisions (Attachment Two-C). The motion passed unanimously.

Having no further business, the Financial Analysis Solvency Tools (E) Working Group adjourned.
Proposed Additions to Financial Analysis Handbook

It is proposed that a new section of guidance be adopted into the NAIC’s Financial Analysis Handbook to contain compensation guidance and recommended salary ranges for financial analysts. The guidance is proposed as follows:

I. Introduction A. Department Organization and Communication

Financial Analyst Salary Guidelines
The compensation guidelines in this section of the Handbook were developed in recognition of the importance of compensation particularly as it affects an Insurance Department’s ability to hire and retain well-qualified employees. The guidelines were developed based on surveys of analyst pay across Insurance Departments, as well as external comparisons to other similar professions, including other financial regulators, internal auditors and external auditors. In using the information below, the following are brief descriptions of the associated positions listed:

Financial Analyst
Financial Analysts are responsible for conducting Risk-Focused Financial Analysis on assigned insurers under the supervision of an Analyst Supervisor. The Financial Analyst reviews annual and quarterly insurer financial statements and all related supplemental regulatory filings to assess and monitor the current financial condition and prospective financial solvency of insurance companies.

Senior Financial Analyst
Senior Financial Analysts are responsible for conducting Risk-Focused Financial Analysis on assigned insurers under the supervision of the Supervising Analyst. The Senior Financial Analyst reviews annual and quarterly insurer financial statements and all related supplemental regulatory filings to assess and monitor the current financial condition and prospective financial solvency of more complex and higher priority insurance companies. Senior Financial Analysts may also be asked to provide guidance, support and training to Financial Analysts.

Supervising & Assistant Chief Analyst
A Supervising or Assistant Chief Analyst is responsible for supervising the Financial Analysts and Senior Financial Analysts conducting Risk-Focused Financial Analysis on assigned insurers. This position provides input on technical matters, acts as a reviewer of the work performed by the Financial Analysts and Senior Financial Analysts and ensures that analyst work is an appropriate execution of the Risk-Focused Analysis approach.

Chief Analyst
This position is responsible for overall staff performance & development and should serve as the department’s main point of contact for analysis and ongoing monitoring of regulated entities. This position should oversee company assignments and priority ratings. This position should work under the general direction of a Commissioner or Deputy Commissioner and should oversee a consistent Risk-Focused Financial Analysis process across the Department.
Use of Compensation Salary Tables:
The compensation salary tables included below generally require certain adjustments before being applied by a State or Jurisdiction in setting analyst compensation. Factors to consider in setting analyst compensation include:

- Specific job responsibilities and expectations
- Location or market based adjustments
- Complexity of industry
- Specialization requirements (e.g. Reinsurance/Investment/IT Specialist)
- Travel expectations (including consideration of amount of travel and in consideration of work from home or other similar arrangements)
- Retirement and other benefits (not included in table)

<table>
<thead>
<tr>
<th>Position</th>
<th>Salary Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Analyst</td>
<td>$46,000 – $75,000</td>
</tr>
<tr>
<td>Senior Financial Analyst</td>
<td>$57,000 – $90,000</td>
</tr>
<tr>
<td>Supervisor/Assistant Chief Analyst</td>
<td>$80,000 – $130,000</td>
</tr>
<tr>
<td>Chief Analyst</td>
<td>$92,000 – $150,000</td>
</tr>
</tbody>
</table>

Note: The data above is based on a national average and is not appropriate to be applied to all locations without consideration of market and cost of living variances.
Discussion of Analysis for Intercompany Pooling Arrangements

Intercompany pooling arrangements involve the establishment of a quota share reinsurance agreement under which pooled business is ceded to a lead entity and then retroceded back to pool participants in accordance with stipulated shares (if any). This generally results in pool participants sharing exposure to the various insurance risks ceded into the pool. Because of this structure, financial analysts may be able to gain efficiencies by conducting and documenting the analysis of insurance risks associated with the pooled business on a combined basis and then leveraging the results of that work to complete legal entity analysis. For example, in situations where the majority of the group’s writings are ceded into the intercompany pool and there are few unique legal entity risks, the analyst may choose to create and maintain a combined risk assessment and/or IPS for all of the legal entities participating in the pool (if domiciled in the same state). In other situations, it may be more appropriate to maintain separate risk assessment worksheets and/or IPSs for each legal entity, but to reference work completed in the pool lead’s documentation or include substantially similar information in each legal entity’s risk assessment worksheet and IPS.

While insurers participating in intercompany pooling arrangements often share exposure to pooled insurance risks, differences in the overall risk exposure of participants may arise due to a number of factors including, but not limited to, the following:

- Surplus/RBC levels
- Balance sheet composition
- Pool participation percentages
- The timing of pool participation
- Premiums not ceded to the pool
- Reinsurance arrangements outside of the pool (e.g., facultative placement prior to cessions to the pool lead).
- Current or legacy risks (e.g., asbestos exposure) disclosed within the financial statement

Regardless of the method utilized to assess and document the analysis of the pool, the financial analyst should ensure that all significant, unique exposures of each pool participant are separately assessed and addressed within analysis documentation.

If pool participants are domiciled in various states, communication and coordination across states is strongly encouraged to achieve efficiencies in analysis. For example, it might be appropriate for the domestic state of the pool lead to complete the analysis of the pooled insurance risks early in the analysis cycle to enable other states with domestics in the pool to leverage the completed work.

In situations where an insurer cedes business to an intercompany pool, but does not participate in retrocession, the analysis of the pooled business should be obtained/reviewed to evaluate reinsurance credit risk. If the pool is troubled or potentially troubled, this may require more in-depth analysis to evaluate the potential impact of claims associated with the insurer’s direct writings not being covered by the pool.
VI.C. Group-Wide Supervision – Insurance Holding Company System Analysis Guidance (Lead State)

Lead State Holding Company Analysis – Process and Procedures

In completing the process of holding company analysis and developing a GPS, analysts are encouraged to customize the work performed and documented at a level commensurate with the nature and complexity of the group. Analysts may elect to limit the amount of analysis and supporting documentation performed outside of the GPS and/or eliminate certain sections of the GPS to promote efficiencies in conducting analysis work. Conversely, analysts working on very complex groups may elect to perform additional analysis (including those listed in the Additional Procedures on Key Risk Areas – Insurance Holding Company System) as well as provide additional documentation within the GPS and/or in supporting analysis workpapers. Keep in mind, the GPS should provide sufficient information about the group and its risks to enable other state, federal and international regulators to understand the group risks that may be relevant to their regulated legal entities.

If the domestic insurers in a holding company system consist of only run-off companies, the domestic regulator, at its discretion, should determine the value, if any, of performing a holding company system analysis. If it is determined that a holding company system analysis would be of no added value, this determination should be documented.

If the ultimate controlling person of the holding company is an insurance company, the analyst may consider preparing one document that includes elements of the IPS and the GPS, in order to promote efficiency in the overall analysis. For example, in addition to the standard elements of the IPS, such a hybrid document may also include sections such as corporate governance, ERM/ORSA, non-insurance affiliates/subsidiaries, etc.

As the lead state, the department should coordinate the ongoing surveillance of companies within the group with input from other affected states (with the understanding that the domestic state has the ultimate authority over the regulation of the domestic insurer under its jurisdiction). The documentation contained in the GPS is considered to be part of the workpapers, and represents proprietary, confidential information that is not intended to be distributed to individuals other than state regulators.

Confidentiality of Information: Financial analysts are reminded that information collected from the group, generally under the authority of their holding company statutes or their more specific statutes dealing with the ORSA Summary Report may be confidential by law. Accordingly, before sharing statutorily confidential information with other jurisdictions, regulators will need to review their own statutory authority to do so, which generally requires that the receiving jurisdiction is able to maintain also the confidentiality of such information.

UCP is an Insurer: If the ultimate controlling person (UCP) of the holding company is a U.S. domiciled insurance company with a cocode, the analyst may consider preparing one document that includes all the elements of the IPS and the GPS, in order to promote efficiency in the overall analysis. For example, in addition to the standard elements of the IPS, the document may also include sections such as corporate governance, ERM/ORSA, non-insurance affiliates/subsidiaries, etc. In addition, depending on the nature and extent of risks, the analyst should consider whether it is more appropriate to assess and document certain risk exposures from a group or legal entity perspective (or both) in the IPS/GPS. In all cases, the analyst is expected to document and complete both the legal entity and holding company analysis work in accordance with timeliness expectations. Therefore, the analyst and supervisor should demonstrate that the combined IPS/GPS is updated for both the results of legal entity analysis and holding company analysis through separate signoffs at different dates, as necessary.
V.A. Domestic and/or Non-Lead State Analysis – Holding Company Procedures (Non-Lead State)

Special Notes: The following procedures are intended to be performed by non-lead domestic states to develop and document an analysis of the impact of the holding company system on the domestic insurer. Form procedures do not supersede state regulation, but are merely additional guidance an analyst may consider useful.

Name of Holding Company System ___________________
Name of Lead State ___________________

Compliance Assessment - Form B (and C)

1. Review the registration statement to determine if it was filed in accordance with the state’s Insurance Holding Company System Regulatory Act\(^1\) and if it included the required current information. The information provided should include a description of the transaction or agreement, including, at least, the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to the transaction, and the relationship of the affiliated parties to the registrant. (LG)

2. Did each domiciled registered insurers properly report dividends and other distributions to shareholders in accordance with the following Model #440 requirements? (LG)

3. If dividends and other distributions to shareholders were considered extraordinary, did the transaction receive proper regulatory approval? (LG)

4. Did the insurer receive proper prior regulatory approval for any transaction, which occurred during the last calendar year involving the insurer and others in its holding company system that required such prior regulatory approval? (LG)

Assess the Impact of the Holding Company Group on the Domestic Insurer

Assessment of Group Profile Summary from the Lead State

5. Obtain a copy of the lead state’s Group Profile Summary (GPS).

6. Consider the GPS’s branded risk assessment in determining the impact of the holding company on the domestic insurer.

7. Review the conclusion and supervisory plan of the GPS. Did the lead state identify any holding company risks impacting the domestic insurers’ in the group and/or supervisory plans that impact your state’s domestic insurer?

8. Consider the nature of the domestic insurer(s)’ interdependence on the holding company group or affiliated entities for business operations or financial stability (e.g., employees, services provided, reinsurance and/or capital support in the near term). (OP, CR, ST)

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\(^1\) The list provided is based on the NAIC Insurance Holding Company System Regulatory Act (#440); however analysts should review the Form B compliance in relation to their own state’s requirements.
9. Consider the level of reputational risk that the holding company (as a group) poses to the domestic insurer(s). (RP)

10. Determine if income of the domestic insurer(s) is being used to service holding company debt or other corporate initiatives (e.g., acquisitions). (OP, ST)

Assessment of Form B (and C)

11. Based upon a review of the registration statement, were any significant and/or unusual items noted, such as, but not limited to, the following?
   a. Person(s) holding 10% or more of any class of voting security who also have a history of transacting business of any kind directly or indirectly with the insurer. (OP, ST)
   b. Biographical information about directors or officers, which may elevate concerns such as convictions of crimes. (OP, ST)
   c. Any litigation or administrative proceeding involving the ultimate controlling entity or any of its directors and officers, such as criminal prosecutions or proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company, such as bankruptcy, receivership, or other corporate reorganization. (LG)
   d. The absence of an affirmative statement that transactions entered into since the filing of the prior year’s annual registration statement are not part of a plan or series of like transactions to avoid statutory threshold amounts. (OP, ST)

Assessment of Affiliated Risks on the Domestic Insurer

12. Were any material deficiencies or risks noted during the annual review of the domestic insurer’s Notes to Financial Statements, Interrogatories, Schedule Y – Part 2, Holding Company, Forms B & C, or recent examination reports with respect to affiliated transactions? (CR, LQ, OP, ST)
   a. Management agreements
   b. Third-party administrative agreements
   c. Managing general agent agreements
   d. Investment management pools
   e. Reinsurance agreements and pools
   f. Consolidated tax sharing agreements
   g. Other

13. If any of the following forms have been filed with the domestic regulator since the last review, indicate if risks or concerns were noted in any of the reviews of these forms.
   a. Form A (Acquisition of Control or Merger)
   b. Form D (Prior Notice of a Transaction)
   c. Form E (Pre-Acquisition Notification) or Other Required Information
   d. Extraordinary Dividend/Distribution
V.A. Domestic and/or Non-Lead State Analysis – Holding Company Procedures (Non-Lead State)

**Assessment of Form F - Enterprise Risk Statement**

14. Obtain either the Form F from the lead state, if available, and/or the lead state’s analysis of the Form F if it addresses the impact of the holding company on each your state’s domestic insurer(s).

15. Based on the analyst’s review of Form F and/or the lead state’s analysis of the Form F, and any additional information related to enterprise risk available (e.g., Form B, other filings), document any material concerns regarding enterprise risk that could impact the financial condition of the domestic insurer.

16. Do any of the risks identified pose an immediate material risk to the insurer’s policyholder surplus or risk-based capital position, insurance operations (e.g., changes in writings, licensure, and organizational structure), balance sheet, leverage or liquidity?

**Assessment of Own Risk and Solvency Assessment (ORSA), if applicable**

17. Obtain the lead state’s analysis of the ORSA Summary Report (see section VI.F-Own Risk and Solvency Assessment Procedures).

18. Did the lead state document in its analysis any risks or concerns that in its opinion have an impact on the overall financial condition of the insurance holding company system? If so, do any of the risks or concerns identified pose a material risk to the domestic insurer?

**Assessment of Corporate Governance Annual Disclosure (CGAD), if applicable**

19. Obtain the lead state’s analysis of the CGAD and determine if it addresses corporate governance policies and practices of the group applicable to your state’s domestic insurer(s).

a. If the CGAD analysis does not address corporate governance policies and practices of the group applicable to the non-lead states’ domestic insurer, request the CGAD from the insurer.

20. Based on the analyst’s review of the CGAD or the lead state’s analysis of the CGAD, and any additional available information related to corporate governance, document any material concerns regarding corporate governance impacting the domestic insurer.

21. Do any of the concerns identified pose an immediate material risk to the domestic insurer’s financial condition (e.g., operations, policyholder surplus or capital position)?

**Communication & Follow-Up with the Lead State**

- Notify the lead state of any additional material events or concerns applicable to the domestic insurer, or the group as a whole, that the lead state may not otherwise be aware of, and that should be considered in the evaluation of the overall financial condition of the holding company system.

- If any material risks or events were identified during your holding company analysis that were not discussed in the lead state’s holding company analysis, communicate those findings to the lead state.
V.A. Domestic and/or Non-Lead State Analysis – Holding Company Procedures (Non-Lead State)

Update the Insurer Profile Summary

Update the Insurer Profile Summary of the domestic insurer with the summary and conclusion of the impact of the holding company system on the domestic insurer based on the above analysis performed.

<table>
<thead>
<tr>
<th>Analyst:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor Review:</td>
<td>Date:</td>
</tr>
<tr>
<td>Supervisor Comments:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

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Non-Lead State Holding Company System Analysis Procedures

Refer to section VI.C. Group-Wide Supervision - Insurance Holding Company System Analysis Guidance (Lead State) for guidance on the Lead State’s holding company analysis procedures.

Procedures #5-17 assist the analyst in assessing the impact of the holding company system on the domestic insurer. This includes five primary segments of the analysis as follows.

- **#5-10** Assessment of the Group Profile Summary (GPS) from the Lead State: If the Lead State is not your state, the Lead State should provide a GPS to the non-lead states in the group by Oct. 31. Using the GPS consider the risks identified and assessed by the Lead State to determine any material impacts on the branded risks of the domestic insurer, the interdependence of the holding company and its affiliated entities, including the domestic insurer, dividend obligations of the domestic insurer to service holding company debt or fund other holding company initiatives, and the holding company’s reputation.

- **#11** Assessment of Form B (and C): Model #440 defines insurance holding companies and the related registration, disclosure, and approval requirements. Form B is the insurance holding company system annual registration statement. Model #440 requires every insurer, which is a member of an insurance holding company system, to register by filing a Form B within 15 days after it becomes subject to registration, and annually thereafter. Any non-domiciliary state may require any insurer that is authorized to do business in the state, which is a member of a holding company system, and which is not subject to registration in its state of domicile, to furnish a copy of the registration statement. An insurance holding company system consists of two or more affiliated individuals, one or more of which is an insurer. An affiliate is an entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, another entity. Control is presumed to exist when an entity or person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies, representing 10 percent or more of the voting securities.

- **#12-13** Assessment of Affiliated Risks on the Domestic Insurer: Affiliated risks may exist due to interdependence of the holding company and its affiliated entities through affiliated transactions. Consider also the guidance included in the Operational Risk Analyst Reference Guide as well as guidance in this section regarding supplemental form filings for review of affiliated agreements.

- **#14-165** Assessment of Form F – Enterprise Risk Statement: The purpose of the Form F is to identify if there is any contagion risk within the group, and domestic states should not be discouraged from reviewing such information because ultimately they are required to relate the financial condition of the group to their domestic state. The Form F must be reviewed by the lead state but other domestic states are also expected to review it. To the extent the Lead State’s analysis of Form F assesses the impact of any contagion risk of the group on the non-lead state’s domestic insurer, that analysis may be leveraged by the non-lead state to reduce the analysis work of the non-lead state. If the Lead State’s analysis of Form F does not assess the impact of the group on the non-lead state’s domestic insurer, consider a review as noted in Procedures #15 and #16, or similar to the procedures in section VI.G. Group-Wide Supervision - Form F - Enterprise Risk Report Procedures for reviewing Form F.
V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

- **#176-187 Assessment of Own Risk and Solvency Assessment (ORSA):** If the Holding Company files an ORSA Summary Report, it is the responsibility of the Lead State to review and perform analysis of the report. At the completion of this review, the lead state should prepare a thorough summary of its review, which would include an initial assessment of each of the three sections. The lead state should also consider and include key information to share with other domestic states that are expected to place significant reliance on the lead state’s review. Non-lead states are not expected to perform an in-depth review of the ORSA, but instead rely on the review completed by the lead state. The non-lead state’s review of an ORSA should be performed only for the purpose of having a general understanding of the work performed by the lead state, and to understand the risks identified and monitored at the group-level so the non-lead state may better monitor and communicate to the lead state when its legal entity could affect the group. Any concerns or questions related to information in the ORSA or group risks should be directed to the lead state.

- **#19-21 Assessment of Corporate Governance Annual Disclosure (CGAD):** Analysis of CGAD only applies where states have enacted such legislation as that in the Corporate Governance Annual Disclosure Model Act (#305) and Corporate Governance Annual Disclosure Model Regulation (#306). The purpose of the CGAD is to provide a summary of an insurer or insurance group’s corporate governance structure, policies and practices to permit the regulator to gain and maintain an understanding of the insurer’s corporate governance framework. The CGAD must be filed to the lead state if on a group basis or the domestic state if on a legal entity basis, but other domestic states are may request the filing. To the extent the Lead State’s analysis of a group CGAD assesses the impact of corporate governance practices and procedures of the group on the non-lead state’s domestic insurer, that analysis may be leveraged by the non-lead state to reduce the analysis work of the non-lead state. If the Lead State’s analysis of CGAD does not assess the impact of the group on the non-lead state’s domestic insurer, review the filing to identify and assess any material concerns and determine if any material immediate risks impact the domestic insurer’s financial condition.

TEXT NOT SHOWN TO CONSERVE SPACE

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VI.D. Group-Wide Supervision – Corporate Governance Disclosure Procedures

Special Note: The following procedures do not supersede state regulation, but are merely additional guidance an analyst may consider useful.

The Corporate Governance Annual Disclosure Model Act (#305) and Corporate Governance Annual Disclosure Model Regulation (#306) provide a summary of an insurer or insurance group’s corporate governance structure, policies and practices to permit the Commissioner to gain and maintain an understanding of the insurer’s corporate governance framework. As of the date of this publication, most states had not adopted such legislation. The following procedures are applicable to only those states that have adopted such legislation.

All other states should instead consider completion of applicable questions within the Operational and Strategic risk repositories of this Handbook based upon the level of concern an analyst may have with management performance and the driving forces behind operations. The risk repositories may also be used by an analyst of a state that has obtained the disclosure for an insurer or insurance group subject to the aforementioned corporate governance disclosure. However, the analyst should avoid duplicate information requests.

Introduction

Model #305 and #306 requires an insurer, or an insurance group, to file a summary of an insurer or insurance group’s corporate governance structure, policies and practices with the commissioner by June 1 of each calendar year. Model #305 allows the information to be at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. Because most corporate governance is driven at a controlling or intermediate holding company level, this guidance is contained within this section dealing with group supervision. Although by inclusion in this section, reviewing the corporate governance disclosure of a group is a responsibility of the lead state, the approach on this is different from that taken with the Own Risk Solvency and Analysis (ORSA).

This is because it’s common for most groups to have different layers of governance that is important in achieving the objectives of the group. More specifically, most groups have some level of governance at the individual legal entity level. However, because it is common for legal entity governance to be a less significant aspect of the governance objectives, even those companies that incorporate governance at the individual legal entity level are likely to include materially less documentation on such, may instead summarize such processes and list those entities for which they exist.

Non-Lead State Reliance on the Lead State Analysis of Corporate Governance Annual Disclosure:

Because Model #305 allows the filing to be made with the lead state, however, non-lead domestic states may request the CGAD filing from the insurer. Because the filing may be made on a group basis or legal entity basis, it may contain group information that applies to all insurers within the group or it may contain information applicable to a specific legal entity. It may be necessary for the lead state to share the filing with another state that has adopted a substantially similar law including similar confidentiality requirements. Alternatively, or in addition, it may be necessary or acceptable for the lead state to share its work papers with another state, related to such filing, provided such information is shared in accordance with the confidentiality provisions of Model #305. This is because similar to other solvency regulation models, Model #305 contemplates both off-site and on-site examination of such information. The Lead State can share the analysis of the filing through NAIC tools (i.e., iSite+ Regulator File Sharing System) or other means deemed appropriate. Before a non-lead states requests the CGAD filing or conducts a full review of CGAD to determine its impact on their domestic insurers, non-lead domestic states should consider obtaining and reviewing the Lead State’s analysis of CGAD to reduce duplication of analysis efforts.
VI.D. Group-Wide Supervision – Corporate Governance Disclosure Procedures

To the extent the Lead State’s analysis of the Corporate Governance Annual Disclosure (CGAD) addresses policies and practices of the group applicable to the non-lead state’s domestic insurer, that analysis may be leveraged by the non-lead state to reduce the analysis work of the non-lead state. If the Lead State’s analysis of CGAD does not assess the impact on the non-lead state’s domestic insurer or the CGAD is on a legal entity basis, the non-lead domestic state should consider a review of CGAD. Analysis steps are included in the non-Lead State analysis procedures.

Procedures #1 - 2 assist the analyst in reviewing the Corporate Governance disclosure for completeness and help guide the analyst through each of the major items of information required by Model #306.

Procedures #3 - 5 assist the analyst in summarizing any concerns relative to the insurer or insurance group’s corporate governance and its impact.

***************************TEXT NOT SHOWN TO CONSERVE SPACE*******************************

Form F-Enterprise Risk Report

The 2010 revisions to Model #440 and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) introduced a new filing requirement for a Form F. The Form F requires the ultimate controlling person to identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The Form F may be completed using information contained in the financial statement, annual report, proxy statement, statement filed with a governmental authority, or other documents if such information meets the disclosure requirements. Form F is focused on disclosing the enterprise risk associated with the entire insurance holding company system including non-regulated entities. The Form F is filed with the lead state commissioner of the insurance holding company system for every insurer subject to registration under Model #440. Adoption of the applicable Form F and related confidentiality provisions outlined in the 2010 revisions to Model #440 is required for a state to be designated the lead state for Form F filings. Lead states and other domestic states receiving and sharing the Form F must have in place confidentiality agreements as prescribed in Model #440.

Non-Lead State Reliance on the Lead State Analysis of Form F:

Although by inclusion in this section, reviewing the group Form F report is a responsibility of the lead state, the approach on this is different from that taken with the ORSA. Generally speaking, a non-lead state should not review the ORSA with the same level of depth as the lead state. However, that same approach is not encouraged with respect to the Form F. The entire purpose of the Form F is to identify if there is any contagion risk within the group, and domestic states should not be discouraged from reviewing such information because ultimately they are required to relate the financial condition of the group to their domestic state. Most believe that the ORSA is much more detailed and less related to contagion as it is the group’s actual risk management processes used to mitigate risk.

The Form F must be reviewed by the lead state and significant findings incorporated into the GPS. However, other domestic states are also expected to review the Form F in order to assess the impact of the group on their domestic insurers. One exception for non-lead states should be noted. To the extent the Lead State’s analysis of Form F assesses the impact of any contagion risk of the group on the non-lead state’s domestic insurer, that analysis may be leveraged by the non-lead state to reduce the analysis work of the non-lead state. If the Lead State’s analysis of Form F does not assess the impact of the group on the non-lead state’s domestic insurer, the non-lead domestic state should review Form F. The Lead State can share the Form F and its analysis through NAIC tools (Form F Sharing Tool for the filings and the iSite+ Regulator File Sharing System for the analysis). Analysis steps are included in the non-Lead State analysis procedures with that in mind. To reduce duplication, domestic states should consider obtaining and reviewing the Lead State’s analysis of Form F before determining if a full review of the filing is necessary to determine its impact on their domestic insurers.

NAIC Enterprise Risk Report (Form F) Implementation Guide

In March 2018, the Group Solvency Issues (E) Working Group adopted the NAIC Enterprise Risk Report (Form F) Implementation Guide, which is located at:

https://www.naic.org/documents/committees_e_isftf_group_solvency_related_form_f_guide.pdf?97

As outlined in the Guide, it is intended to assist insurers and regulators in maximizing the usefulness of the Form F by proposing best practices for consideration in preparing and reviewing filings. Therefore, while the Guide does not constitute authoritative guidance for information to be included in a Form F filing, filers are requested to consider the best practices outlined within the Guide when preparing their Form F filing. By adhering to the best practices outlined within the Guide, registrants will be able to reduce the extent of regulator follow-up and correspondence necessary to utilize the information provided, which should lead to a more effective and efficient process. The regulators’ goal in developing this document was to provide some consistency and uniformity across states in reviewing and utilizing information obtained through the Form F. Therefore, it is recommended that states utilize the best practices outlined in the Guide to support their review and feedback process.

**Procedures**

*Procedures #1 - 2* assist the analyst in reviewing the Form F filing for completeness and help guide the analyst through each of the major items of information required by Form F. The analyst should review Form F in conjunction with a review of Form B and should document any nondisclosure of information.

*Procedures #3 - 7* assist the analyst in evaluating the risks described within Form F. The analyst should consider whether any enterprise risks not reported in Form F exist, and for all risks identified both within Form F and by the analyst, the analyst should review information available and document any concerns. The analyst should also evaluate whether the risks identified result in an impact to the insurers financial condition (e.g., surplus, RBC, insurance operations, or balance sheet, leverage and liquidity).
Financial Analysis Research & Development (E) Working Group

Exposure Draft to Change Life IRIS Ratios No. 4, 10, and 12 for a 30-day Public Comment Period

Public Comment Period Ends August 26, 2019

Updates made since July 25, 2019 call:

1. A YRT Mortality Risk Only Column was added to page 6.1 so the columns were adjusted for Attachment A-2 and A-3.
2. The Group Credit Life Column from page 6.2 was moved from 10.E to 10.D to more accurately match prior year.

Recommendation to change three IRIS ratios due to Blanks changes beginning with the 2019 annual filings.

- **Attachment A-1** – Life IRIS Ratio 4 (Adequacy of Investment Income) change recommendation
- **Attachment A-2** – Life IRIS Ratio 10 (Change in Product Mix) change recommendation
- **Attachment A-3** – Life IRIS Ratio 12 (Change in Reserving) change recommendation

The 2019 Fraternal IRIS report will no longer be available, due to the removal of the Fraternal blanks, beginning with the 2019 filings. Fraternal societies will file on the Life blank beginning in 2019.
Life IRIS Ratio No. 4 (Adequacy of Investment Income)

Adequacy of Investment Income

\[ \text{Result} = \frac{A}{(B+C+D)} \times 100 \]

- If \((B+C+D)\) is zero, result is 999.
- If insurer has no beginning or ending reserves per page 7 of the annual financial statement and item B is zero, no result is calculated (NR).

A. Net Investment Income Page 4, Line 3, Column 1

B. Tabular Interest Involving Life or Disability Contingencies Page 7.1, Line 4, Column 1 + Page 7.2, Line 4, Column 1 + Page 7.3, Line 4, Column 1 + Page 7.4, Line 4, Column 1

C. Tabular Fund Interest on Accident and Health Contracts Page 14, Exhibit of Aggregate Reserve for A&H Contracts, Line 18, Column 1

D. Investment Earnings Credited to Deposit-Type Contract Accounts Page 15, Exhibit of Deposit-Type Contracts, Line 3, Column 1
## Life IRIS Ratio No. 10 (Change in Product Mix)

<table>
<thead>
<tr>
<th></th>
<th>CURRENT YEAR AMOUNT</th>
<th>CY % OF TOTAL</th>
<th>PRIOR YEAR AMOUNT</th>
<th>PY % OF TOTAL</th>
<th>COL (2) LESS COL (4)%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td></td>
</tr>
</tbody>
</table>

### Premiums & Annuity Considerations

**Page 6, Line 1**

A. Industrial Life, **Column 2**

B. Ordinary Life Ins., **Column 3**

C. Ind. Annuities, **Column 4**

D. Credit Life, **Column 6**

E. Group Life, **Column 7**

F. Group Annuities, **Column 8**

G. Group A&H, **Column 9**

H. Credit A&H, **Column 10**

I. Other A&H, **Column 11**

J. Total

K. Total of Ratio Column 5 Disregarding Sign

Result = \( \frac{K}{9} \) %

- If J for either current or prior year is zero or negative, no result is calculated (NR).
- Ratio is calculated as follows: First determine the percentage of premium from each product line for CY and PY. Next, determine the difference in the percentage of premium between the two years for each product line. Finally, the total of these differences, without regard to sign, is divided by the number of product lines to determine the change in the percentage of premium for the average product line.

### Current Year Amount (Col 1)

<table>
<thead>
<tr>
<th>A. Industrial Life</th>
<th>Page 6.1, Line 1, Col. 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Ordinary Life Ins.</td>
<td>Page 6.1, Line 1, Col. 3, 4, 5, 6, 7, 8, 9, 10, 12</td>
</tr>
<tr>
<td>C. Individual Annuities</td>
<td>Page 6.3, Line 1, Col. 1</td>
</tr>
<tr>
<td>D. Credit Life</td>
<td>Page 6.1, Line 1, Col. 11 + Page 6.2, Line 1, Col. 7</td>
</tr>
<tr>
<td>E. Group Life</td>
<td>Page 6.2, Line 1, Col. 2, 3, 4, 5, 6, 7, 8, 9</td>
</tr>
<tr>
<td>F. Group Annuities</td>
<td>Page 6.4, Line 1, Col. 1</td>
</tr>
<tr>
<td>G. Group A&amp;H</td>
<td>Page 6.5, Line 1, Col. 3</td>
</tr>
<tr>
<td>H. Credit A&amp;H</td>
<td>Page 6.5, Line 1, Col. 10</td>
</tr>
<tr>
<td>I. Other A&amp;H</td>
<td>Page 6.5, Line 1, Col. 2, 4, 5, 6, 7, 8, 9, 11, 12, 13</td>
</tr>
</tbody>
</table>

### Prior Year Amount (Col.2)

<table>
<thead>
<tr>
<th>A. Industrial Life</th>
<th>Page 6, Line 1, Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Ordinary Life Ins.</td>
<td>Page 6, Line 1, Column 3</td>
</tr>
<tr>
<td>C. Individual Annuities</td>
<td>Page 6, Line 1, Column 4</td>
</tr>
<tr>
<td>D. Credit Life</td>
<td>Page 6, Line 1, Column 6</td>
</tr>
<tr>
<td>E. Group Life</td>
<td>Page 6, Line 1, Column 7</td>
</tr>
<tr>
<td>F. Group Annuities</td>
<td>Page 6, Line 1, Column 8</td>
</tr>
<tr>
<td>G. Group A&amp;H</td>
<td>Page 6, Line 1, Column 9</td>
</tr>
<tr>
<td>H. Credit A&amp;H</td>
<td>Page 6, Line 1, Column 10</td>
</tr>
<tr>
<td>I. Other A&amp;H</td>
<td>Page 6, Line 1, Column 11</td>
</tr>
</tbody>
</table>
Financial Analysis Solvency Tools (E) Working Group  
Sept. 4, 2019 Conference Call

Life IRIS Ratio No. 12 (Change in Reserving)

Result = \[
\frac{(\text{CY} \times (A+B))}{(\text{CY} \times (C+D+E+F))} - \frac{(\text{PY} \times (A+B))}{(\text{PY} \times (C+D+E+F))}\] \times 100

- If \((A+B)\) and \((C+D+E+F)\) for current or prior year are both zero or negative, \(\frac{(A+B)}{(C+D+E+F)} = 0\) for that year.
- If \((A+B)\) is positive and \((C+D+E+F)\) is zero or negative for current or prior year, \(\frac{(A+B)}{(C+D+E+F)} = 100\%\) for that year.
- This ratio represents the number of percentage points of difference between the reserving ratio for current and prior years. For each of these years, the reserving ratio is equal to the aggregate increase in reserves for individual life insurance taken as a percentage of renewal and single premiums for individual life insurance.
Financial Analysis Solvency Tools (E) Working Group
E-Vote
October 15, 2019

The Financial Analysis Solvency Tools (E) Working Group of the Examination Oversight (E) Task Force conducted an e-vote that concluded Oct. 15, 2019. The following Working Group members participated: Patricia Gosselin, Vice Chair (NH); Kurt Regner (AZ); Emma Hirschhorn (CA); Lynn Reed (CT); N. Kevin Brown (DC); Eric Moser (IL); Debbie Doggett (MO); John Sirovetz (NJ); Tim Biler (OH); Ryan Keeling (OR); Kimberly Rankin (PA); Jack Broccoli (RI); Amy Garcia (TX); and Kristin Forsberg (WI).

1. **Adopted Exposed Revisions to the 2020 Financial Analysis Handbook**

The Working Group conducted an e-vote to consider adoption of exposed revisions (Attachment Three-A) to the 2020

A majority of the Working Group members voted in favor of adopting these revisions. The motion passed.

Having no further business, the Financial Analysis Solvency Tools (E) Working Group adjourned.
### III.B.8.a. Reserving Risk Repository – P/C Annual

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#### Exposure to Discounted Losses and LAE Reserves

5. Determine whether loss and LAE reserves have been discounted and, if so, whether concerns exist regarding the loss reserve discounting.

<table>
<thead>
<tr>
<th>Other Risks</th>
<th>Benchmark</th>
<th>Result</th>
<th>Outside Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Time value of money discount on unpaid losses and LAE</td>
<td>&gt;0</td>
<td>[Data]</td>
<td>[Data]</td>
</tr>
<tr>
<td>b. Time value of money discount on unpaid losses and LAE to surplus</td>
<td>&gt;5%</td>
<td>[Data]</td>
<td>[Data]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Review the Annual Financial Statement, Notes to Financial Statements, Note #32, consider the following:</td>
</tr>
<tr>
<td>• The lines of business with discounted reserves</td>
</tr>
<tr>
<td>• The interest rates used to discount reserves, including the basis indicated for using those rates</td>
</tr>
<tr>
<td>• The amount of discount in relation to surplus</td>
</tr>
<tr>
<td>• If the interest rates used to discount the prior accident years’ reserves have changed from the previous Annual Financial Statement, document the change in discounted reserves due to the change in interest rate assumptions and the effect on surplus</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>d. Determine whether the interest rates used to discount reserves appear to be reasonable considering the insurer’s investment yield and the insurer’s comments in Note #32 regarding the basis for the interest rates used.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>e. If the insurer is using discounting procedures that depart from the guidance in <em>Statement of Statutory Accounting Principles</em> (SSAP) No. 65—<em>Property and Casualty Contracts</em>, ensure that the insurer received a permitted practice to do so. (The insurer may describe permitted practices in the Annual Financial Statement, Notes to Financial Statements, Note #1. The NAIC’s iSite+ also has a Permitted Practices for Accounting report for each insurer in the Financial Analysis/Examination report category.)</td>
</tr>
</tbody>
</table>
Exposure to Salvage and Subrogation

6. Determine whether unpaid losses and LAE are reduced for anticipated salvage and subrogation recoveries and whether concerns exist regarding the use of anticipated salvage and subrogation recoveries in the development of unpaid losses and LAE.

<table>
<thead>
<tr>
<th>a. Anticipated salvage and subrogation</th>
<th>Other Risks</th>
<th>Benchmark</th>
<th>Result</th>
<th>Outside Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;0</td>
<td>[Data]</td>
<td>[Data]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Anticipated salvage and subrogation to surplus</td>
<td>&gt;10%</td>
<td>[Data]</td>
<td>[Data]</td>
<td></td>
</tr>
</tbody>
</table>

| c. Review the Annual Financial Statement, Schedule P, Part 1 to determine which lines of business have unpaid losses and LAE that have been reduced due to consideration of anticipated salvage and subrogation. | Other Risks |
| d. For the more significant lines of business, review Annual Financial Statement, Schedule P – Part 1 and compare the ratio of anticipated salvage and subrogation to unpaid losses and LAE (gross of anticipated salvage and subrogation) to the ratio of salvage and subrogation received to claims paid (gross of salvage and subrogation received) to determine the reasonableness of anticipated salvage and subrogation. | Other Risks |

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DETAIL ELIMINATED TO CONSERVE SPACE-------------------------

w:\national meetings\2019\fall\examo\_draft minutes\3a - attachment 1.docx
### Uncollected Premium and Agents’ Balances

12. Review and assess uncollected premiums and the agents’ balances for potential collectability issues.

<table>
<thead>
<tr>
<th>Other Risks</th>
<th>Benchmark</th>
<th>Result</th>
<th>Outside Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Ratio of uncollected premiums and agents’ balances to surplus [IRIS ratio #10]</td>
<td>LQ</td>
<td>&gt;2040%</td>
<td>[Data]</td>
</tr>
<tr>
<td>b. Change in uncollected premiums and agents’ balances from the prior year</td>
<td></td>
<td>&gt;25% or &lt;-25%</td>
<td>[Data]</td>
</tr>
<tr>
<td>c. Ratio of uncollected premiums to net premium income</td>
<td>LQ</td>
<td>&gt;5%</td>
<td>[Data]</td>
</tr>
<tr>
<td>d. Ratio of non-admitted uncollected premiums to total uncollected premiums</td>
<td>LQ</td>
<td>&gt;10%</td>
<td>[Data]</td>
</tr>
<tr>
<td>e. Net agents’ balances and premium balances charged off and recovered to total uncollected agents’ balances and premium balances</td>
<td></td>
<td>&gt;5%</td>
<td>[Data]</td>
</tr>
</tbody>
</table>

f. Review amounts non-admitted and compare to prior years.

g. With respect to agents’ balances, verify the creditworthiness of the agent.
III.B.1.a. Credit Risk Repository – P/C Quarterly

--- DETAIL ELIMINATED TO CONSERVE SPACE ---

Reinsurance Recoverable and Reinsurer Credit Quality

3. Determine whether amounts recoverable (both paid and unpaid losses on claims and reserve credits) or amounts receivable from reinsurers are significant and collectable.

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Benchmark</th>
<th>Result</th>
<th>Outside Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Reinsurance amounts recoverable on paid losses to surplus</td>
<td>LQ</td>
<td>&gt;1020%</td>
<td>[Data]</td>
</tr>
<tr>
<td>b. Change in reinsurance recoverables, where recoverables are greater than 1020% of surplus</td>
<td>LQ</td>
<td>&gt;10% or &lt;-10% from the prior quarter OR &gt;35% or &lt;-35% from the prior year-end</td>
<td>[Data]</td>
</tr>
<tr>
<td>c. Provision for Reinsurance to surplus</td>
<td></td>
<td>&gt;10%</td>
<td>[Data]</td>
</tr>
</tbody>
</table>

--- DETAIL ELIMINATED TO CONSERVE SPACE ---

Uncollected Premium and Agents’ Balances

5. Review and assess uncollected premiums and the agents’ balances for potential collectability issues.

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Benchmark</th>
<th>Result</th>
<th>Outside Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Ratio of uncollected premiums and the agents’ balances to surplus</td>
<td>LQ</td>
<td>&gt;2040%</td>
<td>[Data]</td>
</tr>
<tr>
<td>b. Change in uncollected premiums and the agents’ balances from the prior year-end</td>
<td>LQ</td>
<td>&gt;25% or &lt;-25%</td>
<td>[Data]</td>
</tr>
<tr>
<td>c. Change in non-admitted uncollected premiums from the prior year-end</td>
<td>LQ</td>
<td>&gt;25% or &lt;-25%</td>
<td>[Data]</td>
</tr>
</tbody>
</table>
III.B.9.a. Strategic Risk Repository – Annual (All Statement Types)

---DETAIL ELIMINATED TO CONSERVE SPACE---

**Capital Adequacy**

10. Evaluate the adequacy of the insurer’s risk-based capital (RBC) position in light of its business/strategic plans and risk exposures.

<table>
<thead>
<tr>
<th>Other Risks</th>
<th>Benchmark</th>
<th>Result</th>
<th>Outside Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. RBC ratio</td>
<td>OP</td>
<td>&lt;250300%</td>
<td>[Data]</td>
</tr>
<tr>
<td>b. If RBC ratio &lt;300350%, has there been a significant change from prior year?</td>
<td>OP</td>
<td>&gt;30 pts or &lt;-30 pts</td>
<td>[Data]</td>
</tr>
<tr>
<td>c. Change in Total Adjusted Capital from prior year</td>
<td>OP</td>
<td>&lt;10%</td>
<td>[Data]</td>
</tr>
<tr>
<td>d. Change in Authorized Control Level from prior year</td>
<td>OP</td>
<td>&gt;10%</td>
<td>[Data]</td>
</tr>
<tr>
<td>e. RBC trend test triggered</td>
<td>OP</td>
<td>=YES</td>
<td>[Data]</td>
</tr>
<tr>
<td>f. Decrease in RBC over last two years</td>
<td>OP</td>
<td>=YES</td>
<td>[Data]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>g. If there has been a downward trend in RBC over the last two years, document the cause(s) of the decline. If a broader trend (e.g., five or more years decline) has been noted, document how the insurer plans to mitigate this continued decline.</td>
</tr>
<tr>
<td>h. If the insurer reported an increase in Total Adjusted Capital due to special surplus or capital infusions, etc., document the source and plan for continued support.</td>
</tr>
<tr>
<td>i. Review the RBC risk component(s) and document the underlying causes of any significant changes.</td>
</tr>
<tr>
<td>j. If the insurer triggered the RBC Trend Test review and document the reason(s).</td>
</tr>
<tr>
<td>k. If the insurer has triggered an RBC Action Level event and if authorized by state statute, obtain and review a copy of the insurer’s RBC plan and monitor the overall progress.</td>
</tr>
</tbody>
</table>

---DETAIL ELIMINATED TO CONSERVE SPACE---

Actuarial Opinion – Assurance That an Actuarial Report Has Been Prepared, Signature, Requirements for Actuarial Report

9. Determine whether the Appointed Actuary indicates that an Actuarial Report has been prepared that supports the findings expressed in the Actuarial Opinion. Determine whether the Actuarial Opinion has been signed according to the Instructions. If the Actuarial Report is requested, determine if the report contains the required elements.

<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The Appointed Actuary indicates that an Actuarial Report and underlying actuarial work papers supporting the Actuarial Opinion will be maintained at the company and available for regulatory examination for seven years.</td>
</tr>
<tr>
<td>b. The Actuarial Opinion concludes with the signature, the printed name, the employer’s name, the address, the telephone number and the email address of the Appointed Actuary, as well as the date the Actuarial Opinion was rendered.</td>
</tr>
<tr>
<td>c. Copy of the Actuarial Report requested.</td>
</tr>
<tr>
<td>d. Requirements of the Actuarial Report (to be verified by analyst if report is requested):</td>
</tr>
<tr>
<td>i. The Actuarial Report is signed and dated by the Appointed Actuary.</td>
</tr>
<tr>
<td>ii. The Actuarial Report is consistent with Actuarial Standard of Practice (ASOP) No. 41, <em>Actuarial Communications</em> and includes:</td>
</tr>
</tbody>
</table>
<pre><code>| • Narrative component that provides sufficient detail to clearly explain to company management, the board of directors, the regulator, or other authority the findings, recommendations and conclusions, as well as their significance. |
| • Technical component that provides sufficient documentation and disclosures for another actuary practicing in the same field to evaluate the work and shows the analysis from the basic data (e.g., loss triangles) to the conclusions. |
</code></pre>

### iii. Actuarial report includes required elements from the Instructions:

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>• Description of the Appointed Actuary’s relationship to the company with clear presentation of the Appointed Actuary’s role in advising the board of directors and/or management regarding the carried reserves. The actuarial report should identify how and when the Appointed Actuary presents the analysis to the board of directors.</td>
<td></td>
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<tr>
<td>• An exhibit that ties to the Annual Statement and compares the Appointed Actuary’s conclusions to the carried amounts consistent with the segmentation of exposure or liability groupings used in the analysis. The Appointed Actuary’s conclusions include the Appointed Actuary’s point estimate(s), range(s) of reasonable estimates or both.</td>
<td></td>
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<tr>
<td>• An exhibit that reconciles and maps the data used by the Appointed Actuary, consistent with the segmentation of exposure or liability groupings used in the analysis, to the Annual Financial Statement, Schedule P line of business reporting. An explanation should be provided for any material differences.</td>
<td></td>
</tr>
<tr>
<td>• An exhibit or appendix showing the change in the Appointed Actuary’s estimates from the prior Actuarial Report, including extended discussion of factors underlying any material changes. If the Appointed Actuary is newly appointed and does not review the work of the prior Appointed Actuary, the Appointed Actuary should disclose this.</td>
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<tr>
<td>• Extended comments on trends that indicate the presence or absence of risks and uncertainties that could result in material adverse deviation.</td>
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<tr>
<td>• Extended comments on factors that led to unusual IRIS ratios for One-Year Reserve Development to Surplus (#11), Two-Year Reserve Development to Surplus (#12) or Estimated Current Reserve Deficiency to Surplus (#13), and how these factors were addressed in current and prior year analyses.</td>
<td></td>
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<tr>
<td>• Disclosure of all reserve amounts associated with A&amp;H long duration contracts</td>
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Risk Assessment Levels and Trends

Developing an Overall Assessment
Risk assessment, either for an individual risk component or for the overall branded risk classification reflected in the heat map of the IPS, should be based on the ultimate overall assessment of the risk to the insurer, which should take into account any known positive attributes including risk-mitigation strategies and internal controls established by the insurer to ensure management’s business objectives are being followed. Risk-mitigation strategies and internal controls are assessed during examinations; however, they may not all be apparent or known to the analyst during interim analysis periods. To the extent known either through current analysis, recent examination results or communication with the insurer, the analyst should factor risk-mitigation strategies and internal controls into the overall assessment of the risk. Analysts should also consider that changes in risk-mitigation strategies and internal controls may occur between examinations, which will affect the overall risk assessment process. Therefore the overall assessment reflects the ultimate impact of unmitigated risks on the insurer after consideration of mitigation strategies and controls.

Examples of risk-mitigation strategies that may be considered positive attributes during the analysis may include (but are not limited to):

- reinsurance programs intended to mitigate underwriting & strategic risks
- derivatives hedging programs intended to mitigate market risks
- strong enterprise management controls over IT systems to mitigate operational risks
- regular auditing and strong oversight of MGAs & TPAs to mitigate underwriting and operational risks
- strong corporate governance and enterprise risk management that mitigate various risk components
- capital maintenance agreements with a financially strong parent holding company that ensure payment of claims and/or maintenance of capital above certain thresholds to mitigate strategic risk
Parental Guarantees and Capital Maintenance Agreements

Procedure #11X assists the analyst in assessing current and prospective risk related to existing Parental Guarantees and/or Capital Maintenance agreements.

Parental Guarantees and Capital Maintenance Agreements are commitments aimed at providing assurance that the insurer will be able to meet minimum financial obligations if financial or liquidity issues arise. These documents should be carefully reviewed along with the financial background of the entity required to fund the guarantee or agreement. The analyst may also inquire of the insurer if a contingency plan is in place in the event the parental guarantee or capital maintenance agreement is not honored.

Review and assess any parental guarantees, capital maintenance agreements or other commitments in place and determine if concerns exist regarding financial support or failures to act on these commitments. The analyst should thoroughly review the terms related to the agreement to gain a clear understanding of what is covered in the agreement (e.g. limit on lines of business, commitment to pay policyholder claims, commitment to maintain RBC level, etc.) and the impact to the insurer.

The analyst should also consider the following:

- Expected source and form of liquidity should guarantees be called upon.
- If the parental guarantee or capital maintenance agreement specifically address the concerns identified and provide adequate support to the insurer:
  - If concerns exist, consider requesting additional information, as necessary to understand the level of commitment.
- Whether the document contains detailed requirements or expectations for capital support.
- The financial stability of the parent holding company to determine if the parent is adequately capitalized to support maintenance of capital in the insurer above certain thresholds.

If a holding company analysis group profile summary (GPS) is available, the analyst should review the GPS for insight into the parent company or ultimate controlling person (UCP) and its ability to meet the financial demands of the guarantee currently or prospectively. Review pertinent data on the holding company and its organizational structure as well as the operations and financial condition of the holding company or UCP. Determine if there are liquidity or other concerns identified within the GPS that warrant additional information from the company.
Considerations for Troubled Insurance Companies

In troubled or potentially troubled insurance company situations, proactive and timely communication to the appropriate persons within the department and with non-domiciliary state departments (for multi-state companies) is critical. It is also important that the non-domiciliary state communicate with the domestic regulator prior to taking any action against the insurer. In certain circumstances, it may also be appropriate to communicate certain information with other parties (e.g., other regulatory bodies, company management, state guaranty funds, etc.) Establishing a coordinated communication system among the relevant parties will help facilitate the domestic regulator’s surveillance of the troubled or potentially troubled insurance company. The *Troubled Insurance Company Handbook* provides additional guidance to assist in enhancing a state’s monitoring and surveillance of troubled insurance companies, including communication and coordination of troubled or potentially troubled insurance companies.

At some point, the insurance department may determine that a corrective action plan cannot be implemented or completed successfully. Under these circumstances, the department may determine that the appropriate course of action is to place the troubled company in receivership. The *Troubled Insurance Company Handbook* outlines specific steps the department should take at all times during the development and implementation of a corrective action plan to prepare itself for this eventuality. This includes knowledge and control over the company’s assets, determining and reviewing the company’s obligations, operational considerations, information gathering, data/IT systems, other jurisdiction/regulatory considerations, etc. In addition to the *Troubled Insurance Company Handbook*, the *Receiver’s Handbook for Insurance Company Insolvencies* provides detailed information and guidance regarding pre-receivership considerations.
The IT Examination (E) Working Group of the Examination Oversight (E) Task Force met via conference call Sept. 26, 2019. The following Working Group members participated: John Jacobson, Chair (WA); Jerry Ehlers, Vice Chair (IN); Blase Abreo (AL); Mel Heaps (AR); Ber Vang (CA); William Arfanis and Ken Roulier (CT); Ginny Godek (IL); Shane Mead (KS); Greg Brelsford (MD); Kim Dobbs and Cynthia Amann (MO); Justin Schrader (NE); Eileen Fox (NY); Metty Nyangoro (OH); Eli Snowbarger (OK); Melissa Greiner (PA); and Dave Jensen (WI).

1. **Adopted Revisions to Handbook Guidance**

Mr. Ehlers and Jacob Steilen (NAIC) provided a brief overview of updates to the revisions to the NAIC Financial Condition Examiners Handbook (Handbook) that were being considered by the Working Group. The guidance considered covered three topics. The first topic relates to the conclusions reached on IT General Controls at the end of an information technology (IT) examination. The second topic relates to updates on using IT work performed by a third party to assist in a state insurance regulator’s IT review process. The final agenda topic for revisions would create a new reference to cyber self-assessments and create a mapping to one of those self-assessments developed by the Financial Services Sector Coordinating Council (FSSCC). The revisions would affect Section 1-3 and Exhibit C of the Handbook guidance. Materials were previously exposed and subject to a public comment period ending Aug. 30, with several comments received and incorporated into the newly updated conference call materials. Mr. Steilen provided an update on updates that were incorporated to the draft guidance.

Tom Finnell (America’s Health Insurance Plans—AHIP) inquired as to whether the updated Section 1-3 guidance was clear enough that the use of cyber assessment tools was optional. The way the guidance is stated, companies may opt to use cyber tools depending on their business type. Mr. Finnell noted that the wording made it sound like IT examiners should choose between the listed examples. A friendly amendment was added to clarify that use of the tool is optional.

The next comment related to the criteria for concluding on a generally effective versus ineffective IT general controls environment. Criteria were added to the existing list that included in-process remediation and management’s risk tolerance as mitigating factors that could be used to conclude that an IT general controls environment is generally effective. Mr. Roulier, Ms. Dobbs and Mr. Mead suggested the revisions be removed as they did not consider the new factors to be appropriate considerations in evaluating the impact of findings on IT general controls. A friendly amendment was therefore made to remove the previously added guidance. As these criteria are also reflected on Exhibit C, the Working Group elected to make the same changes for internal consistency. Michael Monahan (ACLI) had two additional clarification suggestions in Section 1-3 that were accepted as friendly amendments. The first edit changed the phrase “may be required to perform additional testing” to “may perform additional testing.” The second edit changed the phrase “may also need to consider additional procedures” to “may also consider additional procedures.”

On Exhibit C – IT Review Standard Summary Memorandum, Ms. Dobbs suggested a friendly amendment to change a sentence to the past-tense because at the time an IT examiner would be filling out the Summary Review Memorandum, the work would already have been performed. The suggested change was accepted as a friendly amendment. Mr. Nyangoro asked if non-IT factors should be considered in the “mitigating factors” column on the Exhibit C findings chart. Miguel Romero (NAIC) stated that the mitigating factors columns is meant to allow IT examiners to provide context in support of why their individual findings were or were not significant to the broader conclusion on IT general controls. The group did not have questions or concerns on the remainder of Exhibit C.

In conjunction with the edit regarding the optional nature of using cyber assessment reports, Mr. Romero suggested adding a similar clarification to the instructions provided at the beginning of the FSSCC mapping tool. There were no objections to this suggestion.

Mr. Roulier made a motion, seconded by Mr. Jensen, to adopt the Handbook guidance (Attachment Four-A), which would include the friendly amendments noted above. The motion passed.

Having no further business, the IT Examination (E) Working Group adjourned.
III. GENERAL EXAMINATION CONSIDERATIONS

This section covers procedures and considerations that are important when conducting financial condition examinations. The discussion here is divided as follows:

A. General Information Technology Review
B. Materiality
C. Examination Sampling
D. Business Continuity
E. Using the Work of a Specialist
F. Outsourcing of Critical Functions
G. Use of Independent Contractors on Multi-State Examinations
H. Considerations for Insurers in Run-Off
I. Considerations for Potentially Troubled Insurance Companies
J. Comments and Grievance Procedures Regarding Compliance with Examination Standards

A. General Information Technology Review

The examination of information technology (IT) utilized by an insurer has become an increasingly important part of the examination process as companies have placed a greater reliance on IT systems to run their business. IT general controls (ITGCs) are policies and procedures that help ensure proper operation of computer systems, including controls over network operations, software acquisition and maintenance, and access security. ITGCs provide a foundation necessary to ensure the completeness, integrity and availability of IT systems and data and comprise the environment from which application controls are designed, implemented and operated. An effective ITGC environment can, therefore, provide examiners with greater assurance regarding the overall reliability of a company’s IT systems and the reports generated from those systems. In addition, this allows the opportunity to test and rely on automated application controls during Phase 3 of the exam. As such, a formalized process to complete a general IT review has been developed to assist the IT examiner in completing this important section of the financial condition examination. In a risk-focused examination, steps 1–5 of the general IT review process should be performed prior to the completion of planning the overall financial condition examination. Step 6 of the IT review process should be performed in conjunction with the remaining portion of the overall examination. The following steps document the process to be followed in completing the general IT review:

1. Gather Necessary IT Planning Information

The first step in performing a general IT review is to gather the information necessary to plan the IT review of the insurer. At this time, the examiner-in-charge (EIC) and the IT examiner should work together to request that the insurer complete the Information Technology Planning Questionnaire (ITPQ), included in Exhibit C – Part One, to assist in the planning process. In addition, other relevant information to obtain in planning the IT review might include prior examination workpapers, work on IT systems performed by internal/external auditors or consultants, and information maintained by the insurance department’s financial analysts. The reports and results from third-party cyber self-assessment tools may also be utilized for an IT review. Note that if companies do not use these tools, the examiner can continue with the normal IT review process. There are a variety of cyber self-assessment tools that companies may opt to use depending on their business type. Examples of cyber assessment tools that have been developed include, but are not limited to, tools developed by, or to facilitate compliance with the following: the Financial Services Sector Coordinating Council (FSSCC), the Health Information Technology for Economic and Clinical Health Act (HITECH), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Based on a consideration of the assessment tool’s scope, date of preparation, and quality of information presented (including whether or not the information has been validated by an independent third-party), the state insurance regulator may determine the information contained within the assessment that
can be extensively leveraged during the IT review. Depending on the assessment of the IT examiner, the results of the cyber self-assessment tool may be used to:

- Populate Exhibit C with risk statements and controls to be tested.
- Reduce the extent of testing within Exhibit C if the state insurance regulator determines that the self-assessment has already been sufficiently validated.

2. Review Information Gathered

After the information for planning the IT review has been gathered, including the ITPQ, the IT examiner should review the information obtained to assist in planning and determining the scope of the general IT risks to be reviewed. Some factors to consider as part of this process include:

- The complexity of the insurer’s information systems and IT risk mitigation strategies;
- The extent to which reliance will be placed on those risk mitigation strategies in the financial examination;
- The length of time the existing system has been in place and any significant changes to the system;
- The types of subsystems being used and how data is shared among systems;
- The hardware and software being used and whether the software was internally or externally developed;
- The extent to which the insurer outsources its IT functions;
- Past issues the insurer may have had with its systems;
- Answers provided from the insurer via the ITPQ;
- Documentation available from other sources, including external and internal auditors;
- The insurer’s participation in electronic business and electronic data interchange;
- The amount of reliance placed on the work of third parties;
- The type, volume, and external availability of sensitive information that is processed and/or stored by the company and;
- Changes to the company’s controls and/or processes to ensure compliance with the General Data Protection Regulation (GDPR), if applicable, or other relevant data protection requirements.

The IT examiner should consider which risks included on the Evaluation of Controls in Information Technology (IT) Work Program (Exhibit C – Part Two) are applicable to the insurer under examination and determine if there are additional general IT risks that should be reviewed for this insurer. Additionally, based on the review of internal and external audit work, the IT examiner may determine that sufficient testing has been performed to fully address specific risks or areas of concern. In this case, the IT examiner may document in the IT planning memo their comfort with, and planned reliance on, the specific internal and/or external audit work included in the file. Additionally, the IT examiner need not include these specific risks or areas of concern in the IT work program.

3. Request Insurer Control Information and Complete IT Review Planning

After the initial planning information has been gathered and reviewed, the Evaluation of Controls in Information Technology (IT) Work Program (Exhibit C – Part Two) to be utilized in the review should be created. As part of this process, the IT examiner should customize the standard work program to include only the general IT risks that are of concern for the insurer under examination. In addition to providing a list of risks in the work program, the IT examiner may wish to provide a list of common controls that indicate how a typical insurer may mitigate these risks to assist the insurer in developing its response. Finally, the IT examiner may consider prompting the insurer to include information supporting the IT controls in place to mitigate risks by including an information request in the work program distributed to
the insurer. The IT review team should coordinate with the appropriate staff at the insurer to request a response. The insurer’s response should indicate their controls in place to mitigate the risks identified in the work program. The IT examiner should review the company responses, considering the adequacy of the controls identified, and request evidence to test the effectiveness of the insurer’s mitigating controls. The IT examiner may consider some of the examination procedures listed in the Evaluation of Controls in Information Technology (IT) Work Program (Exhibit C – Part Two), and complete the planning of the IT review.

After the work program has been finalized, the IT examiner should document the plan to complete the IT review. The plan should document the staffing to be used to complete the review, the scope of work to be performed and a proposed budget to complete the review. The plan should be subject to the review and approval of the EIC and additional examination supervisors, as considered appropriate by the state. This plan may be documented through the use of an IT review planning memo, or other workpaper that documents the approval of the EIC.

4. Conduct IT Review Fieldwork

The IT examiner should schedule examination fieldwork, with the initial fieldwork to include conducting interviews of key IT staff. These interviews should serve as an opportunity to substantiate and clarify some of the information provided by the insurer in Exhibit C – Part Two. The IT examiner may also gain additional information relating to key activities, risks, and risk mitigation strategies for the financial examination. As such, the IT examiner may want to invite the examiner-in-charge and/or other financial examination staff to participate in the interview process. Some of the potential candidates for interview include the Chief Information Officer, Chief Technology Officer, Chief Security Officer, System Architect, Chief System Engineer, and any other individuals responsible for maintaining, updating and testing the insurer’s business continuity and disaster recovery plans. Example agenda items for IT interviews, subject to the areas of expertise for the interviewee, include but are not limited to:

- IT Strategic Planning;
- IT Governance;
- Leadership development and succession planning;
- Organizational structure;
- Risk management;
- Development and maintenance of policies;
- Budgeting;
- Security;
- E-Business;
- Business continuity;
- Acquisitions and integration;
- Architecture, development and implementation of major programs;
- External environment, and
- Any other items necessary to evaluate the insurer’s general IT controls.

After the IT review team has completed the interviews, the team should begin to test the general controls identified by the insurer. This work should be completed with the assistance of the insurer’s IT staff and should utilize the existing work of others, if deemed appropriate. As noted in step 2 above, if the IT examiner has determined that reliance will be placed on all or some of the work performed by external auditors or the company’s internal audit function (if deemed independent) to fully address a specific risk or area of concern, the IT examiner would not be required to include those specific risks or areas of concern on the work program. However, if the IT examiner determines that the work performed by the third-party only partially addresses a risk, but additional work would be required to fully address that risk, the IT
examiner should include the relevant third-party documentation in the file and map or link it to the respective risk in the work program.

While it is expected that audit work (external/internal) would be the most common type of work relied on by the exam team, work performed by other regulatory agencies and/or cybersecurity experts may also be leveraged to reduce the independent work performed during an exam. Regardless of the work being reviewed, state insurance regulators should specifically consider the scope of work, the independence and qualifications of the entity (or person) performing the work, the timing of the work performed, and the findings included in any report received. Qualifications should be evaluated based on the training, experience, and education of personnel performing the work (see Section 1-2 Letter E for more information on the use of specialists). Based on the state insurance regulator’s review of the third-party work, state insurance regulators may be able to use the work to enhance the risk assessment, interview, and scoping process performed during the IT review. While the IT examiner is responsible for performing his/her own independent risk assessment, third-party work that directly addresses an identified risk may be relied upon in a similar manner to external/internal audit work. In this case, the IT examiner should briefly document his/her understanding of the third-party testing performed and any conclusions reached from the testing procedures. To the extent that findings are noted in the report obtained, state insurance regulators may find it more useful to corroborate the remediation of the findings as opposed to performing an independent review of the company’s controls to confirm the findings’ existence.

After considering the utilization of existing work, testing of general IT controls and other procedures should be performed in order to gain an appropriate level of understanding of the insurer’s IT environment and the effectiveness of general IT controls in place. As noted above, the IT examiner may consider performing examination procedures listed in the Evaluation of Controls in Information Technology (IT) Work Program (Exhibit C – Part Two) or any other procedures necessary to conclude upon the effectiveness of the company’s general controls in mitigating the risks identified. All testing should be documented appropriately to ensure that the work may be referenced within the financial examination workpapers, as necessary.

5. Document Results of IT Review

At the conclusion of the IT review fieldwork (at or prior to the conclusion of planning of the financial examination process), the IT examiner should have a completed IT controls work program supported by documentation and testing as a deliverable. In addition, a summary of findings regarding the insurer’s IT environment and general IT controls should be prepared at this time. The findings may be considered prospective in nature (resulting in recommendations to the company) or current in nature (which may have an impact on the financial exam). These findings should be documented through the use of an IT summary report (or similar document), which should include a description of recommendations to the company and/or how the findings may impact the examiner’s reliance on general IT controls and approach to application control testing in Phase 3. The IT summary report may also include a summary of the insurer’s IT operations, and detail on the IT review work performed. Based on the impact of the findings, the IT examiner should determine whether the ITGC environment is generally effective. A generally effective environment would indicate that IT risks have been sufficiently mitigated and findings are not pervasive enough to limit the ability to allow for testing of application controls in Phase 3. If the IT general control environment is not deemed effective, the examiner would be required to perform additional testing in later phases of the exam before relying on system generated reports or controls in place at the insurer.

Whether the IT general control environment is deemed effective ultimately depends on the IT examiner’s professional judgment. From the IT examiner’s perspective, controls over IT systems are considered generally effective when they maintain the integrity of information and the security of the data that such systems process and when they include effective general IT controls and application controls. Typically, at the end of the IT review, the ITGC environment would be considered generally effective, unless specific
adverse findings summarized in the IT summary memorandum indicate otherwise. Professional judgement and skepticism should be exercised when making this determination. Often, even when issues are identified, the IT examiner may be able to determine that the finding is isolated to a specific system or point in time and, therefore, would not impact the overall reliability of the ITGC environment. In this case, the IT examiner should document in the IT summary memo which key activities or specific applications may be impacted by IT review findings and how.

In some instances, the overall ITGC environment may be deemed ineffective. In reaching this conclusion, the IT examiner should consider whether the findings outlined in the IT summary report:

- Are pervasive throughout the ITGC general control environment.
- Significantly impact the systems used in calculating and reporting financial results or the accuracy of information used in reaching major strategic decisions.
- Indicate deficiencies relating to management involvement and oversight of the IT strategy and direction.
- Are not alleviated by other mitigating factors.

If the ITGC general control environment is not deemed generally effective, the examiner would may be required to perform additional testing in later phases of the exam before relying on system generated reports or application controls in place of the insurer. The additional testing procedures should be designed to prove that the application control or system report is complete and correct despite the generally ineffective ITGC environment. Whether the ITGC general control environment is deemed generally effective ultimately depends on the IT examiner’s professional judgment. To determine the impact of the IT review findings on the remainder of the examination, the examiner should next consider if the nature of the findings affects the quality of information produced by the company’s applications and systems. For instance, a finding that the company has inadequate continuity management controls may be significant. However, such a finding would be unlikely to affect information produced by the company’s IT systems. The IT examiner should assess ITGCs with regard to their effect on applications and data that become part of the financial statements or are used in making strategic business decisions.

The examiner may also consider performing additional procedures to determine the extent of the impact of specific findings. For instance, the company may have deficient user access controls. If the examiner is able to determine that in the period under examination, the key systems to the exam were not accessed inappropriately, the impact of the examination’s findings may not substantively affect the examination in later phases of the exam beyond the reporting of the finding. Given the complexity of evaluating the impact of individual findings and/or findings in the aggregate, communication of the results and mitigating factors in the IT Summary Conclusion Memorandum is important.

The IT examiner is cautioned against defaulting to the conclusion that the overall ITGC environment is ineffective, as such a conclusion could have a significant impact on the approach taken by the financial examiner on the remainder of the examination. For instance, in Phase 3, the examiner would be required to test manual or compensating controls for an identified risk if application controls cannot be relied upon and, therefore, may not be able to reach strong controls reliance. This may lead to additional detail testing in Phase 5 to fully address the identified risk. Additionally, the examiner would be required to test the accuracy and completeness of system generated reports, prior to those reports being utilized in addressing the identified risk in Phase 5.

The IT review process outlined up to this point, along with the corresponding documentation of results, may be performed on each examination, regardless of insurer size. These documents should also be appropriately presented and discussed with the examiner-in-charge to help facilitate a general understanding of the IT systems in place at the insurer and the impact that any findings may have on the ongoing exam.
6. Assist on Financial Examination

Following the completion of the IT review of the examination, the IT examiners involved in the IT review should remain available to assist in the completion of the financial portion of the examination. Such assistance could include data mapping, ACL testing, clarification of work performed during the IT review, assistance in completing the examination report and recommendation letter, and additional assistance in testing IT application controls to mitigate risks identified by the financial examination team.

Although the identification and assessment of risk mitigation strategies is the responsibility of the examination team as a whole, the IT review staff may have additional insight and experience that may be beneficial in identifying and testing IT controls associated with particular insurer applications. The involvement of IT review staff in this area of the examination may be especially beneficial when examining companies with well documented internal controls that may allow the examination team to reduce substantive testing.

Cybersecurity Considerations

As the examiner reviews an insurer’s operations, he or she may determine that the insurer has significant exposure to cybersecurity risks. The specific risk exposure for the insurer may vary based on volume, type of sensitive information (e.g. Social Security numbers, protected health information, personally identifiable health information, etc.) and the broad security environment in which the insurer is operating. The examiner should be mindful that the insurer is not required to use any particular IT security framework, nor are its IT security systems or controls required to include all of the components of any single or particular IT security framework or the examiner’s work program. The examiner should broadly consider not only the volume and type of sensitive information obtained, maintained or transmitted by the insurer, but also the laws and regulations to which the insurer is subject, as well as the size and complexity of the insurer’s operations and the nature and scope of its activities. All of these factors will influence the cybersecurity policies and systems and the IT security framework or frameworks that are appropriate for a particular insurer to effectively protect its sensitive information. As a result, responding to a particular insurer’s risk will require judgment by the examiner in tailoring the use of existing Handbook guidance. In these situations, examination teams should review the insurer’s risk mitigation strategies and/or controls that identify cybersecurity risks to protect against and detect cybersecurity incidents, and respond to and recover from cybersecurity incidents when they do occur.

When assessing the level of an insurer’s cybersecurity controls/processes, the examiner should take into account the distinction between the roles of the insurer’s board of directors and its senior management. The examiner should recognize that, while it is the role of the board to understand and oversee the insurer’s cybersecurity policies, systems and controls, it is the role of its senior management to implement the insurer’s cybersecurity policies and to ensure the performance and outcomes of the insurer’s risk mitigation strategies and controls are appropriate. Strategies and controls should identify, protect against, and detect cybersecurity incidents, as well as allow the insurer to respond/recover from such incidents. Each of the primary information security functions are described below:

- **Identify** - The identification of cybersecurity risks is important in helping the organization understand the best way to deploy its limited resources. Internal risk assessment is crucial for organizations to understand constantly evolving risks. Participation in information networks, though not required, is likely to enhance understanding of risks. In a robust control environment, insurers devote resources to a risk assessment process that includes some amount of management/board involvement, appropriate to the distinct roles of the board and senior management, as well as a sufficient level of technical expertise to ensure that issues are well understood and responded to appropriately.

- **Protect** - Protection is an important element in the overall strategy for any risk and cybersecurity is no exception. A robust risk mitigation strategy may include a combination of strong policies, system and
network access controls, and data security protection (e.g. data-at-rest, in use, in transit, and in storage are protected, etc.), as appropriate to the broad security environment in which the insurer is operating, including the volume and type of sensitive information obtained, maintained, or transmitted by the insurer, the security laws and regulations to which it is subject, its size and complexity, and the nature and scope of its activities. When applicable, controls should directly address risks presented by third party access to the insurer’s network, systems and data (including access by vendors, agents, brokers, third-party administrators [TPAs] and managing general agents [MGAs]). Training is also an important part of the insurer’s response to cybersecurity risks as many incidents occur due to improper execution of controls rather than the lack of controls. Control effectiveness is limited if employees are not provided adequate training to understand the objectives and importance of their assigned responsibilities.

- Detect - Insurers should also have a strong set of detective controls that enable timely identification and mitigation of threats to the organization. These may include anti-virus and anti-malware software as well as network monitoring and intrusion detection related processes and controls. Organizations may perform vulnerability scans and penetration tests to ensure that weaknesses in the protective/detective controls are identified and addressed.

- Respond and Recover - A review of the insurer’s incident response plan is an important consideration in the overall assessment of cybersecurity at an insurer. The response to a cybersecurity incident may leverage concepts from the insurer’s broader disaster recovery plan, but may also require unique considerations since recovering from a cybersecurity incident requires a different response than recovering from an environmental incident (e.g. fire, earthquake, tornado, etc.). The examiner should note, however, that network threats and incidents are not rare events like environmental incidents. It is also important that people with assigned responsibilities within the disaster recovery plan have the necessary background/training to perform the assigned duties. Insurers should include in their plan who they are required to contact in the event of a security incident (regulators, affected parties, etc.) and how public relations will be managed to limit the impact of the incident on the organization’s reputation. Importantly, response plans should be tested to ensure that the organization is ready to deploy the plan in the event of an actual incident.

When significant incidents do occur, it is important that the insurer performs a thorough post-remediation analysis and restores services that were affected as a result of the incident in accordance with the response plan. Examination teams may consider reviewing incident reports to consider how the organization has learned and adapted when security protocols are breached.

Depending on the insurer’s operations, there may be unique risks that the examiner identifies for further review. For instance, some insurers may leverage controls at service providers to provide assurance over cybersecurity risks. While this may be appropriate, insurers should be able to confirm that the service provider has appropriate risk mitigations strategies and controls in place and that appropriate protections are built into their service agreement (e.g. indemnification clauses, right to audit, technology errors and omissions insurance coverage, etc.) to address the risks presented to the insurer.

Although uncommon, if the examiner determines that the insurer has significant exposure to cybersecurity risk, the examiner may consider incorporating the use of a cybersecurity expert to assist in performing cybersecurity procedures. The specific risk exposure assessment for the insurer should be based on the IT examiner’s judgment and may consider the insurer’s line of business, the size and complexity of operations, known cybersecurity incidents; risks presented by third-party access to the insurer’s network systems and data, recent acquisitions, concerns about the controls in place to protect against, detect, respond and recover from cybersecurity incidents, or any other significant risk factors related to cybersecurity. Note that the decision to use additional expertise to address cybersecurity concerns should be based on the accumulation of circumstances and not necessarily due to any one situation discussed above.
The following insights may assist regulators and/or cybersecurity experts as they assess the strength of the insurer’s security program and therefore the risk that cybersecurity events present to the insurer. These insights are for informational purposes and are not intended to be requirements for insurers. Companies may be assessed by their individual risk profile and the organization’s risk strategy.

Events, Incidents and Breaches

As regulators engage insurers in discussion regarding past cybersecurity events, it may be useful to understand the difference between various types of events. A “cybersecurity event” can be defined as an event resulting in unauthorized access to, disruption or misuse of an information system or information stored on such an information system. Insurance companies may also use terms such as incidents and breaches or may distinguish between successful and unsuccessful events as they discuss their cybersecurity program. Regardless, regulators should gain an understanding of how the insurer defines its events and incidents. Insurers should consider both unsuccessful cybersecurity events and successful cybersecurity events (incidents), as appropriate. For instance, while an unsuccessful event may only access the company’s network without accessing sensitive information, it may still represent an event that the insurer should consider, correlate with other activity, and learn from to ensure security practices are enhanced, as appropriate. Timely, effective incident response is extremely critical in minimizing the impact of a cybersecurity incident.

Integration of Cybersecurity Risk into Enterprise Risk Management

As noted before, an insurer’s board and/or senior management often play a significant role overseeing a cybersecurity program. As an insurer’s cybersecurity risk increases, examination teams may want to scrutinize the integration of cybersecurity risk into the insurer’s Enterprise Risk Management. This may include consideration of the level of information provided to the board and/or senior management and the appropriateness of the insurer’s risk identification and assessment process. It may be appropriate for board and/or senior management to receive summary level information, but there should be a designated person with cybersecurity expertise that is responsible for developing the insurer’s response to mitigate cybersecurity risks. This person should be deemed the insurer’s cybersecurity risk owner and should receive information that is tailored to the insurer’s specific cyber risk exposures. For instance, use of third-party service providers, integration of acquired companies, legacy systems, etc. may all represent unique exposures that require specific consideration as mitigation strategies are developed.

Information Security Program

Note: The guidance that follows should only be used in states that have enacted the NAIC Insurance Data Security Model Law (#668). Moreover, in performing work during an exam in relation to the Model #668, it is important the examiners first obtain an understanding and leverage the work performed by other units in the department, including, but not limited to, market conduct-related work.

Specific requirements related to an insurance company’s information security program are included in Model #668. States that have passed the law may have an enhanced ability to encourage remediation of control issues in relation to issues identified during the exam. To the extent a state has adopted Model #668 and it is in effect at the time of the examination, examiners may consider tailoring the IT review to include consideration of the items below. As evidenced below, implementation of each control identified for consideration shall be done based on the insurer’s individual risk assessment:

Section 4-C of Model #668 details the requirements for performing a risk assessment. As part of a risk assessment, the licensee shall perform the following:

1. Designate one or more employees, an affiliate or an outside vendor designated to act on behalf of the licensee who is responsible for the Information Security Program.
2. Identify reasonably foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration or destruction of nonpublic information, including the security of information systems and nonpublic information that are accessible to, or held by, third-party service providers.

3. Assess the likelihood and potential damage of these threats, taking into consideration the sensitivity of the nonpublic information.

4. Assess the sufficiency of policies, procedures, information systems and other safeguards in place to manage these threats, including consideration of threats in each relevant area of the licensee’s operations, including:
   a. Employee training and management.
   b. Information systems, including network and software design, as well as information classification, governance, processing, storage, transmission and disposal.
   c. Detecting, preventing and responding to attacks, intrusions or other systems failures.

5. Implement information safeguards to manage the threats identified in its ongoing assessment, and no less than annually, assess the effectiveness of the safeguards’ key controls, systems and procedures.

Based on this risk assessment, Section 4-D requires the licensee to execute the following:

1. Design its Information Security Program to mitigate the identified risks, commensurate with the size and complexity of the licensee’s activities, including its use of third-party service providers, and the sensitivity of the nonpublic information used by the licensee or in the licensee’s possession, custody or control.

2. Determine which security measures listed below are appropriate, and implement such security measures.
   a. Place access controls on information systems, including controls to authenticate and permit access only to authorized individuals to protect against the unauthorized acquisition of nonpublic information.
   b. Identify and manage the data, personnel, devices, systems and facilities that enable the organization to achieve business purposes in accordance with their relative importance to business objectives and the organization’s risk strategy.
   c. Restrict access at physical locations containing nonpublic information only to authorized individuals.
   d. Protect by encryption or other appropriate means all nonpublic information while being transmitted over an external network and all nonpublic information stored on a laptop computer or other portable computing or storage device or media.
   e. Adopt secure development practices for in-house developed applications utilized by the licensee and procedures for evaluating, assessing or testing the security of externally developed applications utilized by the licensee.
   f. Modify the information system in accordance with the licensee’s Information Security Program.
   g. Utilize effective controls, which may include multifactor authentication procedures for any individual accessing nonpublic information.
h. Regularly test and monitor systems and procedures to detect actual and attempted attacks on, or intrusions into, information systems.

i. Include audit trails within the Information Security Program designed to detect and respond to cybersecurity events and designed to reconstruct material financial transactions sufficient to support normal operations and obligations of the licensee.

j. Implement measures to protect against destruction, loss or damage of nonpublic information due to environmental hazards, such as fire and water damage or other catastrophes or technological failures.

k. Develop, implement and maintain procedures for the secure disposal of nonpublic information in any format.

3. Include cybersecurity risks in the licensee’s ERM process.

4. Stay informed regarding emerging threats or vulnerabilities, and utilize reasonable security measures when sharing information relative to the character of the sharing and the type of information shared.

5. Provide its personnel with cybersecurity awareness training that is updated as necessary to reflect risks identified by the licensee in the risk assessment.

Review section 3 of the Model #668 for legal definitions of relevant and commonly used terms. For purposes of the exam process, licensees include, but are not limited to, insurance companies. Model #668 also covers the topics of board of directors oversight, third-party service providers, program adjustments, incident response plan, and the annual certification to the commissioner of the domiciliary state. Review Model #668 language for further insights on the topics above.

Evaluating Employee Training / Security Awareness Programs

Employees often represent the front line of any strong security program. However, without proper training, employees may also represent vulnerability in the company’s defense program. Therefore, strong security awareness training can help in mitigating the risk presented by phishing e-mails and other social engineering attacks. Strong security awareness training may be characterized by:

- Use of real world examples to help users be able to identify phishing e-mails;
- Use of phishing emails sent to the user community by the insurers internal security specialists or security vendor to measure effectiveness of user training;
- A clear protocol that provides employees help in identifying and reporting phishing e-mails; and
- Elements of a training that are tailored to the employee’s specific roles, responsibilities, and access rights.

Since cybersecurity threats are constantly evolving, it is important to have a strong and up-to-date training regimen. Additionally, in a strong cybersecurity program trainings should be performed on a consistent and periodic (e.g. annually) basis to ensure the information reaching the employees is commensurate with the modern-day threats facing the company. As regulators evaluate the appropriateness of the program, they should consider whether the training is mandatory for all employees and whether it includes procedures and instructions for employees to follow...
in the event that the employee has a good faith, fact-based belief that a breach or cybersecurity event may have occurred.

**Vulnerability Management**

In the most robust information security programs, companies understand that not all vulnerabilities can be eliminated, typically due to business needs or time and resources. However, companies should have an understanding and should inventory their identified vulnerabilities as well as have a plan to ensure vulnerabilities that can’t be eliminated are mitigated as much as possible. For instance, if the insurer is unable to confirm that a third-party service provider is able to secure their own access to the company’s information system, the company should ensure they monitor the service provider’s access to determine if improper activity occurs on the company’s network. As many vulnerabilities originate with a company’s patching practice, it is important that regulators obtain an understanding of the company’s patch management. Research suggests that in any given year, the majority of breaches have a root in a Common Vulnerability and Exposure (CVE) that often has been known and identified for several years. An insurer should maintain a strong practice of patch management, or at least a practice of understanding and mitigating existing vulnerabilities as an important part of a robust security program.

**Company Acquisitions**

Finally, in situations where a company has recently acquired/integrated another company, the IT examiner should also pay special attention to the procedures performed in integrating company systems. This is often when companies are most vulnerable to cybersecurity threats as controls are often in flux and mistakes in integration may create vulnerabilities that are not easily identified or remedied.

Exhibit C, Part Two (Instruction Note 3) includes specific mention of risk statements and sections of the exhibit that can be applied to ensure the examination has an appropriate response to identified cybersecurity risks.

Note that the findings identified through the review of the company’s cybersecurity control environment should be communicated to the financial examiner via the IT Summary Memo.

**Customization for Small Companies**

When conducting an IT review of a small company or a company with a non-complex IT environment, it is acceptable to limit the extent of test procedures performed. However, the examination must adhere to the six-step process outlined above. This includes obtaining the ITPQ responses from the insurer, completing a basic work program, and preparing a summary memo concluding on the results of the IT review and its impact on the rest of the examination.

The most significant area to be customized for small insurers is the IT work program. Regardless of size or complexity, some level of testing is required to be performed to verify the basic design and operating effectiveness of the insurer’s IT environment; however, the presentation of such work may vary. It is recommended that IT examiners perform some level of review for ITGCs in place within each domain of the COBiT Framework. This may be shown using a customized version of Exhibit C – Part Two, where a limited number of controls applicable to the insurer are populated and reviewed. In limited circumstances, as described below, IT examiners may bypass the utilization of Exhibit C – Part Two:

1. If the CPAs or the company’s internal audit function (if deemed independent) have performed a review of ITGCs that sufficiently cover risks within each of the COBiT domains, the IT examiner may rely on such work without mapping or linking the work to a separate work program. However, the IT examiner must document their comfort with and planned reliance on the work performed.

2. When the IT environment is simplistic and the insurer utilizes purchased software programs from well-known vendors, IT examiners may choose to summarize, in memo format, the procedures performed for
each domain of the COBiT Framework. However, before determining that it is appropriate to bypass the utilization of Exhibit C, IT examiners should consider whether the company has made significant modifications to the software being used, as modifications may impact the software’s reliability. In situations where significant modifications have been made and continue to be made, IT examiners should utilize Exhibit C – Part Two to document a consideration of risks relating to change management.

---Detail Eliminated to Conserve Space---
EXHIBIT C
IT REVIEW STANDARD SUMMARY MEMORANDUM

A summary memorandum should be developed by the IT examiner to communicate the results of the IT review to the examiner-in-charge, or any other users. Some of the topics the IT examiner may want to consider incorporating into the summary memorandum are included in the illustration below, along with a brief description of information that could be discussed relating to each topic. This document should provide sufficient detail of the results of the IT review for use during the financial condition examination.

Salutation

This section should be in any format the state deems appropriate for its purposes. At a minimum, all states that are placing reliance on the IT review should be included in the distribution of this memo.

Background and Scope

This section should include an introductory paragraph identifying the following: companies under examination (domiciliary state and type may be helpful), the exam as-of date and time period under examination, where the work was performed, when the work was performed, and who performed the work, and the scope/topic of the work performed.

Summary of Control Environment

This section should provide a summary description of the IT environment and the general IT controls assessed during the IT review. This section should also provide a general description of the insurer’s overall processes and controls, including access controls, in place to protect sensitive information. This section should also include discussion of any breaches identified during the period under exam.

Work Performed

This section of the memo should provide an overview of the work performed to evaluate general IT controls throughout the IT review process, as well as the reliance placed on external sources (e.g., Model Audit Rule documentation/testing, Sarbanes-Oxley documentation, external audit work, etc.). If the results of external audit, third-party work, and/or cyber self-assessment tools are utilized to populate Exhibit C procedures, include a review of the external work in this section. This review could include an assessment of the source, scope, and robustness of the third-party work being utilized.

Summary / Detail of Findings (Including Cybersecurity Related Findings)

This section should provide a summary description of the findings that were identified while performing the IT review. These findings may include: areas that affect the company’s current operations; areas that will be relevant for future examinations; or areas of recommendation for the company to consider. The IT examiner should document the recommendation and impact of the finding on the financial examination and provide reference to the supporting detail located in the completed Exhibit C, Part Two (or similar document). The IT examiner should consider mitigating factors in their assessment of the impact that findings will have on the exam (additional testing may be required to assess the effectiveness of the mitigating factors). Findings that are sufficiently mitigated by other factors may be found to have a minimal ongoing impact for examination purposes. The following table(s) or similar format may be used in assessing findings, mitigating factors, and the overall impact on the exam.
Findings

<table>
<thead>
<tr>
<th>IT Review Finding</th>
<th>Recommendation for Company</th>
<th>Mitigating Factors</th>
<th>Impact on Financial Examination</th>
<th>Supporting Detail Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Conclusion/Results of IT General Control Review

This section should document the conclusion/results of the ITGC review. Based on the impact of the findings, the IT examiner should determine whether the ITGC environment is effective and would, therefore, indicate that IT risks have been sufficiently mitigated to allow for reliance on general IT controls and testing of application controls in Phase 3. If the ITGC environment is not effective, the examiner would be required to perform additional testing in later phases of the exam before relying on system-generated reports or controls in place at the insurer. The IT examiner should consider the impact of the findings on the exam in totality and consider the following when concluding between a generally effective or ineffective ITGC environment. In some instances, the overall ITGC environment may be deemed ineffective. In reaching this conclusion, the IT examiner should consider whether the findings outlined in the IT summary report:

- Are pervasive throughout the ITGC environment.
- Significantly impact the systems used in calculating and reporting financial results or the accuracy of information used in reaching major strategic decisions.
- Indicate deficiencies relating to management involvement and oversight of the IT strategy and direction.
- Are not alleviated by other mitigating factors.

If the impact of a finding is isolated to a point in time or a less significant system, the IT examiner may still determine a generally effective ITGC environment while listing the particular system(s) as an exception. The IT examiner should document the possible implications on the exam with the goal of helping the exam team adjust their testing approach around the affected area. For additional guidance regarding the conclusion of the ITGC review refer to Section 1, Part III, A – General Information Technology Review.

Note: The IT Examiner should provide a conclusion on the effectiveness of the ITGCs using the terminology prescribed by the Handbook (effective or ineffective). Using alternate language may leave the Financial Examiner in an unclear position on whether ITGC’s can be relied upon and may lead to inefficiencies later in the examination process.

Meeting with Examiner-In-Charge and Other Financial Examiners

This section should document the date and time of the meeting with the EIC and other examiners (e.g., examiners from other states participating in the financial examination) that was conducted to discuss the findings and results of the IT review.

Assistance on the Financial Examination

This section should identify the remaining areas of the financial examination in which the IT review team will be asked to provide assistance. This may include testing application controls in conjunction with Phase 3 of the risk-focused examination, performing data mapping or ACL testing, and/or assisting with drafting the examination report and/or management letter.
**Completed Exhibit C, Part Two (or Similar Document) and Supporting Documentation**

A completed IT Review Work Program should be referenced here and provided to the EIC. Detail findings should be noted within the work program and referenced in the “Detail of Findings” section above.
The Financial Examiners Handbook (E) Technical Group of the Examination Oversight (E) Task Force met via conference call Nov. 14, 2019. The following Technical Group members participated: Susan Bernard, Chair (CA); William Arfanis (CT); N. Kevin Brown (DC); Cindy Andersen (IL); Shannon Schmoeger (MO); Justin Schrader (NE); Colin Wilkins (NH); John Sirovetz (NJ); Tracy Snow (OH); Joel Sander (OK); Melissa Greiner (PA); Pat McNaughton (WA); and John Litweiler (WI).

1. Adopted Minutes from its Sept. 12, Conference Call

The Financial Examiners Handbook (E) Technical Group met via conference call Sept. 12 and took the following action: 1) adopted salary range guidelines for inclusion in the Financial Condition Examiners Handbook (Handbook); 2) adopted revisions Handbook guidance to emphasize the importance and timing of interviews; 3) adopted a new template for interviewing a chief marketing officer; 4) exposed Handbook guidance related to troubled insurance companies, management letters, Exhibit V – Overarching Prospective Risk Assessment, and Exhibit AA – Summary Review Memorandum; 5) received an update on the status of the examination repository updates; and 6) received an update from IT Examination (E) Working Group on the status of its projects.

Mr. Schrader made a motion, seconded by Ms. Greiner, to adopt the Sept. 12 conference call minutes (Attachment Five-A). The motion passed unanimously.

2. Adopted Handbook Guidance

a. Troubled Insurance Companies

Ms. Bernard said NAIC staff developed proposed revisions to incorporate considerations when examining a troubled or potentially troubled insurance company in response to a referral from the Financial Analysis (E) Working Group. The revisions provide guidance regarding specific key elements from the Troubled Insurance Company Handbook, including communication expectations for companies that are troubled or potentially troubled, and pre-receivership considerations. Ms. Bernard said the referral also requested consideration of guidance regarding the priority rating framework. However, because existing guidance addresses the priority framework, no additional changes were made. Ms. Bernard said no comment letters were received regarding this proposed change.

b. Management Letters

Ms. Bernard said NAIC staff developed proposed revisions to clarify to whom the management letter should be provided and what information should be provided therein. Ms. Bernard said that a comment letter was received from interested parties during the exposure period. The comment letter suggested that the circumstances in which a management letter is provided to a level beyond the legal entity be more clearly defined.

Ms. Bernard said that the revisions were amended as follows: 1) indicate that depending on the issues to be communicated, it may be appropriate to prepare two different management letters: one to be provided at the legal entity level and one to be provided to a level above the legal entity; and 2) additional guidance for determining which findings would be appropriate to communicate to a higher level within the organizational structure. Ms. Bernard said that the additional guidance describes several considerations to be used when determining the significance of both financial reporting matters and other-than-financial-reporting matters.

These considerations may include: 1) the level at which corrective measures can be taken; 2) whether the findings meet the definitions for significant deficiency or material weakness; 3) the likelihood of the finding having a significant adverse impact on the insurer’s overall condition; 4) whether a conflict of interest exists; and 5) whether management has sufficient understanding and capacity to anticipate and respond to changing conditions.

Tom Finnell (America’s Health Insurance Plans—AHIP) said that it appears that amendments made to the exposure draft, based on the comments provided in the interested party comment letter, appear to capture the spirit of the interested party
feedback. Mr. Finnell requested that the guidance explaining that two management letters may be prepared be moved after the paragraph describing how to determine the significance of the findings. Mr. Finnell suggested that it would be clearer to discuss the difference in issues to be reported and because of that, it may be appropriate to prepare two different letters. There were no objections, and therefore, the suggestion was accepted and incorporated into the proposed revisions.

Mr. Finnell asked if it was common for there to be a conflict of interest with the management at the legal entity level that would necessitate sending a management letter to a level above the legal entity. Ms. Bernard said that there are circumstances when many or all individuals of the management team are also members of the board of directors. In this case, it would be beneficial to be able to send the management letter to a higher level within the organization to ensure independence in considering the communication provided and action taken, if needed. Joe Zolecki (Blue Cross Blue Shield Association—BCBSA) agreed with commentary provided by Mr. Finnell.

Mr. Arfanis requested that additional guidance be added to indicate that the content and recipient(s) of the management letter(s) is at the discretion of the examination team. There were no objections, and therefore, the suggestion was accepted and incorporated into the proposed revisions.

Ms. Bernard said that enhancements will be added to the Financial Exam Electronic Tracking System (FEETS) to all regulators to proactively share the management letter with each other. Changes are expected to be implemented early 2020. Mr. Snow asked if management letters shared in FEETS will be kept confidential. Ms. Henning said that FEETS is a regulator-only tool. Furthermore, it is expected that a management letter is uploaded to FEETS or an explanation is provided regarding why a management letter was not uploaded. Additional language is anticipated to be added to indicate that the viewer should contact the domestic regulator with any questions or to request a management letter if it is not uploaded to FEETS. Mr. Snow asked if all FEETS users would have access to view the management letter. Ms. Henning said that all FEETS users have access to view all information in the application.

c. **Exhibit V and Exhibit AA Enhancements**

Ms. Bernard said NAIC staff developed proposed revisions to Exhibit V – Overarching Prospective Risk Assessment and Exhibit AA – Summary Review Memorandum to enhance the documentation prospective risk assessment. Changes include: 1) revised column headings to clarify the purpose of each column; 2) additional columns to align the assessment made on Exhibit V with the communication used on the SRM/IPS when transitioning information between exam and analysis; and 3) updated the examples shown on Exhibit V. Minor changes to Exhibit AA – Summary Review Memorandum were made to include definitions and considerations related to the trend and risk assessment level for identified risks. Ms. Bernard said no comment letters were received regarding this proposed change.

Mr. Arfanis made a motion, seconded by Ms. Andersen, to adopt the guidance related to 1) Troubled Insurance Companies; 2) Management Letters, as amended; 3) Exhibit V – Overarching Prospective Risk Assessment; and 4) Exhibit AA – Summary Review Memorandum (Attachment Five-B)

3. **Discussed 2019 Project Listing**

Bailey Henning (NAIC) said that most of the items on the project listing have been completed. Ms. Henning said that volunteers from the Technical Group have met to discuss updates to the reserves examination repositories and that work is ongoing. Ms. Henning said that the volunteers expect to wrap up their work and provide a recommendation to the Technical Group to consider in spring 2020. Ms. Henning also stated that the Technical Group will need to consider the impact of changes to the NAIC Credit for Reinsurance Model Law and Regulation (#785/786) on the guidance provided in the Handbook.

4. **Received an Update on IT Examination (E) Working Group Projects**

Mr. Romero informed the Technical Group that the IT Examination (E) Working Group recently adopted revisions related to: 1) language used when documenting the conclusions reached as a result of the information technology (IT) review; 2) considerations when using the work of third parties; and 3) considerations when using company-prepared cybersecurity self-assessments to supplement the IT review.

Having no further business, the Financial Examiners Handbook (E) Technical Group adjourned.
The Financial Examiners Handbook (E) Technical Group of the Examination Oversight (E) Task Force met via conference call Sept. 12, 2019. The following Technical Group members participated: Susan Bernard, Chair, and Laura Clements (CA); Richard Ford (AL); William Arfanis (CT); N. Kevin Brown (DC); Grace Kelly (MN); Levi Nwasoria (MO); Lindsay Crawford (NE); Colin Wilkins (NH); John Sirovetz (NJ); Joel Bengo (NV); Tracy Snow (OH); Jamille Jaffurs (OK); Melissa Greiner (PA); John Jacobson (WA); and John Litweiler (WI).

1. Adopted Handbook Guidance
   a. Salary Range Guidelines

Ms. Bernard said the Risk-Focused Surveillance (E) Working Group referred proposed revisions regarding salary range guidelines for the Technical Group to consider. The proposed salary range guidelines were developed based on a survey of the states, as well as research to understand compensation practices in similar job roles, such as public accounting, private industry and other areas of financial regulation.

To avoid causing undue burden to the states using the existing salary and per diem guidance within the Financial Condition Examiners Handbook (Handbook), the Working Group recommends that the existing guidance be retained, with explanatory language describing its purpose and expectations. The Working Group also recommends that each set of salary guidelines be maintained, with annual updates to the existing salary and per diem guidelines and biennial updates to the proposed salary range guidelines.

Ms. Bernard said no comment letters were received regarding this proposed change.

   b. Interviews

Ms. Bernard said NAIC staff developed proposed revisions to address a referral received in 2018 from the Risk-Focused Surveillance (E) Working Group regarding takeaways from the 2018 Exam Peer Review sessions. These revisions attempt to emphasize the importance of customizing questions that are asked during C-level interviews in examination planning. The proposed revisions also suggest that the chief risk officer be among the first C-level individuals to be interviewed, when possible, as the information obtained through that interview can help inform subsequent interviews. NAIC staff also developed a new template for interviewing a chief marketing officer. This template provides possible questions that the exam team may consider when conducting this interview.

Ms. Bernard said two comment letters were received regarding these proposed changes. Ms. Clements said the comment letter that California submitted suggested additional language to clarify that information obtained during each interview could be used to tailor subsequent interviews. Ms. Bernard said these suggestions were incorporated as friendly amendments.

A comment letter that Tom Finnell (America’s Health Insurance Plans—AHIP) submitted suggested additional language to clarify specific questions on the interview template for the chief marketing officer. These minor revisions were accepted as friendly amendments. Ms. Bernard said that other comments provided in the letter related to items already covered in other sections of the Handbook and, therefore, were not incorporated. Mr. Finnell thanked the Technical Group for considering the comment letter provided.

Mr. Arfanis made a motion, seconded by Mr. Nwasoria, to adopt the guidance related to salary range guidelines and C-level interviews (Attachment Five-A1). The motion passed unanimously.
2. **Exposed Handbook Guidance**

   a. **Troubled Insurance Companies**

   Ms. Bernard said NAIC staff developed proposed revisions to incorporate considerations when examining a troubled or potentially troubled insurance company in response to a referral from the Financial Analysis (E) Working Group. The proposed revisions provide guidance regarding specific key elements from the *Troubled Insurance Company Handbook*, including communication expectations for companies that are troubled or potentially troubled, and pre-receivership considerations. Ms. Bernard said the referral also requested consideration of guidance regarding the priority rating framework. However, because existing guidance addresses the priority framework, no additional changes were made.

   b. **Management Letters**

   Ms. Bernard said NAIC staff developed proposed revisions to guidance for management letters in response to a referral from the Chief Financial Regulator Forum. The proposed revisions clarify that there may be circumstances in which the insurance department provides the management letter to a different level within the holding company structure. Situations when this may be appropriate include when the examination team wishes to issue a group management letter covering multiple entities and when a board of directors with members independent of management exists above the legal entity level.

Ms. Bernard said the referral also requested that the Technical Group consider whether the management letter issued as part of a financial examination should be proactively shared among the states using the Financial Exam Electronic Tracking System (FEETS). Ms. Bernard said that FEETS implementation is pending and asked NAIC staff to continue to monitor the status of implementation.

   c. **Exhibit V – Prospective Risk Assessment and Exhibit AA – Summary Review Memorandum**

Ms. Bernard said the referral regarding 2018 Exam Peer Review takeaways also suggested that the Technical Group consider the format of Exhibit V – Prospective Risk Assessment. The referral indicated that peer review attendees thought the format of the exhibit created confusion and did not appropriately emphasize the importance of the risks that should be addressed using the exhibit. Proposed revisions to the exhibit include revising the columns and column headers to more clearly indicate the expected documentation and aligning the exhibit more closely with the Summary Review Memorandum (SRM) and the Insurer Profile Summary (IPS). The examples provided in the Exhibit were also updated to reflect the proposed format changes. Ms. Bernard said that proposed guidance for the second part of the exhibit clarifies that common areas of concern are included for reference only. Examiners are not required to included risks for each common area of concern, nor are they required to provide a rationale for not identifying a risk for each area of concern. Proposed revisions also include using the Own Risk and Solvency Assessment (ORSA) filing, when available, as a source for identifying potential prospective risks. Ms. Bernard said that Exhibit AA – Summary Review Memorandum was revised to include definitions and considerations for determining the trend and risk assessment level of identified risks.

Mr. Finnell said that examiners may need to engage a specialist to assist in performing some of the procedures that are illustrated within the examples on Exhibit V. He also said that examiners should attempt to test mitigation strategies in place at the insurer before conducting independent testing, as some of the testing can become very specialized and require additional resources. Ms. Bernard agreed that examiners are expected to first gain an understanding of the mitigation strategies and controls in place, and only perform additional independent testing if warranted based on the risk assessment.

The Technical Group agreed to expose the proposed revisions to: 1) Troubled Insurance Companies; 2) Management Letters; 3) Exhibit V – Overarching Prospective Risk Assessment; and 4) Exhibit AA – Summary Review Memorandum for a 30-day public comment period ending Oct. 14.

3. **Received an Update on Reserves/Claims Handling Repository Project**

Bailey Henning (NAIC) said that a group of volunteers from the Technical Group has now reviewed two of the three reserves/claims handling repositories, using input provided by the Life Actuarial (A) Task Force, the Health Actuarial (B) Task Force and the Actuarial Opinion (C) Working Group. She said the volunteers plan to meet at the end of September to discuss the remaining repository. After each repository has been reviewed, the volunteers expect to meet at least once more before providing a recommendation of changes for the Technical Group to consider. Miguel Romero (NAIC) said that it is possible
that this project may extend into 2020.

4. **Received an Update on IT Examination (E) Working Group Projects**

Mr. Romero informed the Technical Group that the IT Examination (E) Working Group plans to meet via conference call Sept. 26 to consider adopting revisions related to: 1) language used when documenting the conclusions reached as a result of the information technology (IT) review; 2) considerations when using the work of third parties; and 3) considerations when using company-prepared cybersecurity self-assessments to supplement the IT review. Mr. Romero said that due to the technical nature of the subject matter, the IT Examination (E) Working Group has authority to adopt guidance directly into the Handbook. Therefore, anybody wishing to be part of the discussion should attempt to participate in the upcoming conference call.

Having no further business, the Financial Examiners Handbook (E) Technical Group adjourned.
II. EXAMINATION PERSONNEL

This section of the Handbook addresses the following subjects:

A. Examiner Definitions and Qualifications
B. Authority and Responsibility of the Examiner-In-Charge
C. Duties and Responsibilities of Non-Domestic Participating Examiners
D. Salary and Per Diem Guidelines
E. General Salary Guidelines

Note: The guidance in A. - D. was initially developed for zone examinations but is also used as a reference point for states in setting compensation for their Department. In contrast, the guidance in E. General Salary Guidelines is intended to provide flexibility in setting salary expectations for purposes of all staff performing Risk-Focused Surveillance.

-----------------------------------------------Detail Eliminated to Conserve Space-------------------------------------------

E. General Salary Guidelines

The compensation guidelines in this section of the Handbook were developed in recognition of the importance of compensation particularly as it affects an Insurance Department’s ability to hire and retain well-qualified employees. The guidelines were developed based on surveys of examiner pay across Insurance Departments, as well as external comparisons to other similar professions, including other financial regulators, internal auditors and external auditors. In using the information below, the following are brief descriptions of the associated positions listed:

Financial Examiner
Financial Examiners are responsible for performing tasks in accordance with the Risk-Focused Examination approach under the supervision of the Examiner-In-Charge. The Financial Examiner is responsible for investigating and analyzing insurance company risks, policies, procedures, and controls in an attempt to assist the Insurance Department in its responsibility to assess and monitor the current financial condition and prospective financial solvency of insurance companies.

Senior Financial Examiner
Senior Financial Examiners are responsible for performing tasks in accordance with the Risk-Focused Examination approach under the supervision of the Examiner-In-Charge. The Senior Financial Examiner is responsible for investigating and analyzing insurance company risks, policies, procedures, and controls in an attempt to assist the Insurance Department in its responsibility to assess and monitor the current financial condition and prospective financial solvency of insurance companies. Senior Financial Examiners may also be asked to provide guidance and support to Financial Examiners and may assist in all areas of examinations, as requested.

Examiner-In-Charge (EIC)

EIC’s are responsible for the execution of the Risk-Focused Examination approach. The EIC is responsible for ensuring the exam approach is appropriately designed to investigate and analyze insurance company risks, policies, procedures, and controls in an attempt to assist the Insurance Department in its responsibility to assess and monitor the current financial condition and financial solvency of insurance companies. The EIC provides guidance to Financial Examiners and Senior Financial Examiners, conducts detailed reviews of examiner work and ensures a proper flow of communication with company management and Department officials, as appropriate.

Supervising & Assistant Chief Examiner

A Supervising or Assistant Chief Examiner is responsible for supervising EIC’s on examinations. This person provides input on technical matters, acts as a reviewer of the work performed by the EIC and ensures that examination work is an appropriate execution of the Risk-Focused Examination approach.

Chief Examiner

This position is responsible for overall examination staff performance & development, the ongoing scheduling of financial examinations and general communications regarding the examinations of regulated entities. This position should work under the general direction of a Commissioner or Deputy Commissioner and should oversee a consistent Risk-Focused Examination process across the Department.

Use of Salary Tables:

The salary tables included below generally require certain adjustments before being applied by a State or Jurisdiction in setting examiner compensation. Factors to consider in setting examiner compensation include:

- Specific job responsibilities and expectations
- Location or market-based adjustments
- Complexity of industry
- Specialization requirements (e.g. Reinsurance/Investment/IT Specialist)
- Travel expectations (including consideration of amount of travel and in consideration of work from home or other similar arrangements)
- Retirement and benefits (not included in table)

Suggested Salary Ranges:

<table>
<thead>
<tr>
<th>Position</th>
<th>Low end</th>
<th>High end</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Examiner</td>
<td>$46,000</td>
<td>$75,000</td>
</tr>
<tr>
<td>Senior Financial Examiner</td>
<td>$57,000</td>
<td>$90,000</td>
</tr>
<tr>
<td>Examiner-In-Charge (EIC)/Supervisor/Assistant Chief Examiner</td>
<td>$80,000</td>
<td>$130,000</td>
</tr>
<tr>
<td>Chief Examiner</td>
<td>$92,000</td>
<td>$150,000</td>
</tr>
</tbody>
</table>

Note: The data above is based on a national average and is not appropriate to be applied to all locations without consideration of market and cost of living variances.
In Phase 1 of a risk-focused examination, key activities will be confirmed or identified using background information gathered on the company from various sources. Some of this information will already have been available in the department prior to the initial planning meeting, or can be obtained from the company’s internal audit department or external auditors. A Phase 1 goal is to gather any additional or current information necessary to begin a risk-focused examination. Sources of information may include organizational charts, filings required by sections 302 and 404 of the Sarbanes-Oxley Act of 2002 (where applicable), interviews with senior management, or other publicly available information.

To ensure the appropriate risk-focused examination scope, it is important to identify the key functional activities (i.e., business activities) of the company. Information gathered by understanding the company, the company’s corporate governance structure, and assessing the company’s audit function will form the basis for determining key activities.

Essential to executing the risk-focused surveillance process is interviewing executive management and possibly board members of the company to identify key activities and risks. Risks identified through these interviews and each part of Phase 1 should be documented on Exhibit CC – Issue/Risk Tracking Template or a similar document to ensure they are carried through the remaining phases of the examination. Examiners and company officials should attempt to maintain an ongoing dialogue to assist the examiners in understanding the company and identifying key functional activities. It is also critical for the examination team to understand and leverage the company’s risk management program; that is, how the company identifies, controls, monitors, evaluates and responds to its risks. For companies required to submit an Own Risk and Solvency Assessment (ORSA) summary report to the lead or domestic state, the report provided by the company may be a useful tool in this evaluation. The discipline and structure of risk management programs vary dramatically from company to company. “Best practices” are emerging for risk management programs and more companies are appointing chief risk managers whose responsibilities go well beyond the traditional risk management function (the buying of insurance). The Committee of Sponsoring Organizations (COSO) has published internal control standards that are widely-held, although not required, in many industries and has released an Enterprise Risk Management Integrated Framework, which is anticipated to be incorporated by several entities, as well as guidance to apply the integrated framework and internal control standards to small public companies. The examination team should evaluate the strength of the company’s risk management process, which can include a “hind-sight” evaluation of why a particular negative surprise or event occurred (i.e., why was it not identified in the current risk management program of the company).

One crucial aspect to a successful planning process is the tailoring of planning procedures to the company under review. As the exam team learns about risks, subsequent planning procedures should be tailored to ensure they provide further information on the risks already identified. For instance, if after meeting with the Department’s analyst, the examination identifies a risk related to the company’s planned expansion of business into new jurisdictions, subsequent procedures performed in planning (i.e. C-Level Interviews, review of company ERM, etc.) should be tailored to include consideration on the risk.

There are five parts to Phase 1 that are key components of performing a risk assessment, the results of which drive the direction of the risk-focused examination: (1) Understanding the Company; (2) Understanding the Corporate Governance Structure; (3) Assessing the Adequacy of the Audit Function; (4) Identifying Key Functional Activities; and (5) Consideration of Prospective Risks for Indications of Solvency Concerns. The Risk Assessment Matrix (Exhibit K), the tool developed to serve as the central location for the documentation of risk assessment and testing conclusions, should be updated with the identified key activities of the company after the
examiner is able to obtain an understanding of the company and corporate governance structure. The five parts of Phase 1 are discussed as follows:

A. Part 1: Understanding the Company
B. Part 2: Understanding the Corporate Governance Structure
C. Part 3: Assessing the Adequacy of the Audit Function
D. Part 4: Identifying Key Functional Activities
E. Part 5: Consideration of Prospective Risks for Indications of Solvency Concerns

A. Part 1: Understanding the Company

Step 1: Gather Necessary Planning Information

Meet with the Assigned Analyst

Gathering information is the first step in gaining an understanding of the company. While general information may have been requested from the company during examination pre-planning through use of Exhibits B and C, the examination team should determine what other information is already available to the department before making additional information requests. To do so, the examination team should meet (in-person or via conference call) with the assigned financial analyst (and/or analyst supervisor) prior to requesting additional information for use in examination planning. An email exchange, in and of itself, is not deemed sufficient to achieve the expectation of a planning meeting with the assigned analyst.

In addition to gaining an understanding of the information already available to the department, the meeting with the analyst should focus on the company’s financial condition, prospective risks and operating results since the last examination. The analyst should be asked to discuss risks and concerns highlighted in the Insurer Profile Summary (IPS)/Group Profile Summary (GPS) and to describe the reasons for unusual trends, abnormal ratios and transactions that are not easily discernible. The analyst may also request specific matters or concerns for verification and review during the financial examination. To summarize the input received from financial analysis, the examination team should document risks identified by the analyst for further review on the examination and post significant items to Exhibit CC – Issue/Risk Tracking Template for incorporation into the examination process. When possible, the examiner should meet with the department analyst prior to scheduling “C”-Level interviews with company personnel. Meeting with the analyst can help the examiner gain a basic understanding of the company, which can then be used in planning and scoping the interview process and subsequent planning procedures.

If the company under examination has redomesticated since the prior exam, the department analyst will typically take a primary role in communicating with the prior domestic regulator in order to adequately transfer regulatory insights accumulated over years of oversight. The department analyst would then share these insights with the examiner in charge during the examiner/analyst meeting during the planning phase of the examination. This communication may include a discussion of the Insurer Profile Summary and key risks, the supervisory plan, the former regulator’s assessment of Senior Management, the Board of Directors and corporate governance, and other relevant solvency monitoring information. If after meeting with the analyst the examiner requires additional information or further clarification, the examiner may consider contacting the former regulator.

The avoidance of redundancy between analysis and examination processes is of critical importance for an enhanced and more efficient overall regulatory process that will benefit both regulators and industry. An efficient regulatory process fosters clarity and consistency, which results in a better understanding of how individual insurers operate across the different aspects of the regulatory spectrum, including the areas of financial examination, financial analysis and other solvency-related regulation.

By utilizing information and input provided by the analysts, the examination team can request updates to existing information available to the department rather than duplicating requests for information already provided to the
analyst. This process eliminates the need for examiners to redevelop the financial analysis information in the examination workpapers so that examination resources may instead be used to update the information while on-site at the insurer. Similar to the benefits of reviewing and using external or internal auditor workpapers, examiners use of detailed financial analysis workpapers in the examination files should result in examinations being more efficient and streamlined.

B. Part 2: Understanding the Corporate Governance Structure

This section’s purpose is to assist the examiner in documenting the understanding and assessment of an insurer’s board of directors and management. A favorable overall assessment of governance does not, by itself, serve to reduce the scope or extent of examination procedures; rather, specific governance controls need to be assessed for their adequacy in managing specific risks, in conjunction with other controls designed to manage the same. See Exhibit M – Understanding the Corporate Governance Structure for additional guidance in understanding the corporate governance structure of the company. When completing this assessment, the examiner should utilize the Corporate Governance Annual Disclosure (CGAD), which is required to be filed with the Department of Insurance (DOI) annually in accordance with Corporate Governance Annual Disclosure Model Act (#305) and Corporate Governance Annual Disclosure Model Regulation (#306). The CGAD provides a narrative description of the insurer’s or insurance group’s corporate governance framework and structure and may enhance examination efficiencies when leveraged. Examiners should inquire of the financial analyst to gain an understanding of and leverage the analyst’s work in assessing the company’s corporate governance.

Management

Interviews with senior management at the “C” level should be used at the beginning of the examination or at any time during the examination as necessary. “C” level management may include the CEO (Chief Executive Officer), CFO (Chief Financial Officer), COO (Chief Operating Officer), CIO (Chief Information Officer), CRO (Chief Risk Officer), Controller, Chief Actuary or other appropriate executive-level management. Examiners should consider the size of the organization in determining which individual(s) would provide the examiner with the most beneficial information regarding the company for the stage of the examination. This interview process is a key step in the “top down” approach, beginning with senior management and then drilling down through the various levels of management to obtain a thorough understanding of the organization to assist in scoping the examination. Topics of these high-level interviews should include, but not be limited to (1) corporate strategic initiatives; (2) external/environmental factors of concern to management; (3) political/regulatory changes that might affect business; (4) competitive advantages/disadvantages; (5) management of key functional activities; and (6) how management establishes and monitors the achievement of objectives.

The examiners should consider which individuals should be interviewed and the sources of data to be evaluated to complete each planning step. The examiners should also consider the order in which the interviews are conducted as information gleaned from certain “C”-level individuals can assist in providing additional information to tailor subsequent interviews. In order to select the individuals to interview, the examiners should obtain an organizational chart from the company and compile a list of potential interviewees. In addition to accounting department personnel, the interview list should include managers of key functional business units (depending on the company structure, lines of business or revenue centers might be more appropriate). Because all companies have different organizational structures, it is important that the interview schedule and the examination plan match the company. Examiners should form their objectives, or what they want to get out of the interview, prior to conducting the interview. In order to accomplish this, the examiner should have a basic knowledge of the job function of the person that they are interviewing. This will allow the examiner to ask relevant questions and get the most information possible in one setting, as it may be difficult to coordinate multiple contacts with a “C”-level interviewee or a member of the board of directors. The information contained in Exhibit Y – Examination Attachment Five-A1 Examination Oversight (E) Task Force 12/8/19 © 2019 National Association of Insurance Commissioners 3
Interviews provides some basic questions that an examiner may consider when conducting “C”-level interviews. Exhibit Y, however, does not provide examples for functional positions at the insurer (e.g., claims handling, sales and marketing, etc.). These functional interviews are typically best documented in a narrative format and may be done in conjunction with walkthroughs or other control documentation procedures. Exhibit CC – Issue/Risk Tracking Template or a similar document may should be used in conjunction with Exhibit Y to document significant risks or concerns accumulated during the interview process.
EXHIBIT Y
EXAMINATION INTERVIEWS

Overview

Interviews are a useful examination tool to gather information about key activities, risks and risk mitigation strategies. Employees can also provide information on fraudulent activity within the company. It is critical for the examination team to understand and leverage the company’s risk management program; i.e., how the company identifies, controls, monitors, evaluates and responds to its risks. The discipline and structure of risk management programs vary dramatically from company to company. Interviews should be performed in the early stages of the examination so that regulators can adjust their procedures accordingly. An examiner can perform alternate, additional or fewer detail and control tests as a result of interviews with the company.

Interviews should be conducted with key members within management of the company, as well as members of the board of directors, audit committee, internal/external auditors and any other employees deemed necessary. These interviews can be used at the beginning of the examination or at any time during the examination, as necessary. In order to conduct a productive interview, the examiner should have However, a basic understanding of the company is essential to obtain prior to conducting commencing the interviews process. When possible, the examiner should meet with the department analyst prior to scheduling interviews with company personnel to assist in gaining this basic understanding. Examiners should continue to tailor each interview as information is learned about the company throughout the planning process.

Examiners should consider the size and complexity of the organization in determining which individuals to interview. The interview process is a key step in the “top–down” approach, beginning with senior management and then drilling down through the various levels of management to obtain a thorough understanding of the organization to assist in scoping the examination. In order to select the individuals to interview, the examiners should obtain an organizational chart from the company and compile a list of potential interviewees. Interviews of board members and senior company management should be conducted by examiners who possess the appropriate background and training. The examiner should also carefully consider the order of interviews as information gleaned from certain “C”-level individuals can inform subsequent interviews. For example, the Chief Risk Officer (CRO) is uniquely positioned to have an awareness of the various risks facing the company from multiple perspectives. The information obtained through an interview with the CRO can help the examiner have a greater understanding of the key risk areas of the company, which can then be used to further customize subsequent interviews as well as determine which additional members of management should be interviewed. While it can be challenging to coordinate the interview schedule with company personnel at this level, examiners are encouraged to attempt interviewing the CRO as early in the interview process as possible.

Interviews should be performed in person, if possible. This allows the interviewer to receive both verbal and nonverbal communication. The interviews should be kept confidential when possible; however, if a significant fraud or other pertinent issue was discovered through the interviews, the regulator has a duty to report the conflict to the appropriate officials.

The examiner should conduct the interview in a location where both parties are free to talk openly. The examiner should ask relevant questions, with the most general questions posed first as building blocks for additional conversation. The examiner may want to consider alternating between open-ended questions (e.g., “Explain to me how this process works?”) vs. closed-ended questions (e.g., “How many claim processors do you have in your department?”) to obtain the information. Open-ended questions are generally better suited for explanation and processes, while closed-ended questions are better suited to obtain concise information. The examiner should be prepared, listen carefully and focus on the speaker’s entire message, as well as the non-verbal cues expressed during the interview process.
Significant risks and concerns identified through completion of the examination interviews should be adequately addressed within the examination workpapers. As such, all significant risks identified by the examiner during the interview process should be recorded in a central location for tracking purposes, such as Exhibit CC – Issue/Risk Tracking Template or a similar document.

Because information obtained from the interview serves as important evidence in the examination process, the examiner should develop techniques to plan, conduct, document and consider interview information. Although interviews play a key role in gaining useful insight into company operations, interviews alone are not sufficient exam evidence and should be corroborated with other exam documentation to evaluate the accuracy of the information.

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Sample Interview Questions for the Chief Marketing Officer

Experience and Background
  • How has your professional experience and background prepared you to be the Chief Marketing Officer for this company?

Duties and Responsibilities
  • Briefly describe your duties and responsibilities.
  • How does management establish objectives, and how is the achievement of those objectives monitored?
  • How is your performance evaluated? Is it based on the performance of the company?
  • How do you evaluate your staff?

Reporting Structure
  • Describe the reporting structure of the marketing function, including to whom you report, as well as those reporting to you.
  • Is there a marketing committee?
    - How is it organized and who are its members?
    - How are differences resolved?
  • Describe your interaction with the CFO/CEO/BOD.
    - Do you provide them with any specific reports?

Ethics
  • Does the company have a code of conduct/ethics in place? Is it enforced? Approved?
  • Explain management’s commitment to ethics and explain how that commitment is conveyed to employees.
  • Do you have any knowledge or suspicion of fraud within the company?

Risk Areas
  • How are key risks faced by the company identified and monitored?
    - What are the key prospective risks the company faces?
  • How are these risks communicated to senior management and throughout the company?
  • What is the current marketing strategy? Describe any changes over the past five years.
Risk Mitigation Strategies (Internal Controls)
- What is the formal procedure for reporting on risk management to senior management and the board?

Corporate Strategy
- Give a general description of the company’s marketing philosophy.
- Where is the company headed strategically? What type of plan is in place to implement this strategy? How does the strategy impact activities within your department?
- Explain strengths or weaknesses of the company, as well as opportunities and threats the company is facing, and how the company’s marketing strategy and tactics is responding to each.
- Explain what types of key tools or reports you utilize to evaluate marketing decisions.
- What key measures do you assess to evaluate the company’s performance and competitive position?

Other Topics
- Explain any significant turnover in the marketing department.
- Explain the distribution channels used by the company.
- What is the compensation/commission structure for each distribution channel?
III. GENERAL EXAMINATION CONSIDERATIONS

This section covers procedures and considerations that are important when conducting financial condition examinations. The discussion here is divided as follows:

A. General Information Technology Review
B. Materiality
C. Examination Sampling
D. Business Continuity
E. Using the Work of a Specialist
F. Outsourcing of Critical Functions
G. Use of Independent Contractors on Multi-State Examinations
H. Considerations for Insurers in Run-Off
I. Considerations for Potentially Troubled Insurance Companies
J. Comments and Grievance Procedures Regarding Compliance with Examination Standards

I. Considerations for Potentially Troubled Insurance Companies

A troubled insurance company is broadly defined as an insurance company that is either in or is moving towards a financial position that subjects its policyholders, claimants and other creditors to greater-than-normal financial risk, including the possibility that the company may not maintain compliance with the applicable statutory capital and/or surplus requirements (Troubled Insurance Company Handbook). The “Prioritization Framework” as discussed in the NAIC’s Financial Analysis Handbook identifies troubled companies as Priority 1.

The Troubled Insurance Company Handbook provides a number of insights to assist in enhancing a state’s monitoring and surveillance, and it outlines several regulatory actions available to Departments of Insurance (DOIs). In situations in which an examination is being planned for a troubled insurance company (i.e., Priority 1 company), the NAIC’s Accreditation Program Manual (Part B3: Department Procedures and Oversight) indicates that “the department should generally follow and observe procedures set forth in the NAIC Troubled Insurance Company Handbook.” However, regulators may also consider leveraging the insights in the Troubled Insurance Company Handbook for Priority 2 companies, which are defined in the Financial Analysis Handbook as “high-priority insurers that are not yet considered troubled but may become so if recent trends or unfavorable metrics are not addressed.”

The following guidance provides an overview of key elements to consider during an examination. Additional insights to assist in enhancing a state’s monitoring and surveillance of troubled insurance companies, including regulatory actions available to Departments of Insurance (DOIs), can be found in the Troubled Insurance Company Handbook.

Communication Expectations

If an examination is planned or ongoing for a troubled or potentially troubled company, or through the course of the examination the domestic regulator elevates the priority level of the company to troubled or potentially troubled, it is critical that the domestic regulator communicates proactively and timely with other impacted state insurance regulators. It is also important that the non-domiciliary state communicate with the domestic regulator prior to taking any action against the insurer. This can be particularly important if the corrective action plan implemented by the domestic regulator depends on continued operations of the insurer in other states. Depending on the circumstances, it may also be appropriate to communicate certain information with other parties, such as other regulatory bodies, company management, and state guaranty funds. Establishing a coordinated
communication system among the relevant parties will help facilitate the domestic regulator’s surveillance of the troubled company.

The timeliness of communication with other regulators should be commensurate with the severity of the event and should include information about the troubled company’s situation and the proposed corrective action. It may also include a request for other jurisdictions to assist in implementation of the plan. When determining which states to notify, the department may consider those in which the company 1) has a significant amount of written, assumed or ceded insurance business; 2) has significant market share; 3) is licensed; 4) has affiliates; 5) utilizes fronting entities; 6) has pooled companies; and 7) is seeking to write business or obtain a license. If it is reasonably anticipated that corrective plans will not prevent a finding of insolvency or insolvency is reasonably possible, advance communication to the guaranty funds is critically necessary for a successful transition to liquidation. If the guaranty funds are notified in a timely manner, they may be able to provide additional guidance and assistance in preparing the company for liquidation.

Pre-Receivership Considerations

Depending on the circumstances of the troubled company’s situation, the department may determine that the appropriate course of action is to place the company in receivership. There are several steps the department can take to ensure a smooth transition to receivership, should that be necessary. Having a thorough understanding of the company’s rights and ownership of its assets, as well as its liabilities and obligations can help the department manage the possible transactions that could occur if the company is placed in receivership. It may also help the regulator understand if inappropriate transactions occur in anticipation of receivership, such as preferential payments to related entities and payment of management bonuses or expense reimbursements. As part of the corrective plan, the department may consider requesting implementation of controls surrounding the troubled company’s operations. For instance, it may be necessary for management to establish controls around acceptance of new business or new commitments by the company, as well as recordkeeping requirements if the insurer is involved with reinsurance.

If an examination is planned or ongoing for a troubled or potentially troubled company, the examination should increase its review of risks and controls surrounding financial reporting processes in the areas discussed above. For example, the exam may have a greater focus on the following areas:

- Gaining an understanding of the location (i.e., bank accounts, deposits, custodial accounts, letters of credit, etc.) and ownership (i.e., funds held with reinsurers, intermediaries, MGAs/TPAs, etc.) of company assets;
- Gaining an understanding of possible encumbrances on company assets that may be triggered if the financial position of the company continues to deteriorate;
- Gaining an understanding of the provisions within various agreements that company has entered into (i.e., reinsurance agreements, agreements with service providers, investment advisors, etc.) that could be impacted by being placed into receivership;
- Reviewing transactions involving the movement of company assets;
- Identifying primary responsibility for obligations and liabilities such as tax payments, pension plan contributions, pledges of assets, etc.; and
- Additional testing to ensure the completeness of policy and claims data.

If receivership or liquidation is triggered, and assets are transferred to the receiver or guaranty fund to settle obligations, it is important that the company’s data be maintained in such a format to ensure that policies can continue to be maintained and claims can continue to be paid. For example, the company should have the ability to export its claims data through a defined format (Uniform Data Standards—UDS) that would allow the data to be received and utilized by a third-party guaranty fund. Therefore, the examination may include additional
procedures as part of the IT review to identify and locate data storage and processes, understand the format of the data, and ensure proper functionality exists for timely and efficient export of policy and claims data in the event of a receivership.
EXHIBIT V – OVERARCHING PROSPECTIVE RISK ASSESSMENT

Background

The concept of risk on a risk-focused examination encompasses not only risks as of the examination date, but also risks that extend or commence during the time in which the examination was conducted, as well as risks that are anticipated to arise or extend past the point of examination completion. As such, consideration of “prospective risks” (including moderate or high residual risks existing at the balance sheet date that will impact future operations, risks anticipated to arise due to assessments of company management and/or operations, or risks associated with future business plans of the company) is an intrinsic element of a risk-focused examination and should occur throughout all phases of the examination process.

Use of this Exhibit

In completing this exhibit and documenting the examiner’s consideration of prospective risks throughout the examination process, the examiner should conduct an evaluation and, if possible, conduct examination procedures on the noted prospective insolvency risks to assess the degree of risk present and recommend future monitoring. Throughout the examination process and at the conclusion of the exam, the examiner should communicate with the department’s financial analysts to keep them informed of the identified prospective risks and examiner assessments. The branded risk classifications, risk assessment level and trend and associated rationale should be used to summarize prospective risks identified for communication to the analyst via Exhibit AA—Summary Review Memorandum (SRM). This communication should include relevant details obtained during the examination that will enhance the ongoing monitoring of the company.

In conducting examinations of insurers that are part of a holding company group, it is important to note that many critical prospective risks may occur at the holding company level. The exam team should seek to coordinate the identification and assessment of prospective risk in accordance with the exam coordination framework and lead state approach outlined in Section 1 of this Handbook. Where possible, in a coordinated examination, the lead state’s work on prospective risk should be utilized to prevent duplication of effort and to leverage examination efficiencies.

As discussed throughout this Handbook guidance, the consideration of prospective risks should occur throughout each phase of the examination process. If the examiner identifies a prospective risk that relates to one specific key activity of the company, this prospective risk should be documented in the corresponding risk matrix for that key activity and treated similarly to other identified risks. However, if the examiner identifies an overarching prospective risk (a prospective risk that does not relate to a specific key activity identified, or relates to more than one key activity identified), the examiner should utilize this exhibit to document the process to consider the investigation of the overarching prospective risks. Individual risks should either be addressed on Exhibit V or a key activity matrix, but not both.

By the end of Phase 1, the examiner should have a preliminary listing of overarching prospective risks included on Exhibit V – Overarching Prospective Risk Assessment. By the end of Phase 2, the list of risks on Exhibit V should be updated to include all significant overarching prospective risks identified on Exhibit CC – Issue/Risk Tracking Template.

Prospective risks may continue to be identified beyond Phase 1 and Phase 2, but all significant overarching prospective risks identified during later phases of the exam should continue to be documented and investigated on Exhibit V, regardless of the phase in which the risk was identified.

All of the instructions for the investigation of prospective risks on Exhibit V should be completed by the end of Phase 5. It is not required that the various steps to investigate prospective risks on Exhibit V directly coincide with the seven-phase exam approach, but it is recommended that examiners complete each step of Exhibit V as early in the exam as practical to ensure each risk identified is sufficiently tested and reviewed.
**Exhibit V, Part One – Overarching Prospective Risk Testing Template**

Examiners should use this worksheet to document a review and testing investigation of overarching prospective risks throughout the examination. Examiners may also use the examples provided on the template as a guide to assist in determining the nature and extent of the prospective risk review to be performed. **Please Note:** The risk mitigation strategies identified in the template are only examples, and the examiner should be aware that the insurer might use other strategies to mitigate the identified risk. Instructions for completing and documenting a review of prospective risk within the template are as follows:

<table>
<thead>
<tr>
<th>Template Column</th>
<th>Instructions for Completing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overarching Prospective Risk Identified</td>
<td>Based on the knowledge and understanding of the company obtained during the planning stages of the exam, document any overarching prospective risks identified.</td>
</tr>
<tr>
<td>Branded Risk Classification</td>
<td>For each identified risk, document the associated branded risk classification(s) from the following list: Credit (CR), Legal (LG), Liquidity (LQ), Market (MK), Operational (OP), Pricing/Underwriting (PR/UW), Reputation (RP), Reserving (RV), and Strategic (ST).</td>
</tr>
<tr>
<td>Risk Mitigation Strategies</td>
<td>Identify risk mitigation strategies in place at the insurer (if any) to address the prospective risk.</td>
</tr>
<tr>
<td>Testing to support mitigation strategies</td>
<td>Test the mitigation strategies identified by management. Consider both the design and operating effectiveness of the mitigation strategies as part of the procedures performed. Provide corroborating evidence and documentation to support the procedures performed. Perform additional independent testing, if necessary, to further understand or address the risk. Testing may include evaluation of the company’s historical trends, stress testing of company exposures, or other additional procedures specifically tailored by the examiner based on the company’s risk. Attach and reference supporting workpapers.</td>
</tr>
<tr>
<td>Corroborating Evidence and Documentation</td>
<td>Provide corroborating evidence and documentation supporting the risk mitigation strategy. Attach and reference supporting workpapers.</td>
</tr>
<tr>
<td>Prospective Risk Assessment</td>
<td>Using professional judgment, determine the appropriate prospective risk level (High, Moderate or Low) after considering the nature of the risk and the company’s mitigation strategies. Provide a brief explanation regarding the prospective risk level determined.</td>
</tr>
<tr>
<td>Risk Assessment Level</td>
<td>Document the risk assessment level of the identified risk considering the test procedures performed (i.e., Significant, Moderate, or Minimal). Refer to Exhibit AA—Summary Review Memorandum for guidance on determining an appropriate risk assessment level.</td>
</tr>
<tr>
<td>Trend</td>
<td>Document the trend level of the identified risk considering the test procedures performed to indicate the direction the risk is moving (i.e., Increasing, Static, or Decreasing). Refer to Exhibit AA—Summary Review Memorandum for guidance on determining an appropriate trend level.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Document the rationale for the trend and level of concern.</td>
</tr>
<tr>
<td>Ongoing Examination Procedures and Follow-Up Communicate Findings to Financial Analysis</td>
<td>Document any additional procedures deemed necessary to be performed to further understand or address the risk. Document specific information to be communicated to the department analyst. Information should include specific procedures for continual monitoring, specific documents to obtain from the company, expected timelines for follow-up, and contact information. Describe the plan for follow-up, such as specific procedures for continual monitoring, communication with the analyst, limited-scope examinations, revisions to the Supervisory Plan or Insurer Profile Summary, etc.</td>
</tr>
</tbody>
</table>
Exhibit V, Part Two – Common Areas of Concern

Examiners should use this as a reference guide to assist in identifying categories of prospective risk that may be relevant for review and inclusion on the Exhibit V, Part One. Note: examiners are not required to identify a risk from each category listed or provide a rationale for not identifying risks from the common areas of concern.
## PART ONE – OVERARCHING PROSPECTIVE RISK TESTING TEMPLATE

<table>
<thead>
<tr>
<th>Overarching Prospective Risk Identified</th>
<th>Branded Risk</th>
<th>Risk Mitigation Strategies</th>
<th>Investigate Risk Exposure</th>
<th>Risk Assessment Level</th>
<th>Trend</th>
<th>Rationale</th>
<th>Communicate Findings to Financial Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example Prospective Risk 1:</td>
<td>ST RP</td>
<td>The company has processes in place to monitor and manage its financial performance in accordance with metrics considered significant by rating agencies. The company utilizes modeling to determine its economic and rating agency capital needs.</td>
<td>Reviewed financial reports for evidence of monitoring of rating agency performance measures and management review, noting that the company appears to be meeting its benchmarks (See wp A.1.4). Obtained and reviewed the economic capital calculation at 12/31/XX, noting that rating agency considerations are included in the process and that the company appears to hold capital in excess of the calculated amount. See A.1.5 for more information.</td>
<td>Moderate</td>
<td>Static</td>
<td>The company has product lines sensitive to a ratings decrease; however, it appears the company has appropriate controls and strategies in place to maintain strong ratings.</td>
<td>If a future rating downgrade occurs the DOI should meet to determine an appropriate course of action (e.g., limited scope exam).</td>
</tr>
<tr>
<td>Example Prospective Risk 2:</td>
<td>LGST</td>
<td>Mergers and acquisitions are part of the company’s growth strategy and incorporated into its 3-year strategic plan. The company has a defined due diligence process which includes detailed procedures for mergers &amp; acquisitions, and business divestitures. The process is reviewed annually, making changes as needed, and approved by the Board of Directors and senior management. The company has a mergers and acquisitions steering committee that meets quarterly to review analyses and forecasts prepared for planned and/or in-process mergers/acquisitions/divestitures. Obtained the most recent strategic plan and verified that it discussed the company’s plan for future mergers and acquisitions to support its strategic goals. Reviewed minutes from the 20XX annual Board of Directors meeting, noting that the mergers &amp; acquisitions process was reviewed and approved by the Board of Directors and Management. (See wp B.2.2) The exam team also obtained documentation from the company’s most recent acquisition of XLX Corporation and confirmed that the due diligence process outlined in the M&amp;A policy was followed. (see additional detail regarding documents reviewed at B.2.PRG) Reviewed minutes from Q1 and Q3 M&amp;A steering</td>
<td>Moderate</td>
<td>Increasing</td>
<td>Although the company is actively involved with merger and acquisition activities, the exam team verified that this activity is part of its strategic plan and that an effective due diligence process is in place. However, given the significance of the last transaction and the stage of implementation, trend is rated as increasing. The exam team is comfortable with the Company’s abilities with regard to mergers and acquisitions. However, if the analyst identifies changes to the Company’s strategic business plan, the DOI should meet to discuss whether the changes warrant action before the next examination date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overarching Prospective Risk Identified</td>
<td>Branded Risk</td>
<td>Risk Mitigation Strategies</td>
<td>Investigate Risk Exposure</td>
<td>Risk Assessment Level</td>
<td>Trend</td>
<td>Rationale</td>
<td>Communicate Findings to Financial Analysis</td>
</tr>
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<td>------------------------------------------</td>
</tr>
<tr>
<td>Example Prospective Risk 3: PR/UW</td>
<td></td>
<td>Company analysts perform significant research regarding current market conditions and demands, product mix and profitability, and other product/market characteristics on a regular basis. Reports summarizing the findings are generated monthly. The company has a group of individuals from departments across the company (legal, actuarial, marketing, financial, etc.) that compose an ad-hoc group specifically charged with product development. This group has significant experience in developing, marketing and pricing new products. Issuance of new products requires input and approval from the board of directors. There is a special subcommittee that meets on a quarterly basis to discuss</td>
<td>Reviewed the monthly market conditions report, noting that the company has compiled detailed industry information regarding similar products and pricing, market demand, customer location, etc. (see A.2.1). Reviewed the qualifications and background of the employees within the product development “team,” noting that all members have extensive experience in the many aspects of product development.</td>
<td></td>
<td>Minimal</td>
<td>Static</td>
<td>The company has a verified history of successful product launches and its process for considering and launching products going forward is fully vetted throughout the company.</td>
</tr>
<tr>
<td>Overarching Prospective Risk Identified</td>
<td>Branded Risk</td>
<td>Risk Mitigation Strategies</td>
<td>Investigate Risk Exposure</td>
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<tr>
<td>company strategy and new product development</td>
<td>Further, noted that this group maintains an action plan, approved by the board of directors, which details key procedures and areas of research necessary for product development, as well as a description of the various levels of review that occur throughout the product development process (see A.2.3). Obtained meeting minutes from the committee of the board of directors demonstrating discussion of potential new products, considerations for pricing, and board approval for the issuance of the new product (see A.2.4). Board meeting materials were also reviewed (A.2.5).</td>
<td></td>
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</tbody>
</table>
PART TWO – COMMON AREAS OF CONCERN

The prospective risk categories provided within this exhibit are not designed to be an all-inclusive list and might not apply to all insurance companies under examination. The examiner’s understanding of the company obtained in Phase 1, including a review of the company’s Enterprise Risk Report (Form F) and/or ORSA Filing, should be utilized to determine whether risks in these categories might be applicable to the company. The company will likely face additional prospective risks that do not fit within the categories in this exhibit.

<table>
<thead>
<tr>
<th>Prospective Risk Category</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merger and Acquisition Activity</td>
<td>If applicable, review the company’s process to identify and perform due diligence on potential acquisitions. In addition, consider reviewing the company’s process to integrate acquired entities and business into its systems.</td>
</tr>
<tr>
<td>Product Development</td>
<td>If applicable, review and assess the company’s process to identify, develop, price and market new products in accordance with the company’s strategy and business needs.</td>
</tr>
<tr>
<td>Legal and Regulatory Changes</td>
<td>If applicable, review how the company identifies, monitors and addresses changes to the legal and regulatory environment it operates within. For example, review the company’s processes in place to analyze the impact that health care reform could have on the company, including support for company projections and strategies for appropriateness.</td>
</tr>
<tr>
<td>HR/Personnel Risks</td>
<td>If applicable, review and assess the company’s HR processes to identify, mitigate and monitor risks related personnel management (including succession planning for critical positions) as well as hiring, managing, retaining and terminating personnel in accordance with company needs.</td>
</tr>
<tr>
<td>Strategic Planning</td>
<td>If applicable, review and assess the company’s processes for strategic planning to determine whether the company regularly analyzes its strengths and weaknesses, as well as opportunities and threats, on an ongoing basis. In addition, it might be appropriate to review the company’s process to update its overall business plan on a regular basis.</td>
</tr>
<tr>
<td>Compensation Structure</td>
<td>If applicable, review the company’s process for developing, monitoring and adjusting its compensation structure to ensure that employees are appropriately compensated without creating an incentive to misrepresent financial results.</td>
</tr>
<tr>
<td>Rating Agency Downgrade</td>
<td>If applicable, review the company’s process to monitor and prepare for potential adverse changes in its credit ratings. If a future rating agency downgrade is deemed likely, consider whether the company is adequately prepared to handle the results of such a downgrade.</td>
</tr>
<tr>
<td>Costs of Capital</td>
<td>If applicable, review the company’s access and ability to obtain capital, reinsurance and letters of credit, if necessary, to meet funding and risk diversification needs.</td>
</tr>
<tr>
<td>Business Continuity</td>
<td>If applicable, review the company's business continuity plan. Follow the steps outlined in Section 1, Part III.</td>
</tr>
<tr>
<td>Climate Change</td>
<td>If applicable, review the company’s process for identifying and monitoring risks resulting directly or indirectly from the impact of climate change risk.</td>
</tr>
</tbody>
</table>
The following is an illustration of how a summary review memorandum (SRM) may be set up to assist examiners in documenting the key issues and results of a risk-focused examination that should be shared with the Chief Examiner and the assigned analyst. The illustration also includes a high-level overview of the insurer’s holding company structure (if applicable) and how that structure affected exam coordination with other states. Additionally, the SRM includes discussion of the insurer’s governance and risk management practices, and a summary, by branded risk classification, of significant exam findings and/or concerns warranting communication. These findings may include overarching solvency concerns, examination adjustments, other examination findings, management letter comments, subsequent events and other residual risks or concerns the examiner may want to communicate to department personnel. The final sections, prioritization level and changes to the supervisory plan, provide discussion of the examiner’s overall conclusions regarding ongoing monitoring, including specific follow-up recommended to the analyst.

This exhibit provides an example template, which is not intended to be all-inclusive and should be tailored to each examination. Reference to each branded risk classification is necessary and should be included in the examination’s SRM; however, it is not necessary to address each of the supporting areas and points discussed herein. Therefore, the examiner-in-charge should use his or her judgment in determining which sections of this illustration are applicable and document any other relevant information deemed necessary. The purpose of the SRM is to provide interpretative analyses relative to significant examination areas and to provide a basis for communicating examination findings and recommendations to department personnel. In so doing, the SRM will provide input into the Insurer Profile Summary (IPS) and the supervisory plan. In fulfilling this purpose, the SRM should not merely repeat comments made in the examination report or management letter, but instead provide a comprehensive summary of examination conclusions both objective and subjective in nature. Conclusions should provide information necessary for ongoing supervision of the insurer that includes areas of concern as well as areas that support a positive outlook for the insurer.

COMPANY NAME:  
EXAMINATION DATE:  

EXAMINATION BACKGROUND

The purpose of this section of the memorandum is to document at a high level what, if any, group the insurer belongs to, if the insurer was part of a coordinated exam and how the coordinated exam was conducted. Additional information regarding the timing of the exam, staffing resources utilized—including what specialists were used—or other background information necessary to understand the results presented in the memo should also be included.

GOVERNANCE AND RISK MANAGEMENT

The purpose of this section of the memorandum is to summarize an understanding and assessment of an insurer’s board of directors, senior management and organizational structure, as well as the results of the review of the enterprise risk management (ERM) function of the insurer. This assessment should include information obtained during both the planning and the completion stages of the examination. Therefore, consideration of information gathered during C-level interviews, completion of Exhibit M and review of the insurer’s Own Risk and Solvency Assessment (ORSA), if applicable, should be combined with information obtained during detail testwork to reach a concise final assessment that focuses on communicating significant areas of strength or weakness within the overall corporate governance and ERM functions of the insurer. When the insurer is part of a holding company, documentation should reference the level at which conclusions are reached. Additional assessment may be necessary at the individual entity level, but the primary focus of the assessment will commonly be at the holding company level in a coordinated examination.
BRANDED RISK ASSESSMENTS

This section of the memorandum should be organized to address each of the nine branded risk classifications: Credit; Legal; Liquidity; Market; Operational; Pricing/Underwriting; Reputation; Reserving; and Strategic. If needed, an Other category may also be used. In documenting each assessment, consideration should first be given to the branded risk assessments provided by the analyst in the initial IPS. The examiner then summarizes the work performed during the examination to arrive at a final assessment for each classification. For those branded risk classifications that are not impacted by examination results and provide no additional information for the ongoing monitoring of the insurer, this can be noted without further explanation. For those classifications that are impacted, documentation in the summary should focus on new information uncovered during the course of the examination and should not duplicate the summary initially provided in the IPS. The summary for each classification should be prepared at a level of detail that will enable the analyst to update the existing IPS and understand the context for items that require additional follow-up or specific monitoring procedures. This may be done within the table format provided below, referencing other examination documents as necessary.

In documenting the key points for each branded risk classification, consideration should be given to the following areas, if deemed applicable:

- Prospective solvency concerns
- Examination adjustments
- Control/risk mitigation strategy issues
- Report findings and management letter comments
- Responses to issues raised by financial analysis
- Subsequent events
- Residual risks and concerns

Following the summary, the examiner should update the areas of concern, as needed, based on the information obtained during the examination and provide an overall assessment of minimal, moderate or significant concern for each branded risk classification. The SRM is a primary tool for communicating the results of an examination to the financial analysis function. Therefore, it is important that the examiners have the same understanding of the considerations going into the risk assessment level and trend. The following guidelines may be used to assist in assigning the risk assessment level and trend, when necessary. Additional guidance for selecting the risk assessment level and trend is available in the Financial Analysis Handbook.

Risk Assessment Level Considerations:

- Significant: The highest level of severity of risk from a solvency perspective. Risks assessed at this level require an elevated level of ongoing monitoring and/or regulatory action.
- Moderate: The medium level of severity of risk from a solvency perspective. Risks assessed at this level require routine ongoing regulatory monitoring and oversight and/or regulatory action.
- Minimal: The lowest level of severity of risk from a solvency perspective. Risks assessed at this level do not currently indicate a need for additional monitoring or regulatory actions.

Risk Assessment Trend Considerations:

- Consider trending within quantitative metrics to assist in determining the trend assessment
- Consider qualitative factors such as the insurer’s planned business strategies to address the risk
- Consider both historical/current and prospective/planned trends in exposure
If the examiner’s assessment is different from the original assessment documented in the IPS, the information summarized must provide sufficient detail to support the change. Issues that require specific monitoring or follow-up by the analyst should then be identified individually in the table under the section designated for recommended follow-up. This table includes a brief reference to the issue, recommended follow-up or action items to be performed and the timeline in which the analyst should expect to obtain information referenced in the follow-up procedures.

### Branded Risk Classification (Example: Credit)

*Note: A separate summary and table should be completed for each of the nine branded risk classifications, as well as a category for Other, if deemed necessary.*

#### Analyst Initial Assessment

**Credit:** This risk is considered moderate, driven primarily by a fairly conservative investment mix (96.4% of bonds are NAIC 1 designation, with 28% U.S. government, 14% U.S. states and most of the rest high-quality corporates) and limited exposure to equities, offset by a relatively high amount of real estate ($33 million), growing agent balances ($99 million) and significant reinsurance recoverables (paid and unpaid) of $81 million. However, the reinsurance recoverables are diversified across a number of highly rated reinsurers.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonds</td>
<td></td>
<td></td>
<td>⇔</td>
</tr>
<tr>
<td>Reinsurance Recoverables</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
<tr>
<td>Real Estate – Home Office</td>
<td></td>
<td></td>
<td>⇔</td>
</tr>
<tr>
<td>Agent Balances and Uncollected Premiums</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
</tbody>
</table>

**Analyst Initial Overall Assessment:** Moderate

**Overall Trend:** ⇔

#### Examiner Summary and Assessment

**Credit:** Examiner agrees with analyst assessment regarding bonds and reinsurance recoverables. Although the reinsurance recoverables balance has increased significantly in recent years, the change is in line with increases in premium volume and strategic plan of partnering with high-quality reinsurers to increase the volume of its product liability business. Real Estate – Home Office was tested during the exam, with a recent appraisal reviewed showing the value of the property to be $40 million. Therefore, the examiner proposes that the credit risk associated with the home office be reclassified as a minimal concern. In reviewing agent balances, the exam team recognized a growing concern regarding slow-paying agents for the company’s growing product liability business. In discussing this with the company, a lack of company controls related to agency audits was noted. As such, the exam team agrees with the analyst’s assessment of high credit risk in this area and has included a management letter comment regarding agency audits as described below.

<table>
<thead>
<tr>
<th>No/Minimal Concern</th>
<th>Moderate Concern</th>
<th>Significant Concern</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonds</td>
<td></td>
<td></td>
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<td>Reinsurance Recoverables</td>
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<td></td>
<td>⇔</td>
</tr>
<tr>
<td>Agent Balances and Uncollected Premiums</td>
<td></td>
<td></td>
<td>↑</td>
</tr>
</tbody>
</table>

**Examination Overall Assessment:** Moderate

**Overall Trend:** ⇔
Recommended Follow-Up

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommended Follow-Up</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>See ML #2 – Lack of a consistent agency audit process</td>
<td>Company was asked to establish a consistent agency audit plan to ensure accurate and complete premium and claim reporting. Analyst is asked to follow-up on company activity in this area by requesting a copy of the audit plan and selecting a sample of agency audit reports to request and review.</td>
<td>Company has stated that it plans to increase its IA staffing over the next six months to support additional agency audits. Therefore, follow-up as part of the next annual financial statement analysis is recommended.</td>
</tr>
</tbody>
</table>

ISSUES OF NON-COMPLIANCE

The purpose of this section is to describe any issues of non-compliance identified during the examination. These issues typically do not have a significant impact on the assessment of each branded risk classification, but are important to communicate and ensure proper follow-up is performed.

Recommended Follow-Up

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommended Follow-Up</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>See ML #1 – Schedule F reporting</td>
<td>Company was asked to report reinsurance data on Schedule F on a gross basis in all instances. Analyst asked to follow-up by closely monitoring Schedule F and reinsurance Jumpstart reports.</td>
<td>Follow-up recommended in conjunction with quarterly and annual financial statement analysis through 20XX.</td>
</tr>
</tbody>
</table>

PRIORITIZATION AND ONGOING MONITORING

The purpose of this section of the memorandum is to allow the examiner to document any suggested changes to the prioritization level and/or to document the examiner’s rationale for maintaining the current prioritization level.

PROPOSED CHANGES TO SUPERVISORY PLAN

The purpose of this section of the memorandum is to propose any changes to the supervisory plan that the examiner believes are necessary based on the preceding information.
**PHASE 7 – DRAFT EXAMINATION REPORT AND MANAGEMENT LETTER**

This section of the Handbook addresses the following subjects:

A. Examination Report  
B. Management Letter  
C. Summary Review Memorandum  
D. Letter of Representation

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**B. Management Letter**

Significant results and observations noted during the examination that are not appropriate or necessary for inclusion in the public report, as determined by the state insurance department conducting the examination, should be communicated to the board and/or management. A management letter is considered an examination workpaper and may be used for this purpose. Those states not utilizing the management letter should communicate comments to the board and/or management during the exit conference or other means deemed appropriate. For group examinations, the lead state, after discussion with other participating states, will determine which results and observations will be included.

The letter to management, or other means of communication as determined by the state, can serve as a vehicle for an ongoing dialogue between the regulator and the insurer and should be shared with those states an insurer is licensed in, as long as confidentiality can be maintained. This letter or communication should be issued and delivered by the regulators to the board members and/or management based on the scope and severity of the issues identified. Judgements on the matters covered within the management letter(s) and the recipient(s) of the management letter(s), and considering the following guidance, are to be determined at the discretion of the examination team.

Based on the findings to be included in the management letter, the examiner should determine the most appropriate party within the holding company structure to whom the letter should be provided. There may be circumstances when the examination team considers sharing the management letter to a level of the organization above the legal entity’s management and/or Board of Directors (i.e. parent company Board). Depending on the issues to be communicated, it may also be appropriate to prepare two different management letters; one to be delivered to management and/or BoD of the legal entity, and one to be delivered to a level of the organization above the legal entity.

When determining which findings are appropriate to communicate to a higher level within the organizational structure, the exam team should consider the significance and severity of the findings or comments, as well as the level at which corrective measures can be taken. For financial reporting matters, the exam team may utilize the definitions for material weakness or significant deficiency (refer to Phase 4 for definitions) to help with this assessment. Findings and comments meeting these definitions may be appropriate for communication to the board of directors and/or audit committee at a level above the legal entity. For other than financial reporting matters and issues or comments related to prospective risks, the examiner should consider the likelihood of such having a significant adverse impact on the insurer’s overall condition. Additional considerations include whether management at the legal entity level has a conflict of interest with the items to be communicated and/or whether management has sufficient understanding and capacity to anticipate and respond to changing conditions. Because there may be differences in the significance of issues to be communicated it may be appropriate to prepare two
different management letters; one to be delivered to management and/or BoD of the legal entity, and one to be delivered to a level of the organization above the legal entity.

Examples of when it may be appropriate to provide the management letter at a level above the legal entity’s management and/or Board of Directors may include when a conflict of interest exists with the legal entity management/Board of Directors, and when a group management letter covering multiple companies is prepared.

The examiner should request a response from the company regarding the plan to address the identified issues. This response should be received within a reasonable time frame (e.g., 90 days) from the date the examiner issued the letter or communication. In addition to communication with the insurer, the examiner is responsible for communicating significant results and observations to the analyst and should consider including the analyst throughout the communication process with the insurer. In accordance with the Financial Analysis Handbook, the analyst must follow-up and document a review of any management letter comments. The examiner should coordinate with the analyst on the follow-up of the identified issues. As the examiner moves on to other examinations, it is important that the analyst be involved with the resolution and monitoring of the identified issues.

Example Management Letter
An example management letter template has been developed below to provide a suggested format to examiners in drafting this correspondence. As with the elements that may be included within these non-public letters, the actual format utilized should be determined by the state insurance department conducting the examination.

June 1, 20XX
Board of Directors
XYZ Insurance Company (XYZ)

The Board of Directors (Board) has a duty to ensure that XYZ Insurance Company is operated in a safe and sound manner in the best interest of the policyholders. The Department of Insurance (the Department) is charged with the responsibility to protect insurance consumers and other creditors.

Following are comments related to the examination of XYZ Insurance Company as of December 31, 20XX, and other related information regarding XYZ. The Department has identified the following issues and concerns regarding specific operations or practices of the Company. In accordance with the nature of these items, the department has chosen not to include these comments within the Report of Examination.

For each item/issue noted:

- State the issue using a concise statement of the problem identified;
- Provide commentary on the examiner’s understanding on what caused or created this issue;
- Illustrate the effect of this issue including the materiality impact, and what impact it has had on the financial statements, the company’s financial condition, or company operations; and
- Provide information regarding the criteria that elevated this issue (i.e., non-compliance with statute).

We will review the response and determine what further actions are appropriate. Please contact me by telephone (number) or email (xxxxx@xxxxx) if you have any questions.

Sincerely,
Examiner
LONG-TERM CARE INSURANCE (E/B) TASK FORCE

The Long-Term Care Insurance (E/B) Task Force did not meet at the Fall National Meeting.
RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

Receivership and Insolvency (E) Task Force Dec. 8, 2019, Minutes .......................................................... 10-771
Receivership Large Deductible Workers’ Compensation (E) Working Group Dec. 2, 2019, Minutes
(Attachment One) .............................................................................................................................................. 10-773
Receivership Large Deductible Workers’ Compensation (E) Working Group Oct. 24, 2019, Minutes
(Attachment One-A) ........................................................................................................................................... 10-774
Presentation on Distributive Variation Between the Insurer Receivership Model Act (#555)
Section 712 and the National Conference of Insurance Guaranty Funds (NCIGF)
Model Large Deductible Legislation (Attachment One-A1) .......................................................... 10-775
NAIC Staff Memorandum Regarding Guideline: Alternative to Section 712 of Insurer Receivership
Model Act (#555), Administration of Loss Reimbursement Policies, Nov. 12, 2019
(Attachment One-B) ........................................................................................................................................... 10-783
Guideline: Alternative to Section 712 of Insurer Receivership Model Act (#555) “Administration
of Loss Reimbursement Policies” (Attachment One-C) .......................................................... 10-786
Revisions to the Receiver’s Handbook for Insurance Company Insolvencies (Attachment Two) ........... 10-789
International Association of Insurance Receivers (IAIR) Presentation Regarding its Professional
Designation Program, Dec. 8, 2019 (Attachment Three) ........................................................................... 10-806
The Receivership and Insolvency (E) Task Force met in Austin, TX, Dec. 8, 2019. The following Task Force members participated: Kent Sullivan, Chair, represented by James Kennedy (TX); Stephen C. Taylor, Vice Chair, represented by N. Kevin Brown (DC); Lori K. Wing-Heier represented by David Phifer (AK); Allen W. Kerr represented by Mel Heaps (AR); Ricardo Lara represented by Joe Holloway (CA); Michael Conway represented by Rolf Kaumann and Eric Unger (CO); Andrew N. Mais represented by Jared Kosky (CT); David Altmairer represented by Toma Wilkerson (FL); Doug Ommen represented by Carrie Mears and Kim Cross (IA); Robert H. Muriel represented by Kevin Baldwin (IL); Vicki Schmidt represented by Tish Becker (KS); Nancy G. Atkins represented by Sandy Batts (KY); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by Christopher Joyce (MA); Chlora Lindley-Myers represented by Shelley Forrest (MO); Matthew Rosendale represented by Steve Matthews (MT); Mike Causey represented by Jackie Obusek (NC); Bruce R. Range represented by Lindsay Crawford (NE); Marlene Caride, represented by Diana Sherman (NJ); John G. Franchini represented by Leatrice Geckler (NM); Glen Mulready represented by Donna Wilson (OK); Jessica Altman represented by Crystal McDonald (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Raymond G. Farmer represented by Lee Hill (SC); Hodgen Mainda represented by Bill Huddleston (TN); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Vicki Ayers (VA); and Mike Kreidler represented by Steve Drutz (WA). Also participating was: Robert Wake (ME).

1. Adopted its 2019 Summer National Meeting Minutes

   Mr. Phifer made a motion, seconded by Ms. Obusek, to adopt the Task Force’s Aug. 4 minutes (see NAIC Proceedings – Summer 2019, Receivership and Insolvency (E) Task Force). The motion passed unanimously.


   Mr. Baldwin said the Receivership Financial Analysis (E) Working Group met Aug. 4 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. The Working Group discussed the status of individual receiverships and related issues.

   Ms. Wilson made a motion, seconded by Mr. Joyce, to adopt the Working Group’s report. The motion passed unanimously.

3. Adopted the Report of the Receivership Large Deductible Workers’ Compensation (E) Working Group


   Ms. Wilson made a motion, seconded by Mr. Phifer, to adopt the Working Group’s report, including its Dec. 2 (Attachment One) and Oct. 24 minutes. The motion passed unanimously.

4. Adopted Revisions to the Receiver’s Handbook

   Mr. Baldwin made a motion, seconded by Ms. Wilkerson, to adopt the Receiver’s Handbook for large deductible workers’ compensation receiverships (Attachment Two). The motion passed unanimously.

5. Exposed Revisions to the Receiver’s Handbook

   Mr. Kennedy said the Macroprudential Initiative (MPI) report adopted at the Summer National Meeting identified outdated references in the Receiver’s Handbook for federal taxes and federal releases was outdated. Revisions were requested and received from several state insurance regulators and interested parties.


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6. Discussed Recommendations from the MPI Report

Mr. Kennedy summarized recommendations from the MPI report. The first item involves legal remedies that ensure the continuity of essential services in a receivership by affiliated entities within the group, including non-regulated entities. This is especially problematic in situations where the insurer has no employees, and all services, employees, and records are provided by an affiliate or the holding company, whose sole purpose is to administer the insurance business. Mr. Kennedy recommended having a discussion with the Financial Condition (E) Committee chair about possible legal remedies in the Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). He asked states to consider their own experiences with this issue in order to have a productive future discussion on this issue. There was no objection to this plan.

The second item is to identify methods for encouraging states to adopt key provisions in receivership laws. Model #555 is not widely adopted by states, and past efforts to encourage states to adopt key provisions from the current model have largely been unsuccessful. One exception is Florida, which amended its laws to incorporate certain Model #555 provisions. Mr. Kennedy recommended delegating the development of recommendations to the Receivership Model Law (E) Working Group, which is within the scope of its charges. He suggested that the Working Group’s process include: 1) identifying a short list of key provisions critical to consistency, focusing on issues in multistate receiverships; 2) determining which states do not currently have those key provisions in their laws, and any impediments to adopting those provisions; and 3) identifying options to encourage states’ adoption of those provisions, including a discussion of the Financial Regulation Standards and Accreditation Program Part A standards for receivership and guaranty fund laws. Currently, these standards include a broad requirement for a receivership scheme and a regulatory framework for guaranty funds. There was no objection to this plan.

Francine Semaya (Legal and Insurance Regulatory Consulting) spoke about an issue in the liquidation of Oceanus Insurance Risk Retention Group (Oceanus), a South Carolina Risk Retention Group (RRG). Ms. Semaya is counsel to the Liquidator and has encountered difficulties with the enforcement of the receivership stay and permanent injunction in other states. Oceanus was defending over 200 cases in New York. An appellate court recently ruled that the stay should not be recognized because Oceanus is an RRG, and the stay is not entitled to recognition under New York’s Uniform Insurers Liquidation Act. Another ruling found that South Carolina courts had no jurisdiction over the plaintiffs, and it was a matter of public policy to provide plaintiffs with a forum in their state of residence. She expressed concerns that the decisions are so broad, they might create precedents in receiverships involving other types of insurers and could be followed in other states. She urged the Task Force to discuss this issue. Mr. Kennedy noted that the Task Force reviewed the enforcement of stays in 2017 and issued guidance to the states regarding stay provisions in receivership laws. He said that the Receivership Model Law (E) Working Group will consider this issue in the context of the MPI work that is delegated to it.

7. Heard a Presentation on the IAIR Designation Program

Wayne Johnson (Risk & Regulatory Consulting LLC) provided an overview of the revised professional designation program adopted by the International Association of Insurance Receivers (IAIR). The program includes requirements, testing and qualifications of an Accredited Insurance Resolutions Director and a Certified Insurance Resolutions Director. The intent of the revised program is to ensure broader expertise for insurance resolutions, promote consistent standards for the administration of receiverships and deepen the pool of qualified individuals (Attachment Three).

Mr. Kennedy commented that a tremendous amount of work was expended to ensure that this is a robust, meaningful process with standards that can be relied upon. He said that state insurance commissioners entrust the handling of receiverships to special deputy receivers, and there needs to be a mechanism to ensure that they are qualified. He said that the life & health and property & casualty guaranty funds have been supportive of this initiative. Mr. Gendron asked if IAIR had consulted with the Society of Financial Examiners (SOFE) or the NAIC about the IAIR classes counting toward continuing education (CE) credits for SOFE or NAIC designations. Mr. Johnson replied he had spoken to SOFE.

8. Heard an Update on International Resolution Activities

Mr. Wake reported that the International Association of Insurance Supervisors (IAIS) Resolution Working Group (ReWG) met in September to finalize the Application Paper on Recovery Planning and to continue development of the Application Paper on Resolution Planning. He said that the U.S. submitted its response to an ReWG questionnaire on resolution authority. Work will continue in 2020. Mr. Kennedy said that states can volunteer to assist in reviewing the ReWG’s drafts.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.
The Receivership Large Deductible Workers’ Compensation (E) Working Group of the Receivership and Insolvency (E) Task Force met via conference call Dec. 2, 2019. The following Working Group members participated: Donna Wilson, Co-Chair (OK); Laura Lyon Slaymaker, Co-Chair (PA); Steve Uhrynowycz (AR); Toma Wilkerson (FL); Kevin Baldwin (IL); Robert Wake (ME); John Rehagen (MO); Tom Green (NE); and James Kennedy (TX).

1. **Adopted its Minutes**

Ms. Wilson presented the minutes from the Working Group’s Oct. 24 conference call (Attachment One-A). Mr. Baldwin made a motion, seconded by Ms. Wilkerson, to adopt the Working Group’s Oct. 24 minutes. The motion passed unanimously.

2. **Exposed a Model Guideline for #555**

Ms. Slaymaker presented the NAIC staff memorandum to the Working Group (Attachment One-B). The Working Group focused their discussion on the variations from the National Conference of Insurance Guaranty Funds (NCIGF) model adopted by some states. The Working Group directed NAIC staff to amend the draft guideline for the *Insurer Receivership Model Act* (#555) as an alternative approach to Section 712 based on the NCIGF model to reflect administrative fees, a state specific citation for the definition of large deductible, and the guaranty association entitlement to the net amount of the reimbursement. The Working Group exposed the model guideline for a 60-day comment period ending Jan. 31, 2020. Comments are to be submitted to Sherry Flippo (NAIC) (Attachment One-C).

Having no further business, the Receivership Large Deductible Workers’ Compensation (E) Working Group adjourned.
The Receivership Large Deductible Workers’ Compensation (E) Working Group of the Receivership and Insolvency (E) Task Force met via conference call Oct 24, 2019. The following Working Group members participated: Donna Wilson, Co-Chair (OK); Laura Lyon Slaymaker, Co-Chair (PA); Steve Uhrynowycz (AR); Kevin Baldwin (IL); Robert Wake (ME); John Rehagen (MO); Tom Green (NE); Christopher Brennan (NJ); and James Kennedy (TX).

1. Adopted Revisions to the Receiver’s Handbook for Insurance Company Insolvencies

Ms. Slaymaker presented the revisions to the Receiver’s Handbook for Insurance Company Insolvencies (Handbook) from the minutes of the Working Group’s May 8 conference call, which were discussed during its July 18 call. Ms. Wilson made a motion, seconded by Mr. Brennan, to adopt the Handbook revisions (Attachment Two). The motion passed unanimously.

2. Heard a Presentation on Distributive Variation Between Model #555 Section 712 and the NCIGF Model

Sherry Flippo (NAIC) presented the PowerPoint presentation (Attachment One-A1). The Working Group directed NAIC staff to draft a model guideline for the Insurer Receivership Model Act (#555) as an alternative approach to Section 712 based on the National Conference of Insurance Guaranty Funds (NCIGF) model.

Having no further business, the Receivership Large Deductible Workers’ Compensation (E) Working Group adjourned.
Receivership Large Deductible Workers’ Compensation Working Group

Distributive variation between:
1. Reinsurance Option Approach - Model #555 section 712
2. Secure Claim Approach - NCIGF Model
2 Approaches Defined

1. Reinsurance option approach which lead to section 712 of NAIC Model #555, and
2. Secured Claim approach which is the NCIGF Model.

• There are strong arguments for both options which made the issue contentious when Model #555 was under development.
• Functionally, in both a scenario where you have a large deductible policy and where an insurer is fronting for a captive reinsurer, the policyholder is economically responsible for the claim. The SAP accounting is not similar to reinsurance because the liability is NOT booked from the first dollar with off-setting credit for deductible recoveries. Rather SAP books the liability starting after the deductible amount on the insurer’s books, unless the insurer goes into receivership
• NCIGF is consistence. There are scenarios where it is proper for policyholder to pay the claims and scenarios where the guaranty fund should have an unconditional right of reimbursement.
• The difference between the large deductible and reinsurance is that you have a statutory right of reimbursement running from the employer to the claimant that preceded the policy. Therefore, it is reasonable to treat the policyholder reimburse obligation as security for the benefits being paid to the claimant.
Distributive Variation

- Distributive variation between the two approach would be minimal where there is appropriate collateral and an efficient collection process in place.
- The significant distributive variation occurs when the collateral is:
  - inadequate,
  - co-mingled, or
  - dissipated
Scenario # 1- NCIGF- 100% of Losses Available

<table>
<thead>
<tr>
<th>Assets/Liability</th>
<th>Distribution from Estate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estate Assets $1M (plus a bond collateral of $500,000)</td>
<td>Liability Classes</td>
</tr>
<tr>
<td>Policyholder Liability $1.5M Minus $500,000 = $1M</td>
<td></td>
</tr>
<tr>
<td>Distribution 50%/50%</td>
<td>Distribution GF Covered after $500,000 bond collection 2/3 covered</td>
</tr>
<tr>
<td>Bond Redeemed and funds transferred directly to Guaranty Funds</td>
<td>Distribution on policy claims not covered by GF: 1/3</td>
</tr>
<tr>
<td></td>
<td>Total</td>
</tr>
</tbody>
</table>
Scenario #1 - NAIC - 100% of Losses Available

<table>
<thead>
<tr>
<th>Assets/Liability</th>
<th>Guaranty Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estate Assets</td>
<td>Liability Classes</td>
</tr>
<tr>
<td>$1.5M (the bond of $500,000 for LD collateral is added to the total estate)</td>
<td></td>
</tr>
<tr>
<td>Policyholder Liability</td>
<td>$1M</td>
</tr>
<tr>
<td>$1.5M</td>
<td></td>
</tr>
<tr>
<td>Distribution GF Covered Amount 2/3-</td>
<td></td>
</tr>
<tr>
<td>Un-Covered 1/3</td>
<td>500,000</td>
</tr>
<tr>
<td>Total</td>
<td>$1.5M</td>
</tr>
</tbody>
</table>
Scenario #2 - NCIGF- $800,000 Available for Distribution from Estate to Policyholder Class

| Assets/Liability | | |
|------------------|------------------|------------------|------------------|------------------|
| **Estate Assets** | $800,000 (plus a bond collateral of $500,000) | **Policyholder Liability** | $1.5M ($1M Allowed from Estate Assets + $500,000 Paid Directly to GF from Bond Proceeds) | **Distributions from the State** | $1M/ $800K |
| **Liability Classes** | **Amounts** | **Estate Assets/Policy Holder Liability less bond** | **Amounts with Admin. Fees** | |
| Distribution GF Covered Amount 2/3 | 500,000 | X 80% | 400,000 plus 500,000 bond |
| Distribution on policy claims not covered by GF: 1/3 | 500,000 | X 80% | 400,000 |
| **Total** | 1,000,000 | | 800,000 |

Bond Redeemed and funds transferred directly to Guaranty Funds
Scenario # 2- NAIC- $800,000 Available for Distribution from Estate to Policyholder

<table>
<thead>
<tr>
<th>Assets/Liability</th>
<th>Pay out %</th>
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</thead>
<tbody>
<tr>
<td>$1,500,000.00</td>
<td>0.87</td>
</tr>
<tr>
<td>$800,000.00</td>
<td></td>
</tr>
<tr>
<td>$500,000.00</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Guaranty Funds</th>
<th>Amounts</th>
<th>Amounts at .87 on the $</th>
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</thead>
<tbody>
<tr>
<td>Liability Classes</td>
<td>Amounts</td>
<td>Amounts at .87 on the $</td>
</tr>
<tr>
<td>Distribution GF Covered Amount 2/3-</td>
<td>$1M</td>
<td>$870,000</td>
</tr>
<tr>
<td>Distribution on policy claims not covered by GF: 1/3</td>
<td>$500,000</td>
<td>$430,000</td>
</tr>
<tr>
<td>Total</td>
<td>$1,500,000</td>
<td>$1.3M</td>
</tr>
</tbody>
</table>

Estate Assets $800,000M (the bond of $500,00 for LD collateral is added to the total)

Policyholder Liability $1.5M
## Comparison of Disbursement under the Models

<table>
<thead>
<tr>
<th>Scenario #1</th>
<th>Scenario #2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NCIGF Model</strong></td>
<td><strong>$800,000 Available for Distribution from Estate to Policyholder Class</strong></td>
</tr>
<tr>
<td><strong>Total GF recoveries:</strong> 500K + 500K Bond = $1M</td>
<td><strong>Total GF recoveries:</strong> $870,000M</td>
</tr>
<tr>
<td>Total Estate Distribution to Policy Claimants not covered GF: $500,000</td>
<td>Total Estate Distribution to Policy Claimants not covered GF: $430,000</td>
</tr>
<tr>
<td><strong>Total $1M</strong></td>
<td><strong>Total $1.3M</strong></td>
</tr>
</tbody>
</table>

**Note Under #1:** LD paid at $500,000 under both methods.

**Note Under #2:** LD paid at $500,000 under NCIGF and at $430,000 under NAIC.
MEMORANDUM

TO: Receivership Large Deductible Workers’ Compensation (E) Working Group
FROM: NAIC Staff
DATE: November 12, 2019
RE: Guideline: Alternative to Section 712 of Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies

Executive Summary

Having the necessary statutory authority specific to large deductible workers’ compensation products in receiverships is key to the successful resolution of these insurers. There are currently two statutory authority options available, and there are differences across states as to which authority has been adopted: 1) Section 712 of the NAIC Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies; and 2) the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Legislation, Administration of Large Deductible Policies and Insured Collateral. Both provide statutory guidance that articulates the respective rights and responsibilities of the various parties, which greatly enhance a state’s ability to manage complex large deductible programs in liquidation.

NAIC staff has been asked to draft the attached Guideline: Alternative to Section 712 of Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies as alternative language to Section 712 of Model #555.

Guideline v. Model Law

The NAIC model law development process helps provide uniformity while balancing the needs of insurers operating in multiple jurisdictions with the unique nature of state judicial, legislative and regulatory frameworks. In 2007, the NAIC changed the way model laws and model regulations were developed. The criteria for development of a model law or regulation now involve a two-pronged test. First, the subject matter of the model law or regulation must call for a minimum national standard or require uniformity among the states. The second part of the test is the NAIC members must be committed to dedicating significant regulator and NAIC staff resources to educating, communicating and supporting the adoption of the model law or regulation.

When issues arise where a proposed model law does not meet the two-pronged test, a group can proceed to develop a guideline to address the regulatory issue. Guidelines are not considered to be equivalent to model laws of the NAIC. They are considered regulatory best practices. While Section 712 of Model #555 is a model law, it is the opinion of NAIC staff that the alternative language to Section 712 should be drafted as a guideline, because it does not meet the two-pronged test to be a model law.
2016 Workers’ Compensation Large Deductible Study

Section 712 of Model #555 was originally adopted in 2007 separately from the other provisions of Model #555. After discussion and consideration of recent workers’ compensation insurer insolvencies, the growth of the large deductible market and the increased number of workers affected by large deductibles, the NAIC/IAIABC Joint (C) Working Group was charged in 2015 to provide an update to the 2006 Workers’ Compensation Large Deductible Study. The 2016 Workers’ Compensation Large Deductible Study provides the following discussion on the use, business practices and potential risks of large deductible policies in workers’ compensation:

Current State of the Law

In most states, there is little guidance governing the rights and obligations of the parties when an insurance company with a large deductible portfolio becomes insolvent. One approach to the problem could be called the “secured claim” approach, which places the highest importance on the principle that claims within the deductible are primarily the obligation of the policyholder. Under this approach, deductible reimbursements are earmarked to pay those claims, and any collateral posted by or on behalf of the policyholder is held to ensure that those claims are paid. Accordingly, when the guaranty association takes on the responsibility of paying a claim within the deductible, it earns the benefit of the reimbursement due from the policyholder, and the right to draw on the collateral if necessary, or to initiate a draw by the receiver, for the benefit of the guaranty fund. [Note: this is the approach of the NCIGF Model].

Another approach could be called the “reinsurance” approach, which places the highest importance on the principle that the insurer’s obligation to pay all covered claims and the policyholder’s obligation to reimburse the insurer are unconditional and that each is independent of the other. Under this approach, deductible reimbursements are a general asset of the estate so that large deductible policies and guaranteed cost policies are essentially identical from the guaranty fund’s perspective, and the guaranty fund only benefits from the deductible reimbursements in proportion to its share as a creditor of the estate. The NAIC has largely taken the second approach. Under the Insurer Receivership Model Act (#555), Section 712—Administration of Loss Reimbursement Policies, the receiver has the right to collect all deductible reimbursements, drawing on collateral as necessary. All such payments are general assets of the estate. Any reimbursements paid to the guaranty association are treated as early access distributions and offset from future recoveries from the estate. However, the receiver also has the option to enter into an agreement under which the policyholder takes on responsibility for claims within the deductible, directly or through a TPA, and any such claims remain off the books of both the estate and the guaranty fund. It should be noted that no state has enacted the reinsurance approach embodied in Model #555. The NCIGF approach, on the other hand, has had some success in state legislatures, as the paragraph below demonstrates. Further, some states may have concerns about the impact of the Model #555 approach on statutory deposit requirements in California.

[Update: Eight Eleven states currently have statutes in place: California, Florida, Illinois, Indiana, Michigan, Missouri, New Jersey, Pennsylvania, Texas, West Virginia and Utah.] Most of these states follow the NCIGF approach and have amended their insurance liquidation acts to clarify the following when to secure competing claims such as deductible amounts owed the insurer and retroactive premium balances: 1) the ownership of the deductible reimbursements or collateral drawdowns; 2) claims-handling matters; 3) collection responsibility; and 4) allocation of collateral.

Variations on NCIGF Model

Some states have adopted variations from the NCIGF model that may be considered by states when they are considering adding such language. For example, Illinois, Michigan, and Pennsylvania adopted laws that provide for a three percent administrative fee for the receiver:
The Director as rehabilitator or liquidator is entitled to deduct from reimbursements owed to guaranty associations or the Illinois Insurance Guaranty Fund or collateral to be returned to a policyholder reasonable actual expenses incurred in fulfilling the responsibilities under this provision, not to exceed 3% of the collateral or the total deductible reimbursements actually collected by the Director as rehabilitator or liquidator. [215 ILCS 5/205.1].

- California noted in their adoption of the NCIGF model that deductible amounts under their law may vary from as little as five thousand dollars to as much as one million dollars or more.
  - Refers to Section A(1)(b): A large deductible shall include any policy with a deductible of fifty thousand dollars or greater.

**Receivership Accreditation Standard**

The NAIC Financial Regulation Standards and Accreditation Program requires that a state have a “receivership scheme” for the administration, by the insurance commissioner, of insurance companies found to be insolvent similar to that set forth in Model #555. Section 712 of Model #555 is part of that receivership scheme, and it will be necessary for the Financial Regulation Standards and Accreditation (F) Committee to determine that the NCIGF Model also satisfies the receivership scheme requirements of this accreditation standard, and may be considered as alternative language that may be adopted by the states. By having two options for the states to consider, it will foster uniformity between the states, because the variation between states will be minimized as the state will consider adopting statutory authority consistent with one of the approaches rather than developing their own framework for large deductible workers’ compensation products.

Attachment
GUIDELINE: ALTERNATIVE TO SECTION 712 OF INSURER RECEIVERSHIP MODEL ACT (#555)
“ADMINISTRATION OF LOSS REIMBURSEMENT POLICIES”

Drafting Note: Having the necessary statutory authority specific to large deductible workers’ compensation products in receiverships is key to the successful resolution of these insurers. There are currently two statutory authority options available, and there are differences across states as to which authority has been adopted: 1) Section 712 of the NAIC Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies; and 2) the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Legislation, Administration of Large Deductible Policies and Insured Collateral. Both provide statutory guidance that articulates the respective rights and responsibilities of the various parties, which greatly enhance a state’s ability to manage complex large deductible programs in liquidation. Generally, both approaches provide for the collection of reimbursements, resolve disputes over who gets the reimbursements and ensure that the claimants are paid. The provisions in each of the two options generally complement each other, except for conflicting provisions regarding the issue of the ultimate ownership of, and entitlement to, the deductible recoveries and collateral as between the estate and the guaranty fund. The issue is whether the guaranty funds, on behalf of the claimants, are entitled to any deductible reimbursements or whether they are a general estate asset that is shared pro rata by the guaranty funds and the uncovered claimants.

The NAIC Financial Regulation Standards and Accreditation Program requires that a state have a “receivership scheme” for the administration, by the insurance commissioner, of insurance companies found to be insolvent similar to that set forth in Model #555. Section 712 of the NCIGF Model has been determined to satisfy the receivership scheme requirements of this accreditation standard, and may be considered as alternative language that may be adopted by the states to meet the essential requirements of Section 712 of Model #555. By having two options for the states to consider, it will foster uniformity between the states, because the variation between states will be minimized as the state will consider adopting statutory authority consistent with one of the approaches rather than developing their own framework for large deductible workers’ compensation products.

Alternative Model Section 712. Administration of Large Deductible Policies and Insured Collateral

This section shall apply to workers’ compensation large deductible policies issued by an insurer subject to delinquency proceedings under this chapter; however, this section shall not apply to first party claims, or to claims funded by a guaranty association net of the deductible unless paragraph B. of this section applies. Large deductible policies shall be administered in accordance with their terms, except to the extent such terms conflict with this section.

A. Definitions. For purposes of this section:

(1) “Large deductible policy” means any combination of one or more workers compensation policies and endorsements issued to an insured, and contracts or security agreements entered into between an insured and the insurer in which the insured has agreed with the insurer to:

(a) Pay directly the initial portion of any claim under the policy up to a specified dollar amount, or the expenses related to any claim; or

(b) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.

The term “large deductible policy” also includes policies which contain an aggregate limit on the insured’s liability for all deductible claims in addition to a per claim deductible limit. The primary purpose and distinguishing characteristic of a large deductible policy is the shifting of a portion of the ultimate financial responsibility under the large deductible policy to pay claims from the insurer to the insured, even though the obligation to initially pay claims may remain with the insurer. A large deductible shall include any policy with a deductible of fifty thousand dollars or greater.

Large deductible policies do not include policies, endorsements or agreements which provide that the initial portion of any covered claim shall be self-insured and further that the insurer shall have no payment obligation within the self-insured retention. Large deductible policies also do not include policies that provide for retrospectively rated premium payments by the insured or reinsurance arrangements or agreements, except to the extent such arrangements or agreements assume, secure, or pay the policyholder’s large deductible obligations.

(2) “Deductible claim” means any claim, including a claim for loss and defense and cost containment expense (unless such expenses are excluded), under a large deductible policy that is within the deductible.

(3) “Collateral” means any cash, letters of credit, surety bond, or any other form of security posted by the insured, or by a captive insurer or reinsurer, to secure the insured’s obligation under the large...
deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Collateral may also secure an insured’s obligation to reimburse or pay to the insurer as may be required for other secured obligations.

(4) “Commercially Reasonable” means, to act in good faith using prevailing industry practices and making all reasonable efforts considering the facts and circumstances of the matter.

(5) “Other secured obligations” means obligations of an insured to an insurer other than those under a large deductible policy, such as those under a reinsurance agreement or other agreement involving retrospective premium obligations the performance of which is secured by collateral that also secures an insured’s obligations under a large deductible policy.

B. Handling of Large Deductible Claims.

Unless otherwise agreed by the responsible guaranty association, all large deductible claims, which are also “covered claims” as defined by the applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for handling. To the extent the insured funds or pays the deductible claim, pursuant to an agreement by the guaranty fund or otherwise, the insured’s funding or payment of a deductible claim will extinguish the obligations, if any, of the receiver and/ or any guaranty association to pay such claim. No charge of any kind shall be made against the receiver or a guaranty association on the basis of an insured’s funding or payment of a deductible claim.

C. Deductible claims paid by a guaranty association.

To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the full amount of the reimbursement, and available collateral as provided for under this section to the extent necessary to reimburse the guaranty association. Reimbursements paid to the guaranty association pursuant to this subsection shall not be treated as distributions under [cite to priority distribution statute] or as early access payments under [cite to early access statute].

To the extent that a guaranty association pays a deductible claim that is not reimbursed either from collateral or by insured payments, or incurred expenses in connection with large deductible policies that are not reimbursed under this section, the guaranty association shall be entitled to assert a claim for those amounts in the delinquency proceeding.

Nothing in this subsection limits any rights of the receiver or a guaranty association that may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association's related expenses, such as those provided for pursuant to [insert cite to guaranty association net worth provision], or existing under similar laws of other states.

D. Collections

(1) The receiver shall have the obligation to collect reimbursements owed for deductible claims as provided for herein and shall take all commercially reasonable actions to collect such reimbursements. The receiver shall promptly bill insureds for reimbursement of deductible claims:

(a) Paid by the insurer prior to the commencement of delinquency proceedings;

(b) Paid by a guaranty association upon receipt by the receiver of notice from a guaranty association of reimbursable payments; or

(c) Paid or allowed by the receiver.
If the insured does not make payment within the time specified in the large deductible policy, or within sixty (60) days after the date of billing if no time is specified, the receiver shall take all commercially reasonable actions to collect any reimbursements owed.

Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the large deductible policy, shall be a defense to the insured’s reimbursement obligation under the large deductible policy.

Except for gross negligence, an allegation of improper handling or payment of a deductible claim by the insurer, the receiver and/or any guaranty association shall not be a defense to the insured’s reimbursement obligations under the large deductible policy.

E. Collateral.

Subject to the provisions of this subsection, the receiver shall utilize collateral, when available, to secure the insured’s obligation to fund or reimburse deductible claims or other secured obligations or other payment obligations. A guaranty association shall be entitled to collateral as provided for in this subsection to the extent needed to reimburse a guaranty association for the payment of a deductible claim. Any distributions made to a guaranty association pursuant to this subsection shall not be treated as distributions under [Insert state insurance liquidation priority distribution statute] or as early access payments under [Insert state early access statute].

All claims against the collateral shall be paid in the order received and no claim of the receiver, including those described in this Subsection, shall supersede any other claim against the collateral as described in Subsection (4) of this Section.

The receiver shall draw down collateral to the extent necessary in the event that the insured fails to:

(a) Perform its funding or payment obligations under any large deductible policy;
(b) Pay deductible claim reimbursements within the time specified in the large deductible policy or within sixty (60) days after the date of the billing if no time is specified;
(c) Pay amounts due the estate for pre-liquidation obligations;
(d) Timely fund any other secured obligation; or
(e) Timely pay expenses.

Claims that are validly asserted against the collateral shall be satisfied in the order in which such claims are received by the receiver.

Excess collateral may be returned to the insured as determined by the receiver after a periodic review of claims paid, outstanding case reserves and a factor for incurred but not reported claims.
Proposed Changes to Receiver’s Handbook for Insurance Company Insolvencies

RE: Large Deductible Worker’s Compensation

Inserts into Existing Handbook shown in “tracked” change.
Text between sections/pages eliminated to conserve space.

Chapter 1 – Takeover & Administration (Page 30)

VIII. CLAIMS

A. Control the Claim Department’s Records

Obtain copies of the insurer’s claim policies and procedures manuals. Review them to determine if the insurer has formal procedures that address the following areas:

- Actual claim processing flow;
- The level of claim file documentation required;
- The coverage confirmation process;
- Claims reserving and settlement philosophy;
- Claims settlement authority;
- Litigated claims;
- Aggregate policy procedures;
- Large Deductible Policy Procedures including collection, collateral and aggregates;
- Reinsurance recovery procedures;
- Theories relevant to property/casualty insurers, such as trigger theories for asbestos and environmental claims; and
- The insurer’s relationships with and responsibilities to managing general agents, TPAs, outside claim adjusters, reinsurance intermediaries and other outside parties.

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<table>
<thead>
<tr>
<th>Checklist 6—Underwriting</th>
<th>Project Assigned To</th>
<th>Date Completed</th>
<th>Completed By</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance</td>
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<tr>
<td>Locate, obtain copies and review all insurance policies and contracts:</td>
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<tr>
<td>- General Liability</td>
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<td>- Property</td>
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<td>- Auto</td>
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<tr>
<td>- Workers’ Compensation</td>
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<tr>
<td>- Fidelity Bond</td>
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<tr>
<td>- Directors and Officers</td>
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<tr>
<td>- Large Deductible Endorsements</td>
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<td>- Errors and Omissions</td>
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<tr>
<td>- Professional Liability</td>
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</tbody>
</table>
### Chapter 1 – Takeover & Administration (Page 84)

<table>
<thead>
<tr>
<th>Large Deductible Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review underwriting, billing and collateral records to determine which policies have large deductible endorsements and the status of collateral held, billings, and reserve calculations</td>
</tr>
</tbody>
</table>

### Chapter 1 – Takeover & Administration (Page 102)

<table>
<thead>
<tr>
<th>Securities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify letters of credit, trust agreements and other collateral held to secure obligations of policyholders under large deductible endorsements, and review and/or establish procedures for reviewing the adequacy of such collateral</td>
</tr>
</tbody>
</table>

### Chapter 1 – Takeover & Administration (Page 105)

<table>
<thead>
<tr>
<th>Receivables</th>
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</thead>
<tbody>
<tr>
<td>Review large deductible billing procedures to determine that all amounts are billed timely. Determine that there are no outstanding items for billing and obtain an aging of outstanding receivables.</td>
</tr>
</tbody>
</table>

### Chapter 1 – Takeover & Administration (Page 105)

<table>
<thead>
<tr>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet with Manager of Large Deductible Collections (and/or other appropriate personnel) to discuss large deductible</td>
</tr>
</tbody>
</table>
**Collection procedures, personnel and responsibilities, staffing and what will be required from staff as a result of the order**
- Conduct interviews of appropriate large deductible collection department personnel to determine policies and procedures. Document same.
- Establish a large deductible recoverable balance as of the receivership date

### Gathering Documentation
- Determine location of large deductible records – secure and inventory. This should include:
  - All policies containing large deductible endorsements
  - Claims files arising under such policies
  - Correspondence files
  - Billing records
    - Letters of credit, trust agreements, deductible reimbursement policies or other collateral
- For all LOCs, trust accounts, funds withheld:
  - Secure all originals
  - Notify all banks and trustees of the order

### Documenting Large Deductible Collection Procedures
- Review recent billings for all large deductible policies
- Obtain a list of large deductible payment history and determine whether insured payments have been ongoing or if payment from collateral has been required.
- Obtain a list of paid and unpaid bills updated after liquidation
- Obtain claim documentation for claims arising under large deductible policies
  - By paid loss and loss reserves and ALAE paid and reserves
  - List of claims in litigation/arbitration
- Review large deductible billing system; determine that all paid losses arising under large deductible policies have been billed.
- Determine whether large deductible endorsements provide that losses within the deductible are limited in the aggregate
- Evaluate recovery processes and determine if new procedures are appropriate
- Determine whether collateral is held by affiliated/unaffiliated third party via large deductible reimbursement policy, trust
agreement or other vehicle, and evaluate whether collateral
can be transferred to the receivership
- Document insured collection disputes
- Determine which functional group handles disputes
- Interview members of each group responsible for
  coordinating, monitoring and controlling large deductible
  collection disputes
- Audit large deductible collection-specific systems. Track
data from source to final product to verify billings are correct
  and inclusive and internal controls are adequate

Chapter 2- Information System (Page 139)

H. Common Systems Applications

8. Email

Virtually every insurer uses an industry standard email system. Emails are important company records
that must be preserved. In addition to performing a backup of the email server at the start of the
receivership, it is also good practice to extract individual email boxes of key employees at that time as
well. Consideration should be given to periodically backing-up these files throughout the receivership
to insure preservation of communications. Email backup restoration often requires the use of outsource
computer forensic experts. Extracting email boxes in readable format at the outset of a receivership will
save costs down the road should email records be required for litigation purposes,

9. Large deductible recoverables can be a large asset of the receivership, and, like reinsurance,
collection is highly dependent on reliable policy and loss information. Use of information systems in
recording and tracking this information is fairly common. As with reinsurance, this system may be a
part of, or at least closely connected with, the accounting or claims systems

Chapter 2- Information System (Page 141)

C. Types of Business Written

Initially, it will be necessary to identify general characteristics of the insurer’s business practices. This analysis
will provide a general idea of systems sizing and related requirements and should include an analysis of:

- Lines of business – The lines of business underwritten and the characteristics of this business may have a
  substantial impact on information systems requirements. If it is a business in which claims will develop
  quickly, the requirement may be quite different from long-tail business in which claims will take a long
time to develop. If the business included large-deductible or loss-sensitive features such a retrospectively
  rated premiums, there will be additional system demands. This also will impact the amount of historical
  information that must be maintained in the systems.
I. Existing Systems

The receiver’s staff (or an independent consultant) needs to determine if the existing systems adequately process the business or if those systems must be supplemented with manual processing. If it is the latter, the receiver should then determine whether the level of supplemental manual processing required is acceptable, in terms of accuracy and the cost of processing. This will establish whether the existing system(s) are adequate to provide the receiver with the amount and types of information required.

The receiver may require various types of information in the administration of an estate. Especially with systems that do not permit online inquiry, it is imperative that reports which are adequate for the receiver’s purposes be produced. At a minimum, the existing systems should have the capability of generating a wide variety of reports. The receiver’s staff should carefully examine the available reports to determine whether they are adequate or if custom reports need to be developed, assuming the data stored in the systems can support custom reports. Reports are normally required for the following types of information:

- Policies and contracts;
- Accounting;
- Claims;
- Accounts receivable/payable;
- Cash;
- Reinsurance;
- Guaranty fund claims counts and reserves by state; and
- Earned and unearned premium.
- Large Deductible Collections and Collateral

D. Salvage and Subrogation (Property/Casualty Only)

5. Salvage and Subrogation (Property/Casualty- Large Deductible Recoveries - Only)

a. Large Deductible Recoveries

Large deductible recoveries are amounts received by an insurer from an insured covered under a policy having an endorsement providing that the insured is responsible to indemnify the insurer for certain losses and LAE incurred. While these policies share some characteristics with retrospectively rated policies, the accounting treatment of recoveries under the two types of policies is different.

b. Accounting Practices

Under statutory accounting practices, recoveries under large deductible policies are not treated as premium. Unpaid losses are booked net of the deductible, except where the deductible is deemed not to be collectible, in which case the losses are booked on a gross basis. Because losses within the large deductible limit are not booked, it is important that the receiver examine the records, systems and procedures to identify and follow up large deductible recoveries on both paid and unpaid claims. Because these recoverables do not appear on the balance sheet...
VI. OTHER SIGNIFICANT TRANSACTIONS

B. Large Deductible Policies

Large deductible recoveries can represent a significant source of recoveries for insolvent companies, especially those property and casualty companies that wrote workers’ compensation insurance. Because these recoverables do not appear on the balance sheet unless uncollectible, but may be a significant recoverable amount, the receiver should examine the scope of the large deductible business written, and the collection and collateral procedures employed by the company.

1. General Considerations

   a. The receiver’s recovery of large deductible recoverables is dependent on the claims handling and reporting of both claims covered and those not covered by guaranty funds.

   b. The key to effective collection and collateral administration is ensuring that the historical records for paid losses under the deductible policies and the program design are maintained and available. Another key is retaining the personnel that have knowledge and history of the insurer's deductible business operations.

   c. Collateral for Large Deductible Balances.

      - The importance of collateral cannot be overstated. But adequate collateral must be established prior to liquidation as it is unlikely to be collected after liquidation.
      - Large Deductible balances frequently will be secured to ensure collectability and preserve the insurer’s statutory accounting credit. The receiver should identify and closely review these security arrangements early in the receivership. Particular attention should be paid to security arrangements where the insured’s collateral is held by third parties, especially affiliates of the insurer.
      - Notices to financial institutions or others involved in security arrangements are critical to preserve the security by ensuring compliance with terms of the security arrangements and the exercise of any related rights or obligations.

2. Communication

   Deductible collection, in addition to requiring collateral, is dependent on communication of all parties (i.e., between receiver and insured, receiver and guaranty associations, guaranty association and insured). It must be quickly established with insured as to procedure for ongoing claim processing, continuation of their responsibility to reimburse the deductible payments and responsibility to maintain appropriate collateral. Guaranty associations must also recognize that they will be required at times to communicate with insureds regarding claims handling. All parties should be mindful of security...
concerns related to communication of sensitive claims data. The SUDS server hosted by NCIGF is a useful tool for communication between receivers and guaranty associations. Guaranty funds may opt for telephonic communication with insureds. The collection process should proceed with minimal delay as the passage of time will impact success of collection efforts. In these efforts it is imperative that the guaranty associations and the receiver work together and offer consistent messages to the insured regarding any collection issues. It should also be noted that the release of collateral from a receiver to a guaranty association may not fully satisfy the policyholder’s obligation for costs related to the claim under a state’s guaranty association law.

3. Deductible Collection Procedure

a. A working process must also be established quickly between the receiver and the guaranty associations to provide claim handling, payment information and all other required claim financials to allow the receiver to bill and collect loss payments.

b. The information would include the receiver providing the guaranty associations all pertinent information to establish the policies that are deductibles along with effective dates, deductible limits, treatment of ALAE and deductible aggregates where available.

c. Copies of deductible policies should be made available if required.

d. Guaranty Association’s will provide, through the establishment of UDS data feed, all financial information regarding deductible claims that they are handling.

e. Receiver will collate data from guaranty associations and review historical billing information to invoice the insureds on a monthly or quarterly basis.

f. Receiver will calculate and track the payment history pre-liquidation and post Liquidation within the deductible and within a deductible aggregate for the policy if applicable. This ensures that the insured is only billed for amounts that remain within their deductible.

g. To assist in the collection process receiver and guaranty association should work to provide sufficient information and explanation to allow the insured to recognize its obligation. In the event where the insured refuses to pay, the receiver will either begin litigation or draw on collateral or both. This should be coordinated with the guaranty associations.

4. Professional Employer Organizations (“PEOs”)

a. Policies issued to PEOs often have large deductible endorsements.

b. Because of the prevalence of abuse in the underwriting of PEOs, post-liquidation collection of deductible payments may be challenging.

c. Clients may have been added without notice (or payment) to the insurer; Client class of business may have been misrepresented or expanded to include riskier classes of business – all of which may lead to inadequate or exhausted collateral.

d. Client companies of PEO may not have received notice of cancelation, leading to coverage disputes. If collateral is inadequate and the PEO does not have assets to pay the deductible reimbursement in full, the policy terms might make the client companies liable for the shortfall, either for their own exposure or on a joint-and-several basis. However, this might not be a meaningful source of recovery, because it could be impractical, inappropriate, or impossible to collect significant amounts from the clients.
5. Commutations

a. Generally, commutations are negotiated terminations of the rights and liabilities between insurers and large deductible insureds. A commutation is a settlement of all obligations, both current and future, between the parties for a lump sum payment.

b. There are many valid reasons for commutations of large deductibles. They may provide immediate cash for the receivership estate, avoid future uncertainties, resolve disputes between insurer and insured, and provide some protection or limitation of exposure from the insolvency of the insured. Commutations of long tail business (i.e., workers’ compensation) may be essential for the early termination of the receivership.

c. Commutations, however, may be a detriment to the receivership if the commutation is consummated for less than fair consideration. A receiver should carefully review the commutation to determine whether the benefit to the insurer outweighs the disadvantages.

Chapter 5 – Claims (Page 288)

V. PAYMENT OF APPROVED CLAIMS

A. Priority of Distribution in Receiverships

5. Class 3 and 4 – Claims for Policy Benefits

a. Deductible and Limits

The policyholder’s claim is for the amount that the insurer should have paid. For some policies (e.g., workers’ compensation policies), the insurer is required to pay the claim and seek the deductible from the insured (thereafter, known as “Large Deductible Policies”). It is common for insureds to post collateral with the insurer for deductible payments that may be made by the insurer, for which the insurer then seeks reimbursement from the insureds. With other policies, the insurer’s liability attaches after the deductible has been paid by the insured (“Non Advancement Policies”). IRMA Section 712 provides for the disposition of Large Deductible Policy or Loss Reimbursement Policy recoveries between receivers and guaranty associations. Individual state statutes (see, for example, 40 PA §221.43a) differ from IRMA Section 712 in certain respects.”

Chapter 9 – Legal Considerations (Page 518)

G. Assets that are not General Assets, Special Deposits and Letters of Credit

3. Letters of Credit

There has been some controversy surrounding the rights and obligations of receivers regarding letters of credit (LOCs). LOCs are typically used to support reinsurance and large deductible obligations. Letters of credit issued in connection with reinsurance transactions are discussed in detail in Chapter 7, Section VIII and in connection with large deductible transactions in Chapter 4, Section A.

Chapter 9 – Legal Considerations (Page 539)
I. Large Deductibles

Many liability policies for large commercial insureds are being written with deductible limits that may exceed $100,000. The purpose of these large deductible amounts is to reduce premiums for the insured while permitting the insured to meet statutory or regulatory insurance requirements. Large deductible policies are most common in the workers’ compensation area but may be found in other types of liability insurance.

Typically, a large deductible policy provides that the insurer will pay claims in full and then collect the deductible amount from the insured (first dollar coverage). Conversely, first party claims against an auto policy with a deductible are paid minus the amount of the deductible. To ensure that the deductible will be paid, most insurers that write this type of policy will require the insured to post some form of security. This can be a letter of credit or securities placed in a trust or escrow account for the benefit of the insurer, or some other form of a third-party commitment to reimburse for claims within the large deductible, such as a bond or large deductible reimbursement insurance policy. When the insurer pays a claim, depending on the agreement with the insured, the insurer may either submit a bill to the insured for the amount of the claim paid within the deductible or collect directly from the collateral.

As long as the insurer and the insured remain solvent, there are seldom any difficulties with large deductible arrangements. If the insured becomes insolvent and stops paying the deductible billings and if the collateral held is insufficient to pay current and future billings, the insurer’s ability to collect the amounts due will be adversely affected. Or funding the collateral account, the insurer remains liable for injuries sustained prior to the termination of the policy.
Proposed Changes to Receiver’s Handbook for Insurance Company Insolvencies

RE: Large Deductibles

(NEW SECTION IN EXISTING HANDBOOK)

Chapter 5 – Claims (Page 304)

VIII. BEST PRACTICES FOR SUCCESSFUL BILLING AND COLLECTION OF LARGE DEDUCTIBLE PROGRAMS IN LIQUIDATION

A. Overview of Large Deductible Worker’s Compensation

A large deductible worker’s compensation policy or program is a method of insuring workers’ compensation risk with the employer assuming some of that risk in a deductible of $100,000, $250,000, or even higher per claim (varies by state) and an insurer taking on the remaining risk. In states that permit professional employer organizations (PEOs), PEO’s often operate large deductible programs. A PEO is an outsourcing firm which provides services to small and medium sized businesses. The PEO enters into a contractual co-employment agreement with its clientele. If the employer or PEO fails to pay for any reason, the insurer incurs an unexpected liability, and the failure of the claim reimbursement mechanism has been a significant factor in a number of insurer insolvencies.

B. Administration of Large Deductible Plans

The administration of large deductible plans is impacted by entry of an order of liquidation. In such cases, there are two options available regarding statutory authority concerning Large Deductible Worker’s Compensation, namely:

1) Insurer Receivership Model Act (Model #555—IRMA) Section 712 Administration of Loss Reimbursement Policies; or

2) National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Act.

Both provide statutory guidance that articulates the respective rights and responsibilities of the various parties, which would greatly enhance the ability to manage complex large deductible programs post-liquidation. Generally, both approaches provide for the collection of large deductible reimbursements from policyholders, clarify entitlement to reimbursement, and ensure that the claimants are paid. The provisions in each of the two options generally complement each other except for conflicting provisions regarding the issue of the ultimate ownership of and entitlement to the deductible recoveries and collateral as between the estate and the guaranty fund.

C. Communication and Reporting Between the Liquidator, Policyholders and Guaranty Associations, Including Administration of Self-Funded Policyholder Programs

1. Claim payment, reserve, and reimbursement reporting.

The administration of large deductible programs requires strong communication and reporting programs between the Liquidator, guaranty associations and policyholders. Under the both Model Acts, the Liquidator is required to administer large deductible programs, and related collateral securing large deductible obligations, consistent with the policyholder’s policy provisions and large deductible agreement (“LDA”) as amended by the provisions of the Model Act. Both Model Acts make provision for two types of LDAs, those that permit self-funding by the policyholder, and those that require initial payment by the insurer or guaranty association with reimbursement by the policyholder. Both arrangements necessitate the reporting of claim payments and outstanding claim reserves to the Liquidator for billing, guaranty association reimbursement, and establishing
collateral need requirements. The Liquidator’s uniform data standard or UDS should be deployed as the reporting protocol for guaranty association claim payments and outstanding claim reserves. Policyholders that continue self-funding under their LDA will need to continue or establish a claim information reporting protocol with the Liquidator through the policyholder’s third-party claim administrator or through a proprietary claim information aggregator. Both Model Acts require the Liquidator to form an independent opinion on outstanding claim reserves reported by policyholders and guaranty associations, including a safety factor and incurred but not reported liability to ensure that collateral remains adequate throughout the administration of the program.

2. Agreements between Liquidator and guaranty associations.

For states that have enacted the either of the two Model Acts or similar statutory framework for the Liquidator’s administration of large deductible programs an agreement between the Liquidator and the guaranty associations is not necessary. The Models provide a comprehensive framework for administration of the program. For states that have not enacted either Model, an agreement between the Liquidator and guaranty associations may be advisable. The Models can serve as an outline for the issues that should be addressed in such an agreement. Among other things, an agreement should address: whether large deductible recoveries are estate assets subject to the Liquidator’s distribution regime or directly pass-through to the guaranty association on account of its prior claim payments, claim reporting protocols, frequency of collateral review and reimbursement activity, and administration of collateral for under collateralized non-performing policyholder accounts.

3. Converting policyholder accounts from an incurred to paid basis under the Model Act.

The NCIGF Model Act provides for the conversion of a policyholder’s LDA at liquidation from an “incurred” to a “paid” basis. Conversion is beneficial to policyholders in several ways. Most importantly, conversion at liquidation treats pre-liquidation incurred loss payments made by the policyholder to the insurer as collateral, and thus property of the policyholder pledged to the insurer and restricted to the satisfaction of that policyholder’s claims, rather than as a general asset of the liquidation estate. Conversion also offers flexibility to a policyholder as to the type of security provided to an insurer in satisfaction of the collateral requirement. Conversion affords policyholders the ability to utilize a letter of credit to secure an insurer for the outstanding portion of their loss, rather than payment of cash, since the outstanding bill after conversion is reflected in the Liquidator’s collateral need analysis, rather than an incurred loss billing.

The NCIGF Model Act recognizes these important policyholder rights and provides incentive to policyholders to cooperate with the Liquidator’s administration of large deductible programs and guaranty association reimbursement. The Liquidator should consider notifying large deductible policyholders of these important policyholder rights at the inception of a liquidation proceeding and offer policyholders the opportunity to elect to convert their large deductible programs from an incurred to paid basis in accordance with the NCIGF Model Act, memorializing any elections with an endorsement that otherwise follows and requires the policyholder to adhere to the provisions of the NCIGF Model Act.

2.4. Large deductible billing by Liquidator.

The Liquidator should establish a large deductible billing and collection program that bills policyholders on a periodic basis, e.g., quarterly, that meets Liquidator and policyholder expectations for claim payments made by the estate prior to liquidation and by guaranty associations after liquidation. The Liquidator’s invoice to policyholders should communicate a claim payment summary that includes detail such as the insurer or guaranty association’s check number, date of payment, payee, account year, and remaining large deductible limits. Large deductible programs that are self-funded by policyholders should also report their claim payments to the Liquidator on a similar periodic basis, so that the Liquidator can establish appropriate claim reserves, track the exhaustion of the policyholder’s deductible limits, report to reinsurers and collect reinsurance. Consideration should be given to using one of many proprietary billing and collection software programs to automate the large deductible billing and collection process. Large deductible recoveries that are subject to
guaranty association reimbursements should be aggregated and distributed on a quarterly or other periodic basis that balances the Liquidator’s accounting requirements and the guaranty associations’ reimbursement needs.

### 3.5. Annual collateral review by Liquidator.

The NCIGF Model Act, consistent with the typical LDA, requires the Liquidator to perform an annual collateral review for each policyholder account to ensure that the Liquidator holds adequate collateral to support a policyholder’s large deductible obligations and to release any excess collateral held back to the policyholder. This review should include a report to the policyholder on total incurred claims, claims paid, outstanding reserves, any additional safety factor and total collateral need. The Liquidator’s collateral review should result in a report to the policyholder and an invoice for additional collateral need or a release and distribution of excess collateral. The Liquidator should consider whether any additional safety factor should be included for non-performing policyholder accounts. The NCIGF Model Act provides flexibility on the timing of the annual review, enabling the Liquidator to perform the annual review process throughout the calendar year so that all policyholder account reviews are not due at the same time.

**D. Administration Fees**

Section 712 (G) OF IRMA provides:

> The receiver is entitled to recover through billings to the insured or from large deductible policy collateral all reasonable expenses that the receiver or guaranty associations incur in fulfilling their responsibilities under this Section. All such deductions or charges shall be in addition to the insured’s obligation to reimburse claims and related expenses and shall not diminish the rights of claimants.

Further, Section 712(F) provides, in part:

> The expenses incurred by a guaranty association in pursuing reimbursement shall not be permitted as a claim in the delinquency proceeding at any priority; however, a guaranty association may net the expenses incurred in collecting any reimbursement against that reimbursement.

Several states have adopted statutory provisions similar to the IRMA provisions regarding handling of large deductibles in an insolvency and provide for the Receiver to retain reasonable actual expenses incurred from the reimbursement to the guaranty association(s). Similarly, statutes may provide for the guaranty association to net expenses incurred in collecting a reimbursement.

When there is no statutory guidance, receivers should include a provision for reimbursement of reasonable actual expenses in an agreement with the guaranty associations regarding the collection and allocation of large deductibles.

**E. Policy and Collateral Definitions**

It is important that state laws define large deductible workers’ compensation policies and large deductible collateral. Defining the treatment of such policies and associated collateral is imperative for developing polices and processes for administering the collection of assets. For purposes of this handbook, “Large deductible policy” means any combination of one or more workers compensation policies and endorsements issued to an insured, and contracts or security agreements entered into between an insured and the insurer in which the insured has agreed with the insurer to:

(a) Pay directly the initial portion of any claim under the policy up to a specified dollar amount, or the expenses related to any claim; or
(b) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.

The term “large deductible policy” also includes policies which contain an aggregate limit on the insured’s liability for all deductible claims in addition to a per claim deductible limit. The primary purpose and distinguishing characteristic of a large deductible policy is the shifting of a portion of the ultimate financial responsibility under the large deductible policy to pay claims from the insurer to the insured, even though the obligation to initially pay claims may remain with the insurer. The dollar amount of “large” will vary by state law. While many states might associate a minimum financial threshold, it is more important to consider the administration of the policy compared to a traditional policy. Deductible amounts can include claim-related payments by the insurer for medical and indemnity benefits, allocated loss adjustment expenses, such as medical case management expenses, legal defense fees and independent medical exam expenses. It is critical that the policy specify the claim-related payments that are the responsibility of the policyholder and not be inside agreements or other agreements outside of the policy. Collateral held by the insurer should be defined as amounts held for large deductible policy. The policy should provide acceptable financial instruments that can be held for large deductible policy. Typical collateral requirements include: cash, letters of credit, surety bonds or other liquid financial means held for the benefit of the insurer.

F. Whether receiver or guaranty fund should be Responsible Party For Collection of Large Deductible Reimbursements

It is critical to immediately establish the party responsible for billing and collecting large deductibles. While some states might have specific statutory language that specifies the entity responsible, some statutes might be silent. In the case where the statutes do not specify responsibility, it is recommended that the receivers and guaranty associations enter into an agreement that allows for the most efficient administration of the large deductible collections.

Specific consideration should be given to large deductible policies that provide coverage in multiple states and have claimants subject to the jurisdiction of multiple guaranty funds. If feasible, the most efficient approach for such policies would likely be for the receiver to administer the deductible billing and collection process. Throughout the life of the estate, claimants continue to incur benefit payments and expenses and deductible collection efforts may last beyond the life of the estate. The party responsible for collections needs the ability to compromise and settle the future obligations.

The receiver should make provisions in its discharge motion and Court order, to the extent possible, regarding the transition of ongoing deductible collections to the guaranty as well as the disposition of any collateral being held by the receiver.

G. Treatment of Collateral in Receivership

When collateral has been posted by or on behalf of a large deductible policyholder, what does the receivership estate actually own? The answer is generally found in the documents pledging the collateral to the insurer.

The Insurance Receivership Model Act, NAIC Model Law # 555 (“IRMA”) defines “property of the estate” to include “all right, title and interest in property ... includ[ing] choses in action, contract rights, and any other interest recognized under the laws of this state.”

In states without an explicit statutory definition, the common-law definition is substantially similar.

1 IRMA § 104(V)(1).
This means that the insurer’s right to draw on the collateral automatically becomes an asset of the receivership estate, but the collateral itself is not an estate asset unless and until it is drawn. In the first instance, the conditions and procedures for drawing the collateral should be spelled out in the relevant contract documents (which could include third-party instruments such as letters of credit or surety bonds), but state law could provide additional rights, and will specify what the receiver may do when the documents are silent, incomplete, or missing.

Possession and control over the collateral are distinct from ownership. The insurer could already be in possession of the collateral before the receivership, or the receiver might act to take possession by enforcing applicable contract rights or by negotiating an agreement. Nevertheless, this does not immediately give the receiver the right to use the collateral to pay claims. The defining characteristic of collateral is that it is intended to serve as a backstop in case the policyholder does not meet its obligations to pay all reimbursements promptly and in full. Commonly, the right to draw on collateral only attaches after the policyholder has defaulted or has consented to a draw, or, if the collateral is a letter of credit, after the issuer has given notice of nonrenewal (in which case the receiver must act promptly to call the LOC or obtain replacement collateral). There could also be the opportunity to negotiate an agreement under which the policyholder turns over the collateral and makes a lump-sum payment to commute any further reimbursement obligations, or the collateral might have been structured from the outset as a “working” loss fund from which the insurer was expected to pay claims in the ordinary course of business.

In any case, while it is essential for the receiver to preserve and exercise the right to access the collateral as needed, it is also essential to ensure that collateral is not dissipated to pay claims that the policyholder should be funding. Special consideration needs to be given in situations where the policyholder is at risk of being or becoming judgment-proof, or where rights to the collateral are shared with other creditors of the policyholder and prompt action is necessary to preserve the receiver’s priority.

When the guaranty association is paying the claims, it is generally entitled to receive the proceeds of any policyholder reimbursements, including draws on the collateral. Under laws substantially similar to IRMA, these payments are considered early access distributions (but without the necessity for court approval) which may be subject to subsequent clawback, while laws substantially similar to the NCIGF Model treat them as the ultimate source of funding for the underlying claims, so that they belong unconditionally to the guaranty association. Either way, however, it is the receiver rather than the guaranty association that has the right and obligation to draw on the collateral, unless there is a formal written agreement assigning that right to the guaranty association.

Finally, there is always the hope that the policyholder’s reimbursement obligations will be oversecured or will become oversecured as claims are run off. In that case, any excess collateral will revert to the policyholder or the policyholder’s guarantor. State law might expressly provide a process for determining when excess collateral is being held by or on behalf of the receiver, or the ability to return collateral before the estate is closed might be part of the general powers of the receiver. However, because workers’ compensation is a long-tail exposure with significant risk of adverse reserve development, receivers must take great care not to make premature or excessive return distributions.

H. Issues Raised by Net Worth Exclusions and Deductible Exclusions

Unlike other lines of insurance, workers’ compensation insurance is generally exempt from the statutory caps on guaranty association coverage, so that the guaranty fund is usually obligated to pay workers’ compensation claims

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2 For example, IRMA § 712(D) specifically provides that the relevant provisions of the policy are not controlling “where the loss reimbursement policy conflicts with this section.”

3 Compare IRMA § 712(C)(3) with NCIGFMA § 712(C).

4 See NCIGFMA § 712(E)(3).

5 See, e.g., NCIGFMA § 712(E)(5).
in full. However individual states may have adopted caps on guaranty association coverage.\textsuperscript{6} States have created this exception to honor their state’s promise that injured workers will be paid the full benefits to which they are entitled. The general purpose of these exclusions is to avoid any obligation for the guaranty association to pay losses that can and should be borne by the policyholder. Net worth exclusions make guaranty association protection unavailable to policyholders with net worth above a specified threshold, while deductible exclusions expressly prohibit guaranty association coverage for amounts within a policy deductible.

Unless these exclusions are drafted and implemented carefully, there is a risk that they could result in delays in claims payments or even a complete loss of coverage. In some states, claimants might be protected by an uninsured employer fund, but that is not the purpose of those funds, so even if such a fund exists in your state, it should be a priority to ensure that however it is done, the estate, employer, or guaranty association will provide for payment in full of all benefits due under the state’s workers’ compensation laws. If this is not possible under current law, regulators should advocate for a change in the law. A variety of successful approaches are available; there is not a single one-size-fits-all solution that is best for every state.

\textit{I. Net Worth Exclusions:}

The PC GA Act contains an optional section, with a variety of alternative provisions states can select, excluding coverage for high-net-worth insureds, whether they are individuals or business entities.\textsuperscript{7} The base version sets the threshold at $50 million, while one of the alternatives sets the threshold at $25 million. Many states have enacted some version of this clause or some comparable net worth exclusion.

The impact on workers’ compensation coverage depends on how the exclusion is structured. In states with provisions substantially similar to any of the three alternatives under the PC GA Act, coverage is excluded completely for first-party claims by high-net-worth insureds, but workers’ compensation claims against high-net-worth policyholders are administered by the guaranty association on a “pay-and-recover” basis: that is, the guaranty association has the obligation to pay the claim in the first instance, and the right to be reimbursed by the policyholder.\textsuperscript{8} Thus, claimants are fully protected, and for large deductible policies, this mirrors the structure of the policy for claims within the deductible. In states with guaranty association laws similar to the NCIGF Model, this is the same reimbursement right the guaranty association would have in the absence of the exclusion as the insurer’s successor.

If the policyholder is cooperative, the guaranty association has the option of negotiating an agreement where the policyholder advances funding for claims within the deductible. However, if the policyholder is not cooperative, guaranty associations have expressed concern that the pay-and-recover framework is burdensome and gives the policyholder too much leverage to avoid or delay paying its obligations in full. If PC GA Act’s Alternative 2 is modified to treat workers’ compensation claims the same as other third-party claims, then the guaranty association has no obligation unless the formerly high-net-worth policyholder has become insolvent.\textsuperscript{9} Otherwise, the claimant’s

\textsuperscript{6} See Property and Casualty Insurance Guaranty Association Model Act, NAIC Model Law # 540 (“PC GA Act”), § 8(A)(1)(a)(i). Almost all states have some provision requiring payment in full of workers’ compensation claims, but some states might have caps or other limitations on coverage.

\textsuperscript{7} PC GA Act, § 13.

\textsuperscript{8} Alternative 1 applies the pay-and-recover obligation to all third-party claims. Alternative 2 excludes most third-party claims as well as all first-party claims, but requires the guaranty association to pay workers’ compensation claims, statutory automobile insurance claims, and other claims for ongoing medical payments. Alternative 3 excludes only first-party claims and claims by out-of-state claimants that are subject to a net worth exclusion in the claimant’s home state; this alternative does not create any statutory right of recovery when the guaranty association is obligated to pay a third-party claim.

\textsuperscript{9} PC GA Act, § 13(B)(2) Alternative 2.
only recourse is against the policyholder or the insured’s estate. As stated above, the injured worker should be protected by some means in these cases.

When a guaranty association net worth exclusion and a large deductible both come in to play on the same claim, it is imperative that the receiver and guaranty association stay in close communication in order to avoid any confusion regarding which entity is responsible for the collection. In both IRMA 712 and the NCIGF large deductible model statute, the guaranty fund is entitled to collect net worth reimbursements. Coordination of these collections with receiver efforts to collect on high deductible will do much to avoid duplication of billings and potential resulting collection delays.

2. Deductible Exclusions:

The PC GA Act does not contain any explicit deductible exclusion. Instead, it simply provides that “In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises.”10 However, some states have enacted explicit language further clarifying that there is no guaranty association coverage for amounts within a policy’s deductible or self-insured retention.11 For example, Minnesota law excludes “any claims under a policy written by an insolvent insurer with a deductible or self-insured retention of $300,000 or more, nor that portion of a claim that is within an insured’s deductible or self-insured retention” from coverage by the property and casualty guaranty association.12 A Minnesota employer entered into an employee leasing arrangement with a PEO, which obtained a workers’ compensation policy with a $1 million deductible. Both the PEO and the insurer became insolvent, and the Minnesota Court of Appeals held that there was no guaranty association coverage for workers’ compensation claims against the client employer because of the statutory deductible exclusion.13 The court observed that the Legislature deliberately chose to protect the guaranty association from unlimited exposure, without mentioning that the Legislature also deliberately created an exception making the cap on coverage inapplicable to workers’ compensation claims (which strongly suggests that the statute in question, which is tied to the statutory $300,000 cap on coverage, was not written with workers’ compensation in mind).14 Likewise, the court took for granted that the statute’s undefined term “deductible” included the contract provision at issue in the case, even though the insurer had assumed the unconditional liability to pay all claims in full. The opinion did not consider the possibility that the Legislature’s intent was simply to clarify that the guaranty association has no obligation to drop down and pay claims from the first dollar if the insurer would have had no obligation to pay those claims.

Therefore, if states determine that there is a need to include express provisions addressing deductibles and self-insured retentions in their guaranty association laws, it is essential to avoid unintended consequences. In particular, the key terms should not be left undefined. For this reason, IRMA coined the term “loss reimbursement policy” in its section addressing these types of policies, to distinguish them from true deductibles, where the insurer has no obligation to pay anything except the portion of the loss that exceeds the deductible.15

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10 PC GA Act, § 8(A)(1)(b). Compare LH GA Act, § 3(B)(2)(a), expressly excluding from life and health guaranty association coverage “A portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner.”

11 Currently, the only states with language specifically excluding claims within policy “deductibles” are Iowa, Louisiana, Minnesota, Missouri, and Nevada. Louisiana’s exclusion applies only to policies issued to group self-insurance funds, and Missouri’s does not apply to workers’ compensation claims.

12 Minn. Stat. § 60C.09(2)(4).


14 Minn. Stat. § 60C.09(3).

15 For example, if a consumer has an auto policy with a collision deductible of $1,000, and the repair costs $5,000, the insurer’s liability is limited to $4,000. “Self-insured retentions” (SIRs) in commercial excess policies are designed to function the same
This is the crucial difference between a “large deductible” workers’ compensation policy and an excess policy. Although “large deductible” policies transfer a significant amount of risk back to the policyholder, they do not extinguish the insurer’s liability. That is why “large deductible” policies, in states that allow them, are accepted as a mechanism for satisfying the policyholder’s compulsory coverage obligations, while excess policies generally are not. Usually, excess workers’ compensation policies may only be issued to self-insurers that have been approved by the state. It is the approved self-insurance program, not the excess policy, that satisfies the employer’s compulsory coverage obligation, and the insurer has no liability for any portion of a claim that falls within the employer’s self-insured retention. Thus, despite the terminology that is commonly used, it is the excess policy, not the large deductible policy, that functions as a “deductible” in the traditional sense of the term.

It is worth noting, however, that commercial self-insured retention and large deductible policies can vary widely in policy terms and sometimes “side agreements” supplement the policies. Arrangements can contain aggregate limits, can vary on the obligation for defense cost and expenses and, in some cases permit the insured to “self-fund” its claims with an account in the possession of the TPA which is handling the claims. Because of these complexities, policy terms and any related endorsements and side agreements should be carefully reviewed. Whether such side agreements are legally enforceable requires a thorough case-by-case analysis in light of applicable state laws.

way on a larger scale. If a business is found liable (or a third-party claim is settled) for $500,000, and its liability policy has an SIR of $300,000, the insurer is never responsible for more than the remaining $200,000, even if the policyholder is bankrupt.

16 In many states, a separate self-insurance guaranty fund protects claimants if a self-insured employer becomes insolvent. Those funds typically operate entirely under the state’s workers’ compensation laws, not the state’s insurance receivership or insurance guaranty fund laws.
Professional Designation Program

December 8, 2019

Objectives of IAIR’s Professional Designation Program

• Broader Expertise in Insurance Resolutions
• Promoting Consistent Standards for Administration of Insurance Resolutions
• Rigorous Program and Objective Designation Testing
• Deepening of the Pool of Qualified Individuals to Assist Commissioners with Troubled Companies
Professional Designation Program  
Effective January 1, 2020

- Accredited Insurance Resolutions Director
  - Verification of Formal Education and Training
  - Verification of References
  - Verification of Continuing Education
  - Background Certification
  - Test of Basic Hazardous Condition, Administrative Supervision and Receivership Knowledge
  - Applicant Interview by the IAIR Ethics Committee

Professional Designation Program  
Effective January 1, 2020

- Certified Insurance Resolutions Director
  - Accounting and Financial Reporting
  - Actuarial
  - Claims and Guaranty Associations
  - Information Technology
  - Legal
  - Reinsurance
  - Resolution Management
Certified Insurance Resolutions Director

- Verification of References
- Verification of Continuing Education
- Background Certification
- Passing Score on Test for Designation Sought
- Minimum of Three Years’ Insurance Company Resolutions Experience
- Applicant Interview by the IAIR Ethics Committee

Website Updates January 1, 2020

- iair.org
- Designation Programs Selection on Home Page
- Overview of the IAIR Professional Designation Program
- Specific Listing of AIRD and CIRD Designation Requirements
- Updated and Streamlined Professional Designation Application and Instructions
- Listing of Recommended AIRD and CIRD Study Materials
- Listing of IAIR Members with IAIR Designations
IAIR Contact Information

• Nancy Margolis
  • nancy@accolademgt.com
  • (610) 992-0017

IAIR Continuing Education Program

• Requirements
  • 30 Hours Total of Eligible Continuing Education over a 2 Year Period
  • 5 Hours of Continuing Education Must be IAIR Programs

• Reporting
  • Annual Reporting Requirement
  • Reporting Period Begins January 1 of Each Odd Numbered Year
  • Reporting Period Concludes December 31 of the Following Even Numbered Year
I’m lost, can you go over that again?
REINSURANCE (E) TASK FORCE

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The Reinsurance (E) Task Force met in Austin, TX, Dec. 8, 2019. The following Task Force members participated: Chlora Lindley-Myers, Chair, and John Rehagen (MO); Raymond G. Farmer, Vice Chair, represented by Lee Hill (SC); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridling represented by Sheila Travis (AL); Allen W. Kerr represented by Mel Anderson (AR); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Kathy Belfi and Wanchin Chou (CT); Stephen C. Taylor represented by Philip Barlow (DC); Trinidad Navarro represented by Rylunn Brown (DE); David Altmaier represented by Virginia Christy and Susanne Murphy (FL); Doug Ommen represented by Kim Cross (IA); Dean L. Cameron represented by Nathan Faragher (ID); Stephen W. Robertson represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by Christopher Joyce (MA); Eric A. Cioppa represented by Robert Wake (ME); Matthew Rosendale represented by Steve Matthews (MT); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by Matt Fischer (ND); Bruce R. Ramey represented by Lindsay Crawford (NE); John Elias represented by Doug Bartlett (NH); Linda A. Lacellw represented by Puran Bheamsain (NY); Jillian Froment represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowbarger (OK); Elizabeth Kelleher Dwyer represented by Jack Broccolli (RI); Hodgen Mainda represented by Trey Hancock (TN); Kent Sullivan represented by Jamie Walker (TX); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); Michael S. Pieciak represented by David Provost (VT); Mark Afable represented by Randy Milquet (WI); and James A. Dodrill represented by Ellen Potter (WV).

1. Adopted its Oct. 22 and Summer National Meeting Minutes

The Task Force met Oct. 22 to: 1) adopt revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions; 2) adopt the re-evaluations of France, Germany, Ireland and the United Kingdom (UK) as Qualified Jurisdictions; and 3) adopt the recommendation on revisions to the Reinsurance Ceded section of the Accreditation Program Manual.

Mr. Eft made a motion, seconded by Mr. Kaumann, to adopt the Task Force’s Oct. 22 (Attachment One) and Aug. 4 (see NAIC Proceedings – Summer 2019, Reinsurance (E) Task Force) minutes. The motion passed unanimously.


Mr. Kaumann provided the report of the Reinsurance Financial Analysis (E) Working Group. He stated that the Working Group met Oct. 10, in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss the applications of four new certified reinsurers and the renewal of 10 certified reinsurers. The Working Group met Nov. 26, in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss the application of one new certified reinsurer and the renewal of 17 certified reinsurers. Mr. Kaumann stated that the Working Group would meet once more during December to consider one additional application for a certified reinsurer.

Mr. Kaumann stated that the Working Group monitors 33 certified reinsurers that have been recommended for passporting, noting that the Working Group will begin discussions to determine the best and most effective approaches for the financial solvency surveillance of these non-U.S. reinsurers as reciprocal jurisdictions.

Mr. Kaumann made a motion, seconded by Mr. Wake, to adopt the report of the Reinsurance Financial Analysis (E) Working Group. The motion passed unanimously.

3. Adopted the Report of the Qualified Jurisdiction (E) Working Group

Mr. Wake provided the report of the Qualified Jurisdiction (E) Working Group. He stated that the Working Group met three times since the Summer National Meeting in regulator-to-regulator sessions, pursuant to paragraph 6 (consultations with NAIC staff members) and paragraph 8 (considerations of strategic planning issues) of the NAIC Policy Statement on Open Meetings.
Mr. Wake stated that the Working Group met Aug. 22 and discussed and agreed upon revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions and approved the Re-Evaluation of Qualified Jurisdiction and Summary of Findings and Determination for France, Germany, Ireland and the UK as qualified jurisdictions. He stated that the documents were exposed for a 30-day public comment period ending Oct. 4, noting that the Task Force adopted the revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions and reapproved France, Germany, Ireland and the UK as qualified jurisdictions during its Oct. 22 conference call.

Mr. Wake stated that the Working Group met Nov. 5 and Oct. 7 to discuss the evaluations of Bermuda, Japan and Switzerland as both qualified jurisdictions and reciprocal jurisdictions. On the Nov. 5 conference call, the Working Group and the Task Force exposed the Re-Evaluation of Qualified Jurisdiction and the Evaluation of Reciprocal Jurisdiction for Bermuda, Japan and Switzerland for 30-day public comment periods ending Dec. 5. Mr. Wake stated that NAIC staff kept the Federal Insurance Office (FIO) and the Office of the U.S. Trade Representative (USTR) updated in accordance with the revised Process for Evaluating Qualified and Reciprocal Jurisdictions.

Mr. Wake made a motion, seconded by Mr. Milquet, to adopt the report of the Qualified Jurisdiction (E) Working Group. The motion passed unanimously.

Craig Swan (Bermuda Monetary Authority) provided a statement supporting the adoption of Bermuda as a reciprocal jurisdiction and the re-evaluation as a qualified jurisdiction.

Mr. Rehagen stated that the qualified jurisdiction re-evaluations for France, Germany, Ireland and the UK were adopted by the Task Force on the Oct. 22 conference call. He stated that with the adoption of Bermuda, Japan and Switzerland as qualified jurisdictions by the Task Force at this meeting, the Executive (EX) Committee and Plenary will be able to adopt the re-evaluations of the seven qualified jurisdictions together at the Fall National Meeting. He noted that the original approvals of these seven qualified jurisdictions are due to expire Dec. 31.

Dan Schelp (NAIC) stated that the use of certified reinsurers domiciled in qualified jurisdictions will be gradually phased-out over the next few years in favor of reciprocal jurisdictions, but these jurisdictions must maintain their status as qualified jurisdictions until that time. Mr. Schelp stated that the meeting materials contained the Summary of Findings and Determination as qualified jurisdictions for Bermuda, Japan and Switzerland. There was only one comment letter from the American Council of Life Insurers (ACLI) (Attachment Five) received when these were exposed for public comment.

Mr. Schelp stated that 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) and the revised Process for Evaluating Qualified and Reciprocal Jurisdictions provide that qualified jurisdictions that are not subject to an in-force covered agreement and that meet certain other requirements may be approved as reciprocal jurisdictions and receive similar reinsurance collateral treatment. He stated that the jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital.

Mr. Schelp stated that a determination was made on a minimum solvency or capital ratios to be applied to reinsurers licensed and domiciled in the Bermuda, Japan and Switzerland because these jurisdictions do not utilize either the solvency capital requirement under Solvency II or risk-based capital under the U.S. system. He added that each jurisdiction must have a memorandum of understanding in place with a state for the purpose of regulatory cooperation and the sharing of confidential information. Mr. Schelp stated that Bermuda, Japan and Switzerland had each completed these requirements and had provided the confirmation letter that is outlined in the Process for Evaluating Qualified and Reciprocal Jurisdictions.

Mr. Schelp stated that the meeting materials contained the Summary of Findings and Determination as reciprocal jurisdictions for Bermuda, Japan and Switzerland. There was only one comment letter from the ACLI (Attachment Nine) received when these were exposed for public comment.

Ms. Belfi made a motion, seconded by Ms. Murphy, to: 1) adopt the Summary of Findings and Determination for Bermuda (Attachment Two), Japan (Attachment Three) and Switzerland (Attachment Four) with respect to their re-evaluations as qualified jurisdictions; 2) adopt the Summary of Findings and Determination for Bermuda (Attachment Six), Japan (Attachment Seven) and Switzerland (Attachment Eight) for their approval as reciprocal jurisdictions; and 3) place them on the NAIC List of Reciprocal Jurisdictions. The motion passed unanimously.
5. Exposed an Annual Reporting Blanks Proposal to Incorporate the 2019 Revisions to Model #785 and Model #786 into the Annual Reporting Blanks and Instructions

Jake Stultz (NAIC) stated that this agenda item updates the annual reporting blanks to allow companies to report reinsurance with reciprocal jurisdiction reinsurers when the 2019 revisions to Model #785 and Model #786 are enacted by the state legislatures. He stated that the reciprocal jurisdiction reinsurers will need to get a new identification number for this reporting, noting that this is the same process as was done with certified reinsurers.

Mr. Stultz stated that the Blanks (E) Working Group plans to expose this agenda item during its Dec. 17 meeting, noting that this exposure will last until approximately Feb. 21, 2020, with final consideration of adoption expected at the 2020 Spring National Meeting.

Ms. Travis made a motion, seconded by Ms. Crawford, to expose the Annual Reporting Blanks proposal, which incorporates the 2019 revisions from the Model #785 and Model #786 into the annual reporting blanks and instructions (Attachment Ten). The motion passed unanimously.

6. Received an Update on Model #787 and the 2019 Revisions to Model #785 and Model #786 as Accreditation Standards

Mr. Schelp stated that the Financial Regulation Standards and Accreditation (F) Committee adopted the 2019 revisions to Model #785 and Model #786 as revisions to the Reinsurance Ceded accreditation standard in the Accreditation Program Manual during its Dec. 9 meeting. He stated that the Committee also adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) as a new accreditation standard.

Mr. Schelp noted that these revisions will be incorporated on an expedited basis and a waiver of process will be used, with an effective date for these accreditation standards of Sept. 1, 2022, with enforcement beginning Jan. 1, 2023. He noted that this date coincides with the date by which the FIO must complete federal preemption determination of state laws under the Dodd-Frank Wall Street Reform and Consumer Protection Act.

Steve Clayburn (ACLI) stated that several state legislatures are beginning work on enacting the 2019 revisions to Model #785 and Model #786, but few have acted on Model #787 or the 2016 revisions to Model #785.

Mr. Schelp stated that a legislative packet with information on the 2019 revisions to Model #785 and Model #786 have been sent to the state legislatures, noting that this packet will be updated to include Model #787 and resubmitted to the state legislatures.

Having no further business, the Reinsurance (E) Task Force adjourned.
The Reinsurance (E) Task Force met via conference call Oct. 22, 2019. The following Task Force members participated: Chlora Lindley-Myers, Chair, represented by John Rehagen (MO); Raymond G. Farmer, Vice Chair, represented by Lee Hill (SC); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridling represented by Richard Ford (AL); Allen W. Kerr represented by Kim Johnson (AR); Ricardo Lara represented by Monica Macaluso and Kim Hudson (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Joel Henry (CT); Stephen C. Taylor represented by Philip Barlow (DC); Trinidad Navarro represented by Dave Lonchar (DE); David Altmaier represented by Susanne Murphy (FL); John F. King represented by Martin Sullivan (GA); Doug Ommen represented by Carrie Mears (IA); Stephen W. Robertson represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Nancy G. Atkins represented by Sandy Batts (KY); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by Christopher Joyce (MA); Eric A. Cioppa represented by Robert Wake (ME); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Colton Schulz (ND); Bruce R. Ramge represented by Lindsay Crawford (NE); John Elias represented by Doug Bartlett and Patricia Gosselin (NH); Marlene Caride represented by John Tirado (NJ); Linda A. Lacewell represented by Michael Campanelli (NY); Jillian Froment represented by Dale Bruggeman (OH); Hodgen Mainda represented by Hui Wattanasankolpat (TN); Kent Sullivan represented by Jamie Walker (TX); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); and Mark Afable represented by Randy Milquet (WI). Also participating was: Susan Berry (IL).

1. **Adopted the Process for Evaluating Qualified and Reciprocal Jurisdictions**

Mr. Wake stated that the Qualified Jurisdiction (E) Working Group met Oct. 7 and Aug. 22 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members) and paragraph 8 (considerations of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to consider revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions (Qualified and Reciprocal Jurisdiction Process). He stated that the Working Group exposed draft revisions to the Qualified and Reciprocal Jurisdiction Process on Sept. 4 for a 30-day public comment period (Attachment One-A) and received eight comment letters (Attachment One-B).

Mr. Wake stated that as a result of the comment letters received and a discussion held with representatives from the U.S. Department of the Treasury, the Office of the U.S. Trade Representative and the Federal Insurance Office (FIO), the Working Group formed a drafting group to address the comments.

Mr. Wake and Dan Schelp (NAIC) provided a summary of the revisions that had been made and a description of the process. Mr. Wake stated that the final draft version of the Qualified and Reciprocal Jurisdiction Process was the version that includes the revisions that were sent out by NAIC staff via email on Oct. 21, and this is the version being considered for adoption.

Mr. Wake also provided a recommendation that the Working Group revise the process for revocation or suspension of a Qualified Jurisdiction or Reciprocal Jurisdiction during 2020.

Karalee C. Morell (Reinsurance Association of America—RAA) thanked the Task Force and Working Group for their efforts during this process and offered her assistance as the process continues.

Yvette Pierre (Bermuda Monetary Authority—BMA) offered to assist in the process of getting Bermuda to Reciprocal Jurisdiction status.

Mr. Wake made a motion, seconded by Mr. Kaumann, to adopt the Process for Evaluating Qualified and Reciprocal Jurisdictions (Attachment One-C). The motion passed unanimously.
2. **Adopted the Re-Evaluation of Qualified Jurisdictions and Summary of Findings and Determinations for France, Germany, Ireland and the UK**

Mr. Wake stated that the Qualified Jurisdiction (E) Working Group met Aug. 22 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members) and paragraph 8 (considerations of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to consider the **Re-Evaluation of Qualified Jurisdictions and Summary of Findings and Determinations** for France, Germany, Ireland and the United Kingdom (UK) as Qualified Jurisdictions. He stated that the Working Group exposed the draft **Re-Evaluation of Qualified Jurisdictions and Summary of Findings and Determinations** on Sept. 4 for a 30-day public comment period and received eight comment letters (Attachment One-B).

Mr. Wake stated that the final drafts to be considered for adoption included nonsubstantive revisions from the exposed versions as a result of the comment letters received. The revisions were: 1) for France, the lead state has been changed from New York to Delaware; and 2) for Germany, a reference has been added to additional information received during the re-evaluation process received from Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin).

Mr. Wake stated that the Working Group has also approved and exposed the **Re-Evaluation of Qualified Jurisdictions and Summary of Findings and Determinations** for a 30-day public comment period ending Nov. 6; it is intended that the seven Qualified Jurisdictions will be re-approved together; and Bermuda, Japan and Switzerland will be approved as Reciprocal Jurisdictions by the Executive (EX) Committee and Plenary at the Fall National Meeting.

Ms. Berry asked for clarification about whether France, Germany, Ireland and the UK must be approved by the Financial Condition (E) Committee or if they must only be adopted by the Executive (EX) Committee and Plenary after the Task Force and if there will be another call of the Task Force to adopt Bermuda, Japan and Switzerland as Qualified Jurisdictions prior to the Fall National Meeting.

Mr. Schelp stated that the way that the Qualified and Reciprocal Jurisdiction Process is written, after adoption by the Task Force, it can then be sent directly to the Executive (EX) Committee and Plenary, and the Task Force does not intend to hold another conference call prior to the Fall National Meeting.

Mr. Wake made a motion, seconded by Mr. Tirado, to adopt the **Re-Evaluation of Qualified Jurisdictions and Summary of Findings and Determinations** for France (Attachment One-D), Germany (Attachment One-E), Ireland (Attachment One-F) and the UK (Attachment One-G) as Qualified Jurisdictions. The motion passed unanimously.

3. **Adopted the Reciprocal Jurisdiction Accreditation Standard**

Mr. Rehagen stated that the Task Force met Sept. 11 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of accreditation issues) to: 1) discuss revisions to the Reinsurance Ceded section of the **Accreditation Program Manual**; and 2) expose draft revisions for a 30-day public comment period ending Oct. 11.

Mr. Rehagen stated that the Task Force received five comment letters (Attachment One-H), and the letters agreed with the revisions. He noted that one letter with combined comments from the RAA, the American Property and Casualty Insurance Association (APCIA), and the National Association of Mutual Insurance Companies (NAMIC) recommended an effective date of April 1, 2021, which is the date when the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement) allows the FIO to begin its federal preemption analysis.

Mr. Schelp provided a brief discussion of the revisions that were considered for adoption.

Ms. Morell stated that using April 1, 2021, as the effective date would be more effective since it would require the states to enact the revisions 18 months before FIO can begin its preemption determination of the states’ laws.

Mr. Schelp clarified the specific provisions of the Covered Agreements that discuss the federal preemption process.

Mr. Rehagen asked if it would be necessary to move the proposed accreditation enforcement from Jan. 1, 2023, to an earlier date if the effective date was moved to April 1, 2021.
Ms. Morell stated that the enforcement date would need to be moved to an earlier date.

Mr. Bruggeman stated that what matters is the date when FIO may begin its actual preemption of state laws.

Mr. Bruggeman made a motion, seconded by Ms. Obusek, to: 1) adopt the revisions to the Reinsurance Ceded section of the Accreditation Program Manual, with a recommended effective date of Oct. 1, 2022, and accreditation reviews beginning on Jan. 1, 2023 (Attachment One-I); and 2) direct NAIC staff to prepare a referral document from the Task Force to the Financial Regulation Standards and Accreditation (F) Committee for consideration as a possible addition to the accreditation standards and with an additional discussion about the beginning of preemption analysis by FIO to start on April 1, 2021. The motion passed unanimously.

4. Discussed Other Matters

Andrew T. Vedder (Northwest Mutual) stated that he had submitted a letter to the NAIC in conjunction with New York Life that recommended that the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) be adopted as an accreditation standard with the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786).

Mr. Schelp stated that this had been recommended to the Financial Regulation Standards and Accreditation (F) Committee in 2017 but has been delayed, pending the revisions to Model #785 and Model #786 for the Covered Agreements.

Mr. Wake asked if the accreditation motion from earlier in the meeting should be revised to add a recommendation that Model #787 be included.

Mr. Schelp advised against revising the motion, and he stated that Model #787 would likely be discussed by the Committee at the Fall National Meeting.

Having no further business, the Reinsurance (E) Task Force adjourned.
Process for Developing and Maintaining the NAIC List of Evaluating Qualified and Reciprocal Jurisdictions
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I. Preamble

Purpose

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

Background

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

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

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

**Reciprocal Jurisdictions**

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

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

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

1. The NAIC model revisions applicable to certified reinsurers are intended to facilitate cross-border reinsurance transactions and enhance competition within the U.S. market, while ensuring that U.S. insurers and policyholders are adequately protected against the risk of insolvency. To be eligible for certification, a reinsurer must be domiciled and licensed in a Qualified Jurisdiction as determined by the domestic regulator of the ceding insurer. A Qualified Jurisdiction not subject to an in-force Covered Agreement under the Dodd-Frank Act may also be determined to be a Reciprocal Jurisdiction, and reinsurers that have their head office or are domiciled in any such Reciprocal Jurisdiction will not be required to post reinsurance collateral, provided they meet the minimum capital and financial strength requirements and comply with the other requirements of the Credit for Reinsurance Models.

2. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions and Reciprocal Jurisdictions will be conducted in accordance with the provisions of the Credit for Reinsurance Models and any other relevant guidance developed by the NAIC.

3. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Financial Regulation Standards and Accreditation Program (Accreditation Program), adherence to international supervisory standards, and relevant international guidance for recognition of reinsurance supervision. It is not intended as a prescriptive comparison to the NAIC Accreditation Program. In order for a Qualified Jurisdiction that is not subject to an in-force Covered Agreement to be evaluated as a Reciprocal Jurisdiction, that Qualified Jurisdiction must agree to adhere to the same reciprocity standards that have been imposed under the EU and UK Covered Agreements, including the requirement that the Qualified Jurisdiction must agree to recognize the states’ approach to group supervision, including group capital, as provided under the Credit for Reinsurance Models.

4. The states shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the Qualified Jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of Qualified Jurisdiction status is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

5. Each state may evaluate a non-U.S. jurisdiction to determine if it is a Qualified Jurisdiction. A list of Qualified Jurisdictions will be published through the NAIC committee process. A state must consider this list in its determination of Qualified Jurisdictions, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Qualified Jurisdictions contained in the Credit for Reinsurance Models. The creation of this list does not constitute a delegation of regulatory authority to the NAIC. The regulatory authority to recognize a Qualified Jurisdiction resides solely in each state and the NAIC List of Qualified Jurisdictions is not binding on the states.

6. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models.
7. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination that a jurisdiction is a Qualified or Reciprocal Jurisdiction. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings. The NAIC Lists of Qualified and Reciprocal Jurisdictions are intended to facilitate the passporting process.

5.8. Both Qualified Jurisdictions and Reciprocal Jurisdictions must agree to share information and cooperate with the state with respect to all certified applicable reinsurers domiciled within that jurisdiction. Critical factors in the evaluation process include but are not limited to the history of performance by assuming insurers in the applicant jurisdiction and any documented evidence of substantial problems with the enforcement of final U.S. judgments in the applicant jurisdiction. A jurisdiction will not be a Qualified Jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

6.9. The determination of Qualified Jurisdiction status can only be made with respect to the reinsurance supervisory system in existence and applied by a non-U.S. jurisdiction at the time of the evaluation.

7.10. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.
III. Procedure for Evaluation of Non-U.S. Jurisdictions

   a. The NAIC will initially evaluate and expedite the review of those jurisdictions that were approved by the states of Florida and New York prior to the adoption of the revised Credit for Reinsurance Models (i.e., Bermuda, Germany, Switzerland and the United Kingdom). The NAIC may also consider expediting the review of additional jurisdictions, as outlined in paragraph 1(d) below. While the same evaluation procedure and methodology will be applicable to any jurisdiction under review, U.S. state insurance regulators’ familiarity with these particular jurisdictions may lead to a more expeditious review. Subsequent priority will be on the basis of objective factors including but not limited to ceded premium volume and reinsurance capacity issues raised by the states. Priority will also be given to requests from the states and from those jurisdictions specifically requesting an evaluation by the NAIC.
   b. Formal notification of the NAIC’s intent to initiate the evaluation process will be sent by the NAIC to the reinsurance supervisory authority in the jurisdiction selected, with copies to the FIO and other relevant federal authorities as appropriate. The NAIC will issue public notice on the NAIC website upon confirmation that the jurisdiction is willing to participate in the evaluation process. The NAIC will at this time request public comments with respect to consideration of the jurisdiction as a Qualified Jurisdiction. The process of evaluation and all related documentation are private and confidential matters between the NAIC and the applicant jurisdiction, unless otherwise provided in this document, subject to a preliminary confidentiality and information sharing agreement between the NAIC, relevant states and the applicant jurisdiction.
   c. Relevant U.S. state and federal authorities will be notified of the NAIC’s decision to evaluate a jurisdiction.
   d. Expedited Review Procedure. Based on the prior review and approval by Florida and New York of reinsurers domiciled in Bermuda, Germany, Switzerland and the United Kingdom, the NAIC will apply an expedited review procedure with respect to these jurisdictions. The NAIC may also consider extending this expedited review procedure to other jurisdictions approved by a state as a Qualified Jurisdiction, provided that:
      i. The state provides a report to the Qualified Jurisdiction Working Group confirming that it has completed a full review of the jurisdiction in accordance with that set forth in Part IV: Evaluation Methodology. If current information as outlined in paragraph 1(e)(i) (i.e., FSAP Report and ROSC) is not available to the state, it must demonstrate that it has obtained and reviewed information consistent with Appendix A and Appendix B.
      ii. The state completes the full review and lists the jurisdiction as a Qualified Jurisdiction within 60 days of the NAIC’s adoption of the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions. This procedure is not intended to eliminate or reduce any element provided under Part IV: Evaluation Methodology, but is intended to allow for a designation of Conditional Qualified Jurisdiction of these jurisdictions in order to facilitate the certification of reinsurers domiciled therein. Final qualification of each jurisdiction will be contingent upon completion of the full, outcomes-based evaluation procedure.
e. Upon confirmation that a jurisdiction is willing to be considered for designation as a Conditional Qualified Jurisdiction, the following expedited review procedure will apply:

i. The Qualified Jurisdiction Working Group will perform an initial review of the jurisdiction’s most recent Detailed Assessment of Observance on Insurance Core Principles under the International Monetary Fund (IMF)/World Bank Financial Sector Assessment Program (FSAP Report), Report on Observance for Standards and Codes (ROSC), and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system in conjunction with the information provided under Section C through Section G of the Evaluation Methodology. The NAIC will invite each jurisdiction (or its designee) to provide information relative to Section C through Section G of the Evaluation Methodology in order to complete or supplement publicly available information. The NAIC may designate the jurisdiction as a Conditional Qualified Jurisdiction, to be effective immediately, upon: (1) receipt of all necessary initial information requested in this section; (2) opportunity for comment by interested parties; and (3) conclusion of any appropriate communication with the FIO, USTR and other relevant federal authorities.

ii. During this period as a Conditional Qualified Jurisdiction, the Qualified Jurisdiction Working Group will complete its full analysis of the information provided by the jurisdiction, in addition to any specific information that is subsequently requested by the NAIC, in order to evaluate the jurisdiction’s laws, regulations, practices and procedures from an outcomes-based perspective in accordance with the guidance provided under Appendix A and Appendix B of the Evaluation Methodology. Upon satisfactory completion of the outcomes-based review of this information, the NAIC may upgrade the jurisdiction’s designation to Qualified Jurisdiction. The NAIC may also address any issues identified within the review or revoke the designation of Conditional Qualified Jurisdiction.

iii. A jurisdiction may be permitted to maintain the designation of Conditional Qualified Jurisdiction for one year, unless: (1) an extension is granted by the Qualified Jurisdiction Working Group; or (2) a determination is made that the jurisdiction is not a Qualified Jurisdiction.

2. Evaluation of Jurisdiction

a. Evaluation Materials. The Qualified Jurisdiction Working Group will initiate evaluation of a jurisdiction’s regulatory system by using the information identified in Section A through Section G of the Evaluation Methodology (Evaluation Materials). The Qualified Jurisdiction Working Group will begin by undertaking a review of the most recent Financial Sector Assessment Program (FSAP) Report prepared by the International Monetary Fund (IMF), including the Technical Note on Insurance Sector Supervision, ROSC and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Qualified Jurisdiction Working Group will also invite each jurisdiction or its designee to provide information relative to Section A through Section G of the Evaluation Methodology in order to update, complete or supplement publicly available information. The Qualified Jurisdiction Working Group may also request or accept relevant information from reinsurers domiciled in the jurisdiction under review.

b. The Qualified Jurisdiction Working Group will notify the jurisdiction of any additional information upon which the Working Group is relying beyond the information provided by the jurisdiction. In that communication, the NAIC will invite the supervisory authority to compare the materials identified by the
NAIC to the materials described in Appendix A and Appendix B, and provide information required to update the identified public information or supplement the public information, as required, to address the topics identified in Section A through Section G of the Evaluation Methodology. The use of publicly available information (e.g., the FSAP Report and/or the ROSC: Insurance Sector Technical Note) is intended to lessen the burden on applicant jurisdictions by requiring the production of information that is readily available, while still addressing substantive areas of inquiry detailed in the Evaluation Methodology. The Qualified Jurisdiction Working Group’s review at this stage will be focused on how the jurisdiction’s laws, regulations, administrative practices and procedures, and regulatory authorities regulate the financial solvency of its domestic reinsurers in comparison to key principles underlying the U.S. financial solvency framework1 and other factors set forth in the Evaluation Methodology.

c. After reviewing the Evaluation Materials, the Qualified Jurisdiction Working Group may request that the applicant jurisdiction submit supplemental information as necessary to determine whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. The Working Group will address specific questions directly with the jurisdiction related to items detailed in the Evaluation Methodology that are not otherwise addressed in the Evaluation Materials.

d. The NAIC will request that all responses from the jurisdiction being evaluated be provided in English. Any responses submitted with respect to a jurisdiction’s laws and regulations should be provided by a person qualified in that jurisdiction to provide such analyses and, in the case of statutory analysis, qualified to provide such legal interpretations, to ensure that the jurisdiction is providing an accurate description.

e. The NAIC does not intend to review confidential company-specific information in this process, and has focused the procedure on reviewing publicly available information. No confidential company-specific information shall be disclosed or disseminated during the course of the jurisdiction’s evaluation unless specifically requested, subject to appropriate confidentiality safeguards addressed in a preliminary confidentiality and information-sharing agreement. If no such agreement is executed or the jurisdiction is unable to enter into such an agreement under its regulatory authority, the NAIC will not accept any confidential company-specific information.

3. NAIC Review of Evaluation Materials

a. NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise will review the jurisdiction’s Evaluation Materials.

b. Expenses with respect to the evaluations will be absorbed within the NAIC budget. This will be periodically reviewed.

c. Timeline for review. A project management approach will be developed with respect to the overall timeline applicable to each evaluation.

d. Upon completing its review of the Evaluation Materials, the internal reviewer(s) will report initial findings to the Qualified Jurisdiction Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to FIO and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.

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1 The U.S. financial solvency framework is understood to refer to the key elements provided in the NAIC Financial Regulation Standards and Accreditation Program. Appendix A and Appendix B are derived from this framework.
4. Discretionary On-site Review

a. The NAIC may request the jurisdiction under consideration for the opportunity to perform an on-site review of the jurisdiction’s reinsurance supervisory system. Factors that the Qualified Jurisdiction Working Group will consider in determining whether an on-site review is appropriate include the completeness of the information provided by the jurisdiction under review, the general familiarity of the jurisdiction by the NAIC staff or other state regulators participating in the review based on prior conduct or dealings with the jurisdiction, and the results of other evaluations performed by other regulatory or supervisory organizations. If the review is performed, it will be coordinated through the NAIC, utilizing personnel with the appropriate knowledge, experience and expertise. Individual states may also request that representatives from their state be added to the review team.

b. The review team will communicate with the supervisory authority in advance of the on-site visit to clearly identify the objectives, expectations and procedures with respect to the review, as well as any significant issues or concerns identified within the review of the Evaluation Materials. Information to be considered during the on-site review includes, but is not limited to, the following:

i. Interviews with supervisory authority personnel.

ii. Review of organizational and personnel practices.

iii. Any additional information beneficial to gaining an understanding of document and communication flows.

c. Upon completing the on-site review, the reviewer(s) will report initial findings to the Qualified Jurisdiction Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation.

5. Standard of Review

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

6. Additional Information to be Considered as Part of Evaluation

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

a. Documents, reports and information from appropriate international, U.S. federal and U.S. state authorities.

b. Public comments from interested parties.

c. Rating agency information.

d. Any other relevant information.
7. Preliminary Evaluation Report

a. NAIC staff and/or outside consultants will prepare a Preliminary Evaluation Report for review by the Qualified Jurisdiction Working Group. This preliminary report will be private and confidential (i.e., may only be reviewed by Working Group members, designated NAIC staff, consultants, the states, the FIO and other relevant federal authorities that specifically request to be kept apprised of this information, provided that such entities have entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction. Any outside consultants retained by the NAIC will be required to enter into a confidentiality and nondisclosure agreement.).

b. The report will be prepared in a consistent style and format to be developed by NAIC staff. It will contain detailed advisory information and recommendations with respect to the evaluation of the jurisdiction’s reinsurance supervisory system and the documented practices and procedures thereunder. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a Qualified Jurisdiction.

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


a. The Qualified Jurisdiction Working Group’s review of the Preliminary Evaluation Report will be held in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings.

b. The Qualified Jurisdiction Working Group will make a preliminary determination as to whether the jurisdiction under consideration satisfies the Standard of Review and is deemed acceptable to be included on the NAIC List of Qualified Jurisdictions. If the preliminary determination is that the jurisdiction should not be included on the NAIC List of Qualified Jurisdictions, the Qualified Jurisdiction Working Group will set forth its specific findings and identify those areas of concern with respect to this determination.

c. The results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review.


a. Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. This is not intended to be a formal appeals process that would initiate U.S. state administrative due process requirements.

b. The Qualified Jurisdiction Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Qualified Jurisdiction Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings. This report will be approved upon an affirmative vote of a majority of the members in attendance at this meeting.
c. Upon approval of the Final Evaluation Report, the Qualified Jurisdiction Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the summary for public comment. The detailed report will be a confidential, regulator-only document. The report may be shared with any state indicating that it is considering relying on the NAIC List of Qualified Jurisdictions and has entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction.

10. NAIC Determination regarding List of Qualified Jurisdictions

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

b. In the event that a jurisdiction is not approved as a Qualified Jurisdiction, the supervisory authority will be eligible for reapplication at the discretion of the NAIC.

c. Upon final adoption of the Qualified Jurisdiction Working Group’s determination with respect to a jurisdiction, the Final Evaluation Report will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential.

11. Memorandum of Understanding (MOU)

a. A Qualified Jurisdiction must agree to share information and cooperate on a confidential basis with the U.S. state insurance regulatory authority with respect to all certified reinsurers domiciled within that jurisdiction.

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

d. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.

12. Process for Periodic Evaluation after Initial Approval

a. The process for determining whether a non-U.S. jurisdiction is a Qualified Jurisdiction is ongoing and subject to periodic review.

b. Qualified Jurisdictions must provide the Qualified Jurisdiction Working Group with notice of any material change in the applicable reinsurance supervisory system that may affect the status of the Qualified Jurisdiction. A U.S. jurisdiction should also notify the Qualified Jurisdiction Working Group if it receives notice of any material change in the applicable reinsurance supervisory system, or any adverse developments with respect to enforcement of final U.S. judgments, that may affect the status of the Qualified Jurisdiction. Upon receipt of any such notice, the Qualified Jurisdiction Working Group will consider whether it is necessary to re-evaluate the status of the Qualified Jurisdiction.

c. Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate.

d. If the Qualified Jurisdiction Working Group finds the jurisdiction to be out of compliance at any time with the requirements to be a Qualified Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review, and the status as a Qualified Jurisdiction may be placed on probation, suspended or revoked. The Qualified Jurisdiction Working Group will perform a yearly due diligence review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. This yearly review shall follow such abbreviated process as may be determined by the Qualified Jurisdiction Working Group to be appropriate.

e. The Qualified Jurisdiction Working Group will monitor those jurisdictions that have been approved as Qualified Jurisdictions by individual states, but are not included on the NAIC List of Qualified Jurisdictions.

13. Review of Qualified Jurisdictions as Reciprocal Jurisdictions

a. In undertaking the evaluation of a Qualified Jurisdiction as a Reciprocal Jurisdiction, the Qualified Jurisdiction Working Group shall utilize such processes and procedures as outlined in the immediately-preceding paragraphs 1 – 12 of Section III, Procedure for Evaluation of Non-U.S. Jurisdictions such as the Qualified Jurisdiction Working Group deems is appropriate. Specifically, the Qualified Jurisdiction Working Group will use processes and procedures outlined in paragraph 1 (Initiation of Evaluation of the Reinsurance Supervisory System of an Individual Jurisdiction), paragraph 3 (NAIC Review of Evaluation Materials), paragraph 7 (Preliminary Evaluation Report), paragraph 8 (Review of Preliminary Evaluation Report), paragraph 9 (Opportunity to Respond to Preliminary Evaluation Report), paragraph 10 (NAIC Determination regarding List of Qualified Jurisdictions), paragraph 11 (Memorandum of Understanding) and paragraph 12 (Process for Evaluation after Initial Approval), as modified for use with Reciprocal Jurisdictions.
b. A Qualified Jurisdiction may not be reviewed for inclusion on the NAIC List of Reciprocal Jurisdictions, unless it has undergone the Evaluation Methodology outlined in Section IV, and remains in good standing with the NAIC as a Qualified Jurisdiction. The Qualified Jurisdiction Working Group may, if it determines an extended review period to be appropriate after its initial approval of a new Qualified Jurisdiction, defer consideration of that jurisdiction as a possible Reciprocal Jurisdiction until there has been sufficient United States experience with that jurisdiction and its Certified Reinsurers that the Working Group believes it is appropriate to progress from collateral reduction to collateral elimination. Nothing in this process requires a finding that a Qualified Jurisdiction meets the standards for recognition as a Reciprocal Jurisdiction, and the Qualified Jurisdiction Working Group may base such recommendation on factors not specifically included in this process.

c. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the NAIC List of Reciprocal Jurisdictions. In making its recommendation with respect to whether a Qualified Jurisdiction should be added to the NAIC List of Reciprocal Jurisdictions, the Qualified Jurisdiction Working Group shall undergo the following analysis in making its evaluation:

i. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in that jurisdiction is received by United States ceding insurers;

ii. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

iii. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the Qualified Jurisdiction;

iv. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information
shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

v. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each assuming insurer that is domiciled in the Qualified Jurisdiction, and has been granted an exemption from state collateral requirements under Section 9 of Model #786, continues to comply with the requirements set forth in in Section 9C(2) and (3) of Model #786; i.e., must maintain minimum capital and surplus of no less than $250,000,000, and maintains on an ongoing basis the required minimum solvency or capital ratio, as applicable.

d. In order to satisfy the requirements of subsection (c) above, the chief insurance supervisor of the Qualified Jurisdiction being evaluated as a Reciprocal Jurisdiction may provide the NAIC with a written letter confirming, as follows:

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

- An insurer which has its head office or is domiciled in [Jurisdiction] shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in [Jurisdiction] is received by United States ceding insurers. [Jurisdiction] does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by [Jurisdiction] or as a condition to allow the ceding insurer to recognize credit for such reinsurance.

- [Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that insurers and insurance groups that are domiciled or maintain their headquarters in jurisdictions accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the [Jurisdiction].

- [Jurisdiction] confirms that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the [Jurisdiction].

- [Jurisdiction] will annually provide to the states confirmation that applicable assuming insurers domiciled in [Jurisdiction] maintain minimum capital and surplus of no less than $250,000,000, and maintain on an ongoing basis the required minimum solvency or capital ratio, as applicable.
• Finally, I confirm that [Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

e. The Qualified Jurisdiction Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate, and will prepare for the review by the Reinsurance Task Force a Summary of Findings and Determination recommending that the Qualified Jurisdiction be recognized as a Reciprocal Jurisdiction. Upon approval by the Task Force, the Summary of Findings and Determination must be adopted by a vote of the NAIC Executive (EX) Committee and Plenary for inclusion on the List of Reciprocal Jurisdictions.

f. The Qualified Jurisdiction Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable equivalency assessment conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

g. Except for Reciprocal Jurisdictions entitled to automatic recognition, a jurisdiction’s status as a Reciprocal Jurisdiction may be placed on probation, suspended or revoked for good cause in the same manner as provided for Qualified Jurisdictions under paragraph 12. If cause is found to question the fitness of a Reciprocal Jurisdiction that is subject to an in-force covered agreement, or its compliance with applicable requirements of the covered agreement, the Qualified Jurisdiction Working Group shall promptly bring the matter to the attention of the applicable dispute resolution mechanism under the covered agreement.
IV. Evaluation Methodology

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

The Evaluation Methodology consists of the following:

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

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

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

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

1. Confirmation of the jurisdiction’s most recent FSAP Report, including relevant updates with respect to descriptions or elements of the FSAP Report in which changes have occurred since the assessment or where information might otherwise be outdated.

2. Confirmation of the jurisdiction’s ROSC, including relevant updates with respect to descriptions or elements of the ROSC in which changes have occurred since the report was completed or where information might otherwise be outdated.

3. If materials responsive to the topics under review have been provided in response to information exchanges between the jurisdiction under review and the NAIC, such prior responses may be cross-referenced provided updates are submitted, if required to address changes in laws or procedures.

4. Any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC’s evaluation process in order to address, on an outcomes basis, the key elements described within Appendix A.

The NAIC will review the information provided by the applicant jurisdiction and determine whether it is adequate to reasonably conclude whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. After reviewing the initial submission, the NAIC may request that the applicant jurisdiction

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2 The basic considerations under this section are derived from Model #786, Section 8C(2), which include: (a) the framework under which the assuming reinsurer is regulated; (b) the structure and authority of the jurisdiction’s reinsurance supervisory authority with regard to solvency regulation requirements and financial surveillance; (c) the substance of financial and operating standards for reinsurers domiciled in the jurisdiction; and (d) the form and substance of financial reports required to be filed or made publicly available by reinsurers domiciled in the jurisdiction and the accounting principles used.
submit supplemental information as necessary in order to make this determination. An applicant jurisdiction is strongly encouraged to provide thorough, detailed and current information in its initial submission in order to minimize the number and extent of supplemental information requests from the NAIC with respect to Section A of this Evaluation Methodology. The NAIC will provide a complete description in the Final Evaluation Report of the information provided in the Evaluation Materials, and any updates or other information that have been provided by the applicant jurisdiction.

**Section B: Regulatory Practices and Procedures**

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

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

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

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

**Section D: Regulatory Cooperation and Information-Sharing**

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

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

a. Number of reinsurers domiciled in the jurisdiction, and a list of any reinsurers domiciled in the jurisdiction that have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, of no less than $250,000,000.

b. Up to a 10-year history of any regulatory actions taken against specific reinsurers.

c. Up to a 10-year history listing any reinsurers that have gone through insolvency proceedings, including the size of each insolvency and a description of the related outcomes (e.g., reinsurer rehabilitated or liquidated, payout percentage of claims to priority classes, payout percentage of claims to domestic and foreign claimants).

d. Up to a 10-year history of any significant industry-wide fluctuations in capital or profitability with respect to domestic reinsurers.

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

Section F: Enforcement of Final U.S. Judgments

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

Section G: Solvent Schemes of Arrangement

The jurisdiction is requested to provide a description of any legal framework that allows reinsurers domiciled in the jurisdiction to propose or participate in any solvent scheme of arrangement or similar procedure. In addition, the jurisdiction is requested to provide a description of any solvent scheme of arrangement or similar procedure that a domestic reinsurer has proposed or participated in and the outcome of such procedure.
V. Appendices: Specific Guidance with Respect to Section A and Section B

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

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

1. Examination Authority

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

   a. Frequency and timing of examinations and reports.

   b. Guidelines for examination.

   c. Whether the jurisdiction has the authority to examine reinsurers whenever it is deemed necessary.

   d. Whether the jurisdiction has the authority to have complete access to the reinsurer’s books and records and, if necessary, the records of any affiliated company.

   e. Whether the jurisdiction has the authority to examine officers, employees and agents of the reinsurer when necessary with respect to transactions directly or indirectly related to the reinsurer under examination.

   f. Whether the jurisdiction has the authority to share confidential information with U.S. state insurance regulatory authorities, provided that the recipients are required, under their law, to maintain its confidentiality.

2. Capital and Surplus Requirement

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

   a. Whether the jurisdiction has the authority to require reinsurers to maintain minimum capital and surplus, including a description of such minimum amounts.

   b. Whether the jurisdiction has the authority to require additional capital and surplus based on the type, volume and nature of reinsurance business transacted.

   c. Capital requirements for reinsurers, including reports and a description of any specific levels of regulatory intervention.

3. Accounting Practices and Procedures

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

   a. Description of the accounting and reporting practices and procedures.

   b. Description of any standard financial statement blank/reporting template, including description of content/disclosure requirements and corresponding instructions.

4. Corrective Action

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

   a. Identification of specific standards which may be considered to determine whether the continued operation of the reinsurer might be hazardous to the general public.

   b. Whether the jurisdiction has the authority to issue an order requiring the reinsurer to take corrective action when it has been determined to be in hazardous financial condition.
5. **Regulation and Valuation of Investments**

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

a. Whether the jurisdiction has the authority to require a diversified investment portfolio for all domestic reinsurers as to type, issue and liquidity.

b. Whether the jurisdiction has the authority to establish acceptable practices and procedures under which investments owned by reinsurers must be valued, including standards under which reinsurers are required to value securities/investments.

6. **Holding Company Systems**

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

a. Whether the jurisdiction has access to information via the parent or other regulated group entities about activities or transactions within the group involving other regulated or non-regulated entities that could have a material impact on the operations of the reinsurer.

b. Whether the jurisdiction has access to consolidated financial information of a reinsurer’s ultimate controlling person.

c. Whether the jurisdiction has the authority to review integrity and competency of management.

d. Whether the jurisdiction has approval and intervention powers for material transactions and events involving reinsurers.

e. Whether the jurisdiction has authority to monitor, or has prior approval authority over:
   i. Change in control of domestic reinsurers.
   ii. Dividends and other distributions to shareholders of the reinsurer.
   iii. Material transactions with affiliates.

7. **Risk Management**

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

a. Whether the jurisdiction has Own Risk and Solvency Assessment (ORSA) requirements and reporting.

b. Any requirements regarding the maximum net amount of risk to be retained by a reinsurer for an individual risk based on the reinsurer’s capital and surplus.

c. Whether the jurisdiction has authority to monitor enterprise risk, including any activity, circumstance, event (or series of events) involving one or more affiliates of a reinsurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the reinsurer or its insurance holding company system as a whole.

d. Whether the jurisdiction has corporate governance requirements for reinsurers.
8. **Liabilities and Reserves**

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

a. Liabilities incurred under reinsurance contracts for policy reserves, unearned premium, claims and losses unpaid, and incurred but not reported (IBNR) claims (including whether discounting is allowed for reserve calculation/reporting).

b. Liabilities related to catastrophic occurrences.

c. Whether the jurisdiction requires an opinion on reserves and loss and loss adjustment expense reserves by a qualified actuary or specialist for all domestic reinsurers, and the frequency of such reports.

9. **Reinsurance Ceded**

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

a. Credit for reinsurance requirements applicable to reinsurance retroceded to domestic and non-domestic reinsurers.

b. Collateral requirements applicable to reinsurance contracts.

c. Whether the jurisdiction requires a reinsurance agreement to provide for insurance risk transfer (i.e., transfer of both underwriting and timing risk).

d. Requirements applicable to special purpose reinsurance vehicles and insurance securitizations.

e. Affiliated reinsurance transactions and concentration risk.

f. Disclosure requirements specific to reinsurance transactions, agreements and counterparties, if such information is not provided under another item.

10. **Independent Audits**

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

a. Requirements for the filing of audited financial statements prepared in conformity with accounting practices prescribed or permitted by the supervisory authority.

b. Contents of annual audited financial reports.

c. Requirements for selection of auditor.

d. Allowance of audited consolidated or combined financial statements.

e. Notification of material misstatements of financial condition.

f. Supervisor’s access to auditor’s workpapers.

g. Audit committee requirements.

h. Requirements for reporting of internal control-related matters.
11. **Receivership**

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

12. **Filing with Supervisory Authority**

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

   a. The use of standardized financial reporting in the financial statements, and the frequency of relevant updates.

   b. The use of supplemental data to address concerns with specific companies or issues.

   c. Filing format (e.g., electronic data capture).

   d. The extent to which financial reports and information are public records.

13. **Reinsurance Intermediaries**

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

14. **Other Regulatory Requirements with respect to Reinsurers**

Any other information necessary to adequately describe the effectiveness of the jurisdiction’s laws and regulations with respect to its reinsurance supervisory system.
Appendix B: Regulatory Practices and Procedures

1. Financial Analysis

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

a. **Qualified Staff and Resources**
   The resources employed to effectively review the financial condition of all domestic reinsurers, including a description of the educational and experience requirements for staff responsible for financial analysis.

b. **Communication of Relevant Information to/from Financial Analysis Staff**
   The process under which relevant information and data received by the supervisory authority are provided to the financial analysis staff and the process under which the findings of the financial analysis staff are communicated to the appropriate person(s).

c. **Supervisory Review**
   How the jurisdiction’s internal financial analysis process provides for supervisory review and comment.

d. **Priority-Based Analysis**
   How the jurisdiction’s financial analysis procedures are prioritized in order to ensure that potential problem reinsurers are reviewed promptly.

e. **Depth of Review**
   How the jurisdiction’s financial analysis procedures ensure that domestic reinsurers receive an appropriate level or depth of review commensurate with their financial strength and position.

f. **Analysis Procedures**
   How the jurisdiction has documented its financial analysis procedures and/or guidelines to provide for consistency and continuity in the process and to ensure that appropriate analysis procedures are being performed on each domestic reinsurer.

g. **Reporting of Material Adverse Findings**
   The process for reporting material adverse indications, including the determination and implementation of appropriate regulatory action.

h. **Early Warning System/Stress Testing**
   Whether the jurisdiction has an early warning system and/or stress testing methodology that is utilized with respect to its domestic reinsurers.
2. **Financial Examinations**

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

a. **Qualified Staff and Resources**
   The resources employed to effectively examine all domestic reinsurers. This should include whether the jurisdiction prioritizes examination scheduling and resource allocation commensurate with the financial strength and position of each reinsurer, and a description of the educational and experience requirements for staff responsible for financial examinations.

b. **Communication of Relevant Information to/from Examination Staff**
   The process under which relevant information and data received by the supervisory authority are provided to the examination staff and the process under which the findings of the examination staff are communicated to the appropriate person(s).

c. **Use of Specialists**
   Whether the supervisory authority’s examination staff includes specialists with appropriate training and/or experience or whether the supervisory authority otherwise has available qualified specialists that will permit the supervisory authority to effectively examine any reinsurer.

d. **Supervisory Review**
   Whether the supervisory authority’s procedures for examinations provide for supervisory review.

e. **Examination Guidelines and Procedures**
   Description of the policies and procedures the supervisory authority employs for the conduct of examinations, including whether variations in methods and scope are commensurate with the financial strength and position of the reinsurer.

f. **Risk-Focused Examinations**
   Does the supervisory authority perform and document risk-focused examinations and, if so, what guidance is utilized in conducting the examinations? Are variations in method and scope commensurate with the financial strength and position of the reinsurer?

g. **Scheduling of Examinations**
   Whether the supervisory authority’s procedures provide for the periodic examination of all domestic reinsurers, including how the system prioritizes reinsurers that exhibit adverse financial trends or otherwise demonstrate a need for examination.

h. **Examination Reports**
   Description of the format in which the supervisory authority’s reports of examinations are prepared, and how the reports are shared with other jurisdictions under information-sharing agreements.

i. **Action on Material Adverse Findings**
   What are the jurisdiction’s procedures regarding supervisory action in response to the reporting of any material adverse findings.

3. **Information Sharing**

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

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

5. Organization, Licensing and Change of Control of Reinsurers

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

a. Licensing Procedure
   Whether the supervisory authority has documented licensing procedures that include a review and/or analysis of key pieces of information included in a primary licensure application.

b. Staff and Resources
   The educational and experience requirements for staff responsible for evaluating company licensing.

c. Change in Control of a Domestic Reinsurer
   Procedures for the review of key pieces of information included in filings with respect to a change in control of a domestic reinsurer.
Re: Process for Evaluating Qualified and Reciprocal Jurisdictions & evaluations of France, U.K., Ireland and Germany

Dear Messrs. Stultz and Schelp:

The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. ACLI also represents all professional life reinsurers assuming mortality and morbidity risks in the United States.

We appreciate the opportunity to comment on the exposure draft updating the process for evaluating qualified and reciprocal jurisdictions. We generally support the exposure draft, although there were a few areas we felt could benefit from additional clarity or minor revisions. Our technical comments are below:

TECHNICAL COMMENTS

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

Item 3, page 5
The proposed language in item 3 states that in order for a Qualified Jurisdiction to become a Reciprocal Jurisdiction it must "agree to adhere to the same reciprocity standards" as Covered Agreement Jurisdictions “including the requirement that the Qualified Jurisdiction must agree to recognize the states’ approach to group supervision, including group capital, as provided under the Credit for Reinsurance Model Act.” While this is true, the reciprocity standards go beyond the recognition of the U.S. group capital and group supervision regime (e.g., the qualified jurisdiction cannot require a local presence requirement in exchange for reinsurance credit, impose group supervision/group capital at the world-wide parent level, and must establish an information sharing agreement).

**Recommendation:** Consider expanding this section to include all relevant reciprocity standards.

Questions about item 3, page 5:
- How will adherence to reciprocity be evaluated by the Qualified Jurisdiction Working Group?

**Section III. Procedure for Evaluation of Non-US Jurisdictions**

**Item 2b (Evaluation of Jurisdiction), page 8**

In item 2b (page 8), the draft adds a provision indicating the NAIC will notify non-US jurisdictions of any “additional information” upon which the Working Group is relying on “beyond the information” provided by the jurisdiction.

Item 2a notes that the Working Group may request or accept relevant information from reinsurers domiciled in the jurisdiction under review. It is unclear if information from reinsurers domiciled in the jurisdiction is the “additional information” that the Working Group is referencing in 2b, or if the Working Group is contemplating sources other than reinsurers who are domiciled in the jurisdiction and the other listed sources in 2a. In any case, it might be useful to know the authority surrounding the collection of “additional” information. It would also be instructive to know if the Working Group currently relies on this type of “additional information” in their evaluation practices.

**Item 13(c)(iii) (Review of Qualified Jurisdictions as Reciprocal Jurisdictions), page 14**

Item 13(c)(iii) tracks section 9(B)(3)(c) of the Credit for Reinsurance Model Regulation (#786) very closely. It appears that the intent of item 13(c)(iii) is to establish that an insurer’s group supervisor, and the corresponding group supervisory authority and rules, should be controlling. Thus, all other supervisors should respect the jurisdiction’s supervisory authority and not apply additional “group governance, solvency, capital or reporting requirements.” While we recognize that this language mirrors section 9(B)(3)(c) of the Credit for Reinsurance Model Regulation, we are recommending a small change to improve the clarity of the provision:

**Recommendation:** We suggest rewording, as follows, to clarify the applicable supervisor authority:

“The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another US jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as by the applicable US regulator, and will not be subject to group supervision, at the level of the worldwide parent undertaking of the insurance or reinsurance group, by the Qualified Jurisdiction;”
Item 13(c)(v), page 14-15
This item requires that non-U.S. jurisdictions must confirm that their assuming insurers who have been granted an “exemption” from state collateral requirements are complying with the minimum capital and surplus levels and ratios required in section 9(c)(2) and 9(c)(3) of the Credit for Reinsurance Model Regulation.

We recommend substituting the word “relief” for exemption, because “relief” is a better representation of the public policy positions guiding the collateral reduction provisions in section 9. The sections providing for reduced and zero collateral are just two, among a variety of ways, that a U.S. ceding insurer may receive credit for reinsurance. We don’t believe that these two mechanisms for credit are “exemptions” – instead they represent public policy decisions based on sound domiciliary regulation and the assuming insurers ability and willingness to pay.

Recommendation: Substitute the word “relief” for exemption in item 13(c)(v), page 14.

Item 13(d), bullet 2, page 15
This section sets the criteria for the written confirmation that the chief insurance supervisor of a Qualified Jurisdiction being evaluated as a Reciprocal Jurisdiction must provide to the NAIC. We recommend clarifying the language in bullet 2, for the same reasons we cited in item 13(c)(iii).

Recommendation: We suggest rewording, as follows, to clarify the applicable supervisor authority:

“The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another US jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as by the applicable US regulator, and will not be subject to group supervision, at the level of the worldwide parent undertaking of the insurance or reinsurance group, by the Qualified Jurisdiction;”

Conclusion
Again, thank you for the opportunity to review and submit comments on the exposure draft, as well as the opportunity to review the re-evaluations and approvals of the United Kingdom, France, Germany, and Ireland. We look forward to the opportunity to review the re-evaluations of Bermuda, Switzerland and Japan. Thank you for your ongoing work on this task.

Sincerely,

Mariana Gomez-Vock  Steven Clayburn, FSA, MAAA
9/30/2019

Dear Mr. Schelp,

Many thanks for giving us the opportunity to comment the report.

We have read it and have no further comments to the current text. We would be satisfied with the proposed result of your evaluation.

In addition to it we would like to take the opportunity to inform you that our new leaflet for US reinsurers is online in English language (please see link below).

The planned amendment of § 67 (1) VAG with respect to the exemption from the license requirement in cases where the EU has concluded an agreement is now part of another legislative procedure (implementation of the Money Laundering Directive). Although the clarification in the law will still take some time, nonetheless, the leaflet describes the situation for US reinsurers with the sufficient legal clarity.

Just as a suggestion, an additional reference on this in your report may be also helpful for the understanding and could provide the reader of the report with the latest information of the German market.

Link to the English version: https://www.bafin.de/dok/13008940

Best regards,

Petra Faber-Graw
Deputy Head of Departement International Policy, Financial Stability and Regulation (IFR)
Head of Section IFR 5
International Policy Insurance and Pensions

Bundesanstalt für Finanzdienstleistungsaufsicht
Graueheindorfer Strasse 108
53117 Bonn
Law & Regulation

18.09.2019
Reinsurers from the USA to carry out reinsurance business with primary insurance or reinsurance undertakings in Germany

Content
- I. Conditions for carrying out business without the need for authorisation
- II. Submission process
- III. Information to be provided to market participants

The EU and the USA have signed a bilateral agreement that, among other things, will make it possible for reinsurers from the USA to carry out reinsurance business with primary insurance or reinsurance undertakings in the EU without a branch being required in the relevant EU member state ("Bilateral Agreement between the European Union and the United States of America on prudential measures regarding insurance and reinsurance", referred to in the following as "the Agreement"). This is only possible, however, if the reinsurer from the USA meets the requirements set out in the Agreement.

I. Conditions for carrying out business without the need for authorisation

If the undertaking-specific criteria set out in the Agreement are met, no authorisation or branch under section 67 (1) sentence 1 of the Insurance Supervision Act (Versicherungsaufsichtsgesetz - VAG) is required to carry out reinsurance business in Germany. The relevant requirements can be found in Article 3(4) of the Agreement. These relate on the one hand to certain financial conditions. On the other, reinsurers from the USA are required to submit certain declarations to the insurance supervisory authority responsible for the ceding insurer and to meet further conditions applying to their business activities. A distinction is made here between initial and subsequent submissions.

1. Initial submission

The following documents must be submitted to BaFin for the initial submission:

1.1. a declaration by the assuming reinsurer that it will provide prompt written notice and explanations to BaFin if:
a. it falls below the minimum capital and surplus or own funds, as applicable, specified in Article 3(4)(a) of the Agreement, or the capital ratio specified in Article 3(4)(b) of the Agreement; or

b. any regulatory action is taken against it for serious noncompliance with applicable law (Article 3(4)(c) of the Agreement).

1.2. a written confirmation by the assuming reinsurer regarding its consent to the jurisdiction of the courts of the territory in which the ceding insurer has its head office or is domiciled (Article 3(4)(d) of the Agreement).

1.3. a written declaration that the assuming reinsurer will pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained (Article 3(4)(f) of the Agreement).

1.4. submission of the following documents and information:

a. annual audited financial statements in accordance with the applicable law of the territory of the head office of the assuming reinsurer, including the external audit report, with respect to the preceding two years (Article 3(4)(h)(i) of the Agreement).

Note: if the undertaking is not subject to a requirement to prepare its own audit annual financial statements and if it is included in annual financial statements that cover several undertakings, this must be stated explicitly.

b. solvency and financial condition reports or actuarial opinions, if filed with the assuming reinsurer's supervisor, with respect to the preceding two years (Article 3(4)(h)(ii) of the Agreement);

c. a list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance contracts from ceding insurers from Germany (Article 3(4)(h)(iii) of the Agreement);

Note: if this information is not evident from the documents submitted, reference must be made to the precise location of the information. If there are no such reinsurance claims, an express statement to this effect must be made.

d. information regarding the assuming reinsurer's assumed reinsurance by ceding undertaking, ceded reinsurance by the assuming reinsurer, and reinsurance recoverable on paid and unpaid losses by the assuming reinsurer, to allow for the evaluation of the criteria defined in Article 3(4)(i) of the Agreement (Article 3(4)(h)(i) of the Agreement).

Note: The undertaking is at liberty to submit the annual statement, or extracts from it, prepared under national law in the home country. Reference must be made to the precise source of the information. To determine whether payments are prompt as required by Article 3(4)(i) of the Agreement, the following information must always be submitted in summary form:

• the amount of reinsurance recoverables due from the assuming reinsurer from the USA and
• the amount of reinsurance recoverables due from the assuming reinsurer in the USA that are
  overdue and in dispute (see Article 3(4)(i)(i) of the Agreement);
• the number of ceding insurers and reinsurers of the assuming reinsurer from the USA and
• the number of ceding insurers and reinsurers of the assuming reinsurer from the USA that have
  overdue reinsurance recoverables on paid losses of 90 days or more that are not in dispute and
  that exceed USD 100,000 for each ceding insurer (see Article 3(4)(i)(ii) of the Agreement);
• the aggregate amount of reinsurance recoverables due from the reinsurer from the USA that are
  not in dispute but are overdue by 90 days or more (see Article 3(4)(i)(iii) of the Agreement).

1.5. written confirmation by the assuming reinsurer that it is not presently participating in any solvent
    scheme of arrangement that involves European Union ceding insurers, and a declaration that it will
    notify the ceding insurer and BaFin and provide 100 per cent collateral to the ceding insurer consistent
    with the terms of the scheme should the reinsurer enter into such an arrangement (Article 3(4)(j) of the
    Agreement).

1.6. confirmation by the competent authority that the reinsurer complies with the risk-based capital
    ratio within the meaning of Article 3(4)(b) (Article 3(4)(l) of the Agreement).
Note: Evidence of compliance with the capital requirements as defined in Article 3(4)(a) of the
Agreement must be provided. Where compliance with the capital requirements is not already evident
from the confirmation by the competent authority, compliance with the capital requirements as
defined in Article 3(4)(a) of the Agreement must be evidenced by other means. Where attached
documents are referred to, reference must be made to the precise location of the information.

2. Subsequent submissions
Under the Agreement, the supervisory agency can periodically require the reinsurer from the USA to
submit documents. BaFin expects the following documents to be submitted each year:

a. annual audited financial statements in accordance with the applicable law of the territory of the
   head office of the assuming reinsurer, including the external audit report (Article 3(4)(h)(i) of the
   Agreement).

b. a list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding
   reinsurance contracts from ceding insurers from Germany (Article 3(4)(h)(iii) of the Agreement);

c. information regarding the assuming reinsurer’s assumed reinsurance by ceding company, ceded
   reinsurance by the assuming reinsurer, and reinsurance recoverable on paid and unpaid losses by the
   assuming reinsurer, to allow for the evaluation of the criteria set forth in Article 3(4)(l) of the
   Agreement (Article 3(4)(h)(l) of the Agreement).
d. confirmation by the competent authority that the reinsurer complies with the risk-based capital ratio within the meaning of Article 3(4)(b) of the Agreement (Article 3(4)(l) of the Agreement).

The notes contained in paragraph 1.4 above must be observed in this respect. BaFin presumes that the documents will be submitted directly after the audit of the annual financial statements within the meaning of Article 3(4)(h)(i) of the Agreement.

3. Other conditions

The reinsurer must additionally observe the following conditions:

3.1 the assuming reinsurer must meet certain capital requirements (“capital and surplus” of at least EUR 226 million (Article 3(4)(a) of the Agreement) as well as certain local risk-based capital requirements (at least 300% “Authorized Control Level” (Article 3(4)(b) of the Agreement)).

3.2. the assuming reinsurer agrees in each reinsurance contract subject to the Agreement that it will provide collateral for 100 per cent of the assuming reinsurer’s liabilities attributable to reinsurance ceded pursuant to this agreement if the assuming reinsurer resists enforcement of a final judgment that is enforceable under the law of the territory in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its resolution estate, if applicable (Article 3(4)(g) of the Agreement).

3.3. the assuming reinsurer maintains a practice of prompt payment of claims under reinsurance contracts; the lack of prompt payment will be evidenced if any of the criteria specified in Article 3(4)(i)(i–iii) of the Agreement is met (Article 3(4)(i) of the Agreement).

3.4 if subject to a legal process of resolution, receivership or winding-up proceedings as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the resolution, receivership or winding-up proceedings is pending, may obtain an order requiring that the assuming reinsurer post collateral for all outstanding ceded liabilities (Article 3(4)(k) of the Agreement).

3.5. In addition, the assuming reinsurer is subject to requirements to provide information to BaFin in the cases referred to in Article 3(4)(c) and to BaFin and the ceding insurer in the cases referred to Article 3(4)(j) of the Agreement.

3.6. BaFin presumes that the declaration by the assuming reinsurer under Article 3(4)(f) of the Agreement that it will pay all final judgments obtained by a ceding insurer, wherever enforcement is sought, that have been declared enforceable in the territory where the judgment was obtained, will also be communicated to the German ceding insurer or will be embedded in reinsurance contracts.

II. Submission process

1. Formal requirements
Original versions of all declarations by the assuming reinsurer referred to above must be submitted to BaFin in writing and signed by the governing body authorised to represent the assuming reinsurer. Scans are not sufficient in this respect.

The documentation can be filed in English. If no translation into German of the submitted documents is filed, an original version of a declaration, signed by the governing body authorised to represent the assuming reinsurer, must be submitted in which the reinsurer undertakes to submit a translation of the documents to BaFin on request.

2. Submission method

Submissions and questions can be sent by email to reinsurance@bafin.de. For the submissions, it should be noted that the declarations referred to above that must be notified to BaFin must be submitted as original documents, and not merely as scans. The other documents can be submitted electronically.

3. Contact data and communication

It is recommended to provide details of contacts at the undertaking to which questions about the submissions can be sent as well as details of contacts at the competent authority. BaFin will respond in writing to submissions. This can be sent in advance by fax on request if the undertaking has notified a fax number.

III. Information to be provided to market participants

A summary of reinsurers from the USA that have submitted the necessary documents and information by 30 June of each year will be made available in a table published on BaFin's website. The table will only contain reinsurers that have expressly given their consent to be included in the table. Where market participants send questions to BaFin about individual reinsurers from the USA, BaFin will only provide information about the submissions if the reinsurer from the USA has consented to the communication of information about the status of the submissions.

https://www.bafin.de/dok/13008940

© BaFin
4 October 2019

**VIA EMAIL to jstultz@naic.org and dschelp@naic.org**

Reinsurance Task Force at the National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

**RE: Qualified Jurisdiction (E) Working Group: Notice of Exposures - Process for Evaluating Qualified and Reciprocal Jurisdictions (the “Exposure”)**

The Bermuda International Long Term Insurers and Reinsurers ("**BILTIR**") thanks the National Association of Insurance Commissioners ("**NAIC**")’s Qualified Jurisdiction (E) Working Group ("**QJWG**") for its commendable work. The following comments are submitted by BILTIR, on behalf of our member companies, regarding the Exposure.

BILTIR was formally incorporated on June 9, 2011 and represents 63 companies. BILTIR is committed to supporting the long-term insurance and reinsurance industry’s growth and success in Bermuda and globally.

We have outlined the thoughts and comments of our BILTIR members to the Exposure below.

<table>
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<tr>
<th>Section</th>
<th>Comment</th>
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<tr>
<td>Delay in re-approving Bermuda, Switzerland, and Japan as Qualified Jurisdictions (general comment)</td>
<td>The QJWG’s delay in exposing the Qualified Jurisdiction (&quot;QJ&quot;) status of the non-covered-agreement countries arguably is not consistent with the NAIC’s commitment to try to achieve parity. On one hand it is understandable that the NAIC would wait to assess QJ’s status and Reciprocal Jurisdiction status at the same time. On the other hand, the process to re-approve Bermuda, Japan, and Switzerland as QJ’s is not very onerous. Likewise, since there could be unexpected developments during updating of the process or related workstreams, setting the re-designation process in motion would be worthwhile. Consideration should be given to moving forward with QJWG re-approval for all jurisdictions, rather than just those under a covered agreement.</td>
</tr>
<tr>
<td>Switch from 5-year to 1-year review (page 13)</td>
<td>While this change may create additional regulatory burdens, we are operating on the assumption that the regulators’ intent is to make the designation process more regular rather than to create additional process. We ask the NAIC to ensure that the diligence related to the annual process not be overly burdensome, since the process will now be more frequent.</td>
</tr>
<tr>
<td>Ambiguity regarding regulatory authority (page 14)</td>
<td>Page 14 of the Exposure contains some inartful drafting. The language in paragraph 13.c.iii does not confirm whom a group will be &quot;subject only to worldwide prudential insurance group supervisions …&quot; One clarifying approach would be as follows: The QJ must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its</td>
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competent regulatory authority that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, from the U.S. national state-based system of regulation, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the QJ... If a change is made in 13.c.ii, a corresponding change should be made in 13.d on page 15, regarding the confirming letter provided by a Reciprocal Jurisdiction.

Characterization of “Exemption” (page 14)

Page 14, paragraph 13.c.v refers to collateral relief through the Reciprocal Jurisdiction process as an “exemption” however in our view the collateral relief is better thought of as one of the ways to qualify for full credit for reinsurance. Reference to the Reciprocal Jurisdiction provisions as an “exemption” mischaracterizes the basis for collateral relief as an exception to the rule rather than an avenue specifically contemplated as a way to get credit for reinsurance cessions.

Consider referring to the collateral relief as “qualifying for credit for reinsurance,” rather than an “exemption.”

We look forward to working with the NAIC’s QJWG further in this regard.

Sincerely,

BILTIR

Copy to: BILTIR Board of Directors
VIA E-MAIL

Mr Daniel Schelp
Chief Counsel, Regulatory Affairs
National Association of Insurance Commissioners

Banc Ceannais na hÉireann
Central Bank of Ireland
Eurosystème

8 October 2019

Re: Re-Evaluation of Ireland as a Qualified Jurisdiction

Dear Mr. Schelp,

I refer to your email of 3rd of September advising the Central Bank of Ireland of a 30-day public comment period on the proposed recommendation for Ireland to continue to be recognized as a Qualified Jurisdiction based on the conclusions reached in the “Summary of Findings and Determination with respect to Ireland”.

Considering that this time has just expired, we are looking forward to continue to engage with the NAIC in order to finalize the process and we are committed to providing whatever assistance is required.

Yours sincerely

Gerry Cross
Director, Financial Regulation - Policy & Risk

CC:  Jake Stultz (jstultz@naic.org)
     John Rehagen (John.Rehagen@insurance.mo.gov)
     Robert Wake (Robert.A.Wake@maine.gov)
     Ekrem Sarper (ESarper@naic.org)
     Ethan Sonnichsen (ESonnichsen@naic.org)
October 4, 2019

Director Chlora Lindley-Myers, Chair (Missouri)
Director Ray Farmer, Vice Chair (South Carolina)
National Association of Insurance Commissioners, Reinsurance (E) Task Force
Via email to jstultz@naic.org, dschelpe@naic.org

Re: GIAJ Comments on the proposed Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions

Dear Director Lindley-Myers and Director Farmer,

The General Insurance Association of Japan (GIAJ) appreciates the opportunity to comment on the proposed revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions.

We note that the proposed revisions incorporate principles such as consistency with existing rules, fair treatment among insurers, efficiency of supervision, and removal of duplicative regulations, which the GIAJ has been seeking.

We expect the actual evaluation processes regarding the Reciprocal Jurisdictions to which Qualified Jurisdictions are to be subjected and criteria which will be applied on Certified Reinsurers to be transparent and efficient.

We wish to submit some comments on the proposed revisions to individual paragraphs and the future evaluation processes.

I. Preamble

The sentence in the last paragraph, “recognize key NAIC solvency initiatives, including group supervision and group capital standards”, does not seem to be used in the Credit for Reinsurance Model Law (#785) and Regulation (#786). From the standpoint of eliminating any prejudgments, we propose aligning the phrase with Section 9.B.(3)(c) in #786 and III. 13. c. iii. in this proposed revision. Specifically, it should be rewritten as follows: ”recognize the U.S. state regulatory approach to group supervision and group capital”

Also, another sentence in the same paragraph, ”receive similar treatment as that provided under the EU and UK Covered Agreements”, seems ambiguous. Those jurisdictions which are RJ should be given the same treatment whether they conclude Covered Agreement with the US or not. Therefore, we propose revising it to ”the same
treatment as that of the EU and UK”. Where it is necessary to cater for unintended legal interpretations caused by conclusion/non-conclusion of Covered Agreement, we propose revising it to "substantially the same treatment as that of the EU and UK”.

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

Paragraph 3.
The sentence ‘recognize the states’ approach to group supervision, including group capital” does not seem to be used in the Credit for Reinsurance Model Law (#785) and Regulation (#786). From the standpoint of eliminating any prejudgments, we propose aligning the phrase with Section 9.B.(3)(c) in #786 and III. 13. c. iii. in this proposed revision. Specifically, it should be rewritten as follows: "recognize the U.S. state regulatory approach to group supervision and group capital”

Paragraph 7.
We welcome a reference to the “passporting” process which facilitates multi-state recognition of assuming insurers and encourages uniformity among states.

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


We note that “a yearly due diligence review” will be performed to determine whether ‘significant changes’ that might affect their status as Qualified Jurisdictions exist. We expect the review will not be too specific and will be performed efficiently. We would like the NAIC to clarify what will be assumed to be ‘significant changes’ as soon as the specific process of the review is determined.


From the standpoint of the efficiency of the regulations, we support the sentences below: “utilize such processes and procedures as outlined in the immediately-preceding paragraphs 1 – 12 of Section III. Procedure for Evaluation of Non-U.S. Jurisdictions such as the Qualified Jurisdiction Working Group deems appropriate.”

13. Review of Qualified Jurisdictions as Reciprocal Jurisdictions b.

At the same time, we propose clarifying to the extent possible from the standpoint of clarity of regulation, what are required in “until there has been sufficient United States experience with that jurisdiction and its Certified Reinsurers that the Working Group believes it is appropriate to progress from collateral reduction to collateral elimination” and "Nothing in this process requires a finding that a Qualified Jurisdiction meets the standards for recognition as a Reciprocal Jurisdiction, and the Qualified Jurisdiction Working Group may base such recommendation on factors not specifically included in this process”.

13. Review of Qualified Jurisdictions as Reciprocal Jurisdictions d.

In line with the points we made in our past comments, from the standpoint of efficiency, it should be sufficient if the recognition of the U.S. state regulatory approach to group supervision by Qualified Jurisdictions is secured in effect.
Others

We would like the NAIC to clarify the future process and schedule which Qualified Jurisdictions not subjected to an in-force Covered Agreement including Japan will go through, with regard to a yearly due diligence review of Qualified Jurisdictions and review of Qualified Jurisdictions as Reciprocal Jurisdictions.

Sincerely,

Makoto Kawagoe
General Manager,
International Business Planning Department
The General Insurance Association of Japan
October 2, 2019

Via Email

Robert Wake
Chair, Qualified Jurisdictions Working Group

Re: Exposure Re: Qualified Jurisdictions

Dear Mr. Wake,

This comment letter is submitted on behalf of Underwriters at Lloyd's, London ("Lloyd's"). We appreciate the hard work of the Qualified Jurisdictions Working Group in conducting the re-evaluation process for France, Germany, Ireland and the United Kingdom. Lloyd's supports the Working Group's recommendations to re-affirm these regulatory regimes as Qualified Jurisdictions.

We have also reviewed the proposed update to the process document to create a method for evaluating Reciprocal Jurisdictions. Lloyd's support the proposed updates and the new process for Reciprocal Jurisdictions.

We would like to thank the regulators on the Qualified Jurisdictions Review Group for their swift and efficient work on this implementation.

Regards,

Signature

Lloyd's America, Inc. The Museum Office Building 42 West 54th Street 14th Floor New York NY 10019 www.Lloyds.com/America
Telephone +1 212 382 4081 Fax +1 212 382 4070 Email: Sabrina.Miesowitz@lloyds.com
Lloyd's is authorised under the Financial Services and Markets Act 2000
October 4, 2019

Director Chlora Lindley-Myers, Chair
Reinsurance (E) Task Force
National Association of Insurance Commissioners
c/o Mr. Jake Stultz
Via e-mail jstultz@naic.org

Re: NAIC Request for Comments on Draft Process for Evaluating Qualified and Reciprocal Jurisdictions

Dear Director Lindley-Myers:

The Reinsurance Association of America (RAA) and the American Property and Casualty Insurance Association (APCIA) appreciate the opportunity to submit comments on the NAIC’s exposure draft of its Process for Evaluating Qualified and Reciprocal Jurisdictions.

The Reinsurance Association of America (RAA) is a national trade association representing reinsurance companies doing business in the United States. RAA membership is diverse, including reinsurance underwriters and intermediaries licensed in the U.S. and those that conduct business on a cross-border basis. The RAA also has life reinsurance affiliates.

Representing nearly 60 percent of the U.S. property casualty insurance market, the American Property Casualty Insurance Association (APCIA) promotes and protects the viability of private competition for the benefit of consumers and insurers. APCIA represents the broadest cross-section of home, auto, and business insurers of any national trade association. APCIA members represent all sizes, structures, and regions, which protect families, communities, and businesses in the U.S. and across the globe.

NAMIC membership includes more than 1,400 member companies. The association supports regional and local mutual insurance companies on main streets across America and many of the country’s largest national insurers. NAMIC member companies write $268 billion in annual premiums. Our members account for 59 percent of homeowners, 46 percent of automobile, and 29 percent of the business insurance markets. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.

We appreciate the swift action on the part of the Reinsurance Task Force to prepare a revised draft of its Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (now renamed the Process for Evaluating Qualified and Reciprocal Jurisdictions) to reflect the recently adopted 2019 revisions to the NAIC Credit for Reinsurance Model Law and Model Regulation. This is another important step in the implementation process for the U.S./EU and U.S./UK covered agreements and in the NAIC’s expressed goal to revise the credit for reinsurance framework in the
U.S. to create an equal playing field for all reinsurers that meet the legal requirements and commitments from the new category of “Reciprocal Jurisdictions.” The Process for Evaluating Qualified and Reciprocal Jurisdictions provides the framework through which U.S. and non-U.S. jurisdictions will be evaluated as Reciprocal Jurisdictions, principles for that evaluation and a structure for review of Reciprocal Jurisdiction status.

At a high level, the exposure draft makes the necessary changes to implement the changes reflected in the Credit for Reinsurance Model Law and Regulation. We appreciate the changes with respect to treatment of jurisdictions subject to an in-force covered agreement as well as those relevant to the treatment of U.S. NAIC-accredited jurisdictions and other non-U.S. jurisdictions seeking Reciprocal Jurisdiction status. That said, we ask RTF to consider the following comments:

Enforcement/Evaluation Process

As set forth in Section III (12), the Reciprocal Jurisdiction itself is obligated to provide notice to the Qualified Jurisdiction Working Group (QJWG) of a material change in their law that might affect their status as a Reciprocal Jurisdiction. Self-reporting without any enforcement mechanism is ineffective. At a minimum, a process should be specified for a dialogue between the QJWG and the Reciprocal Jurisdiction to address any issues once they have been identified. The framework should provide a mechanism for potential suspension of a Qualified or Reciprocal Jurisdiction’s status if it fails to bring a material detrimental change in their supervisory system to the attention of the QJWG and the matter cannot be promptly resolved. Suspension would continue while the matter is being fully evaluated by the QJWG and would be lifted upon resolution of the matter. With respect to jurisdictions subject to an in-force covered agreement, the framework should include a process for notification to relevant supervisory authorities for evaluation (such as the Joint Committee as specified in the U.S./EU and U.S./UK covered agreements).

In addition, the process for re-evaluation of the Reciprocal Jurisdiction’s status should be clearly set forth in the framework. We appreciate that the QJWG has moved away from reevaluation at specified time periods; however, the process followed by the QJWG should have some greater detail, including clear direction on how U.S. companies experiencing issues in a foreign jurisdiction may bring those to the attention of the Working Group. The framework does not specify a mechanism for companies to directly raise their concerns with the QJWG. While a U.S. jurisdiction (i.e. a company’s domestic regulator) can notify the QJWG of material changes to a Reciprocal Jurisdiction’s supervisory system as set forth in Section III (12) b, we recommend that the right of a U.S. company to bring an issue directly to the attention of the QJWG, any time they experience a serious issue, should be formally recognized in the Process document.

In addition, the framework does not provide immediacy to the review and suspension process for a Reciprocal or Qualified Jurisdiction. No timelines are specified in Section III (12) or elsewhere. The QJWG should consider adding timelines to Section III (12) b for notice by the jurisdiction of the adoption of a material adverse change, the time period in which a decision to re-evaluate or not will be made, with written reports relating to that decision whatever the outcome, and adding a timeframe for when suspensions and revocations take effect, as well as reinstatement upon proof that the law in question has been withdrawn.
Points of Clarification

Sections III (13) c iii and III (13) d address the commitments that a Reciprocal Jurisdiction not subject to an in-force covered agreement must make through a written conformation letter. With respect to the bullet point addressing recognition of the U.S. approach to group supervision we suggest the following clarifying revision:

*The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another U.S. jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as by the applicable U.S. regulator, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the Qualified Jurisdiction;*

In addition, in Section III (13) (c) (v) there is reference to Qualified Jurisdiction having “been granted an exemption” from state collateral requirements. We suggest that this phrase be edited to read “been granted relief” from state collateral requirements.

Conclusion

We appreciate the opportunity to offer comments and work with the NAIC to effectively implement revisions to framework for evaluating Qualified and Reciprocal Jurisdictions consistent with the U.S./EU and U.S./UK covered agreements and as reflected in the 2019 revisions to the NAIC Credit for Reinsurance Model Law and Regulation. Please do not hesitate to contact us with any questions or concerns.

Sincerely,

Reinsurance Association of America (RAA)
American Property Casualty Insurance Association (APCIA)
National Association of Mutual Insurance Companies (NAMIC)
October 4, 2019

Dear Mr. Stultz,
Dear Mr. Schelp

Thank you and the NAIC for the possibility to comment on the proposed revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions. We appreciate the substantial effort the NAIC and state regulators have invested into bringing forward this subject matter.

As to the reciprocal jurisdiction’s recognition of the U.S. state regulatory approach to group supervision and group capital,
We would like to comment on one specific subparagraph in section III.13.d. on page 15 of the exposed document. In the draft, this paragraph reads:

[Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that insurers and insurance groups that are domiciled or maintain their headquarters in jurisdictions accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the [Jurisdiction].

Our understanding during the process has been that US state insurance regulators want to prevent (sub-)group supervisors of other jurisdictions from performing a worldwide insurance group supervision if the worldwide parent is domiciled in the US. In lieu thereof, such an insurance group should be supervised by one of the U.S. state regulators. As a matter of fact, Switzerland never has and would not claim to supervise the global group in this context, hence we have no objection against the intention of the paragraph cited above.

However, we believe the drafted wording is ambiguous as it is not sufficiently clear that the term “worldwide parent undertaking” refers to the worldwide insurance parent undertaking domiciled in the US. We illustrate this with the following example: In the case of an insurance group with the worldwide parent undertaking domiciled in the qualified jurisdiction and with a subgroup domiciled in the US, the paragraph could be interpreted and read in a way that the supervisor in the qualified jurisdiction would not be allowed to perform the worldwide group supervision, while this would be rather done by a U.S. state supervisor. This means that a regulator of a U.S. state being home to a subgroup of an international insurance group would request to be the global group supervisor.

This second interpretation is probably not the intended goal of the exposure draft. In order to avoid any ambiguity and legal uncertainty in this respect, we suggest an alternative wording, for instance:

[Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that insurers and insurance or reinsurance groups that maintain their headquarters and the worldwide insurance parent undertaking in jurisdictions accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the [Jurisdiction].
The same observation and suggestion applies also to a corresponding paragraph in section III.13.c, which could be amended as well.

We thank you for carefully considering our concern and thank again for the opportunity to comment. We stand ready to address any questions you may have.

Sincerely,

Thomas Luder

Insurance & Risks
Financial System & Financial Markets
State Secretariat for International Finance SIF
Swiss Federal Department of Finance FDF
Bundesgasse 3, CH-3003 Bern – Schweiz
Process for Evaluating Qualified and Reciprocal Jurisdictions
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I. Preamble

Purpose

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

Background

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

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

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

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

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

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

1. The NAIC model revisions applicable to certified reinsurers are intended to facilitate cross-border reinsurance transactions and enhance competition within the U.S. market, while ensuring that U.S. insurers and policyholders are adequately protected against the risk of insolvency. To be eligible for certification, a reinsurer must be domiciled and licensed in a Qualified Jurisdiction as determined by the domestic regulator of the ceding insurer. A Qualified Jurisdiction not subject to an in-force Covered Agreement under the Dodd-Frank Act may also be determined to be a Reciprocal Jurisdiction, and reinsurers that have their head office or are domiciled in any such Reciprocal Jurisdiction will not be required to post reinsurance collateral, provided they meet the minimum capital and financial strength requirements and comply with the other requirements of the Credit for Reinsurance Models.

2. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions and Reciprocal Jurisdictions will be conducted in accordance with the provisions of the Credit for Reinsurance Models and any other relevant guidance developed by the NAIC.

3. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Financial Regulation Standards and Accreditation Program (Accreditation Program), adherence to international supervisory standards, and relevant international guidance for recognition of reinsurance supervision. It is not intended as a prescriptive comparison to the NAIC Accreditation Program. In order for a Qualified Jurisdiction that is not subject to an in-force Covered Agreement to be evaluated as a Reciprocal Jurisdiction, that Qualified Jurisdiction must agree to adhere to the same reciprocity standards that have been imposed under the EU and UK Covered Agreements, including the requirement that the Qualified Jurisdiction must agree to recognize the states’ approach to group supervision, including group capital, and such other requirements as provided under the Credit for Reinsurance Models.

4. The states shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the Qualified Jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of Qualified Jurisdiction status is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

5. Each state may evaluate a non-U.S. jurisdiction to determine if it is a Qualified Jurisdiction. A list of Qualified Jurisdictions will be published through the NAIC committee process. A state must consider this list in its determination of Qualified Jurisdictions, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Qualified Jurisdictions contained in the Credit for Reinsurance Models. The creation of this list does not constitute a delegation of regulatory authority to the NAIC. The regulatory authority to recognize a Qualified Jurisdiction resides solely in each state and the NAIC List of Qualified Jurisdictions is not binding on the states.

6. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models.
7. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination that a jurisdiction is a Qualified or Reciprocal Jurisdiction. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings. The NAIC Lists of Qualified and Reciprocal Jurisdictions are intended to facilitate the passporting process.

8. Both Qualified Jurisdictions and Reciprocal Jurisdictions must agree to share information and cooperate with the state with respect to all applicable reinsurers domiciled within that jurisdiction. Critical factors in the evaluation process include but are not limited to the history of performance by assuming insurers in the applicant jurisdiction and any documented evidence of substantial problems with the enforcement of final U.S. judgments in the applicant jurisdiction. A jurisdiction will not be a Qualified Jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

9. The determination of Qualified Jurisdiction status can only be made with respect to the reinsurance supervisory system in existence and applied by a non-U.S. jurisdiction at the time of the evaluation.

10. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.
III. Procedure for Evaluation of Non-U.S. Jurisdictions

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

2. Evaluation of Jurisdiction
   a. Evaluation Materials. The Qualified Jurisdiction Working Group will initiate evaluation of a jurisdiction’s regulatory system by using the information identified in Section A through Section G of the Evaluation Methodology (Evaluation Materials). The Qualified Jurisdiction Working Group will begin by undertaking a review of the most recent Financial Sector Assessment Program (FSAP) Report prepared by the International Monetary Fund (IMF), including the Technical Note on Insurance Sector Supervision, and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Qualified Jurisdiction Working Group will also invite each jurisdiction or its designee to provide information relative to Section A through Section G of the Evaluation Methodology in order to update, complete or supplement publicly available information. The Qualified Jurisdiction Working Group may also request or accept relevant information from reinsurers domiciled in the jurisdiction under review.
   b. The Qualified Jurisdiction Working Group will notify the jurisdiction of any additional information upon which the Working Group is relying beyond the information provided by the jurisdiction. In that communication, the NAIC will invite the supervisory authority to compare the materials identified by the NAIC to the materials described in Appendix A and Appendix B, and provide information required to update the identified public information or supplement the public information, as required, to address the topics identified in Section A through Section G of the Evaluation Methodology. The use of publicly available information (e.g., the FSAP Report and/or the Insurance Sector Technical Note) is intended to lessen the burden on applicant jurisdictions by requiring the production of information that is readily available, while still addressing substantive areas of inquiry detailed in the Evaluation Methodology. The Qualified Jurisdiction Working Group’s review at this stage will be focused on how the jurisdiction’s laws, regulations, administrative practices and procedures, and regulatory authorities regulate the financial
solvency of its domestic reinsurers in comparison to key principles underlying the U.S. financial solvency framework\(^1\) and other factors set forth in the Evaluation Methodology.

c. After reviewing the Evaluation Materials, the Qualified Jurisdiction Working Group may request that the applicant jurisdiction submit supplemental information as necessary to determine whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. The Working Group will address specific questions directly with the jurisdiction related to items detailed in the Evaluation Methodology that are not otherwise addressed in the Evaluation Materials.

d. The NAIC will request that all responses from the jurisdiction being evaluated be provided in English. Any responses submitted with respect to a jurisdiction’s laws and regulations should be provided by a person qualified in that jurisdiction to provide such analyses and, in the case of statutory analysis, qualified to provide such legal interpretations, to ensure that the jurisdiction is providing an accurate description.

e. The NAIC does not intend to review confidential company-specific information in this process, and has focused the procedure on reviewing publicly available information. No confidential company-specific information shall be disclosed or disseminated during the course of the jurisdiction’s evaluation unless specifically requested, subject to appropriate confidentiality safeguards addressed in a preliminary confidentiality and information-sharing agreement. If no such agreement is executed or the jurisdiction is unable to enter into such an agreement under its regulatory authority, the NAIC will not accept any confidential company-specific information.

3. **NAIC Review of Evaluation Materials**

   a. NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise will review the jurisdiction’s Evaluation Materials.

   b. Expenses with respect to the evaluations will be absorbed within the NAIC budget. This will be periodically reviewed.

   c. Timeline for review. A project management approach will be developed with respect to the overall timeline applicable to each evaluation.

   d. Upon completing its review of the Evaluation Materials, the internal reviewer(s) will report initial findings to the Qualified Jurisdiction Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to FIO and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.

4. **Discretionary On-site Review**

   a. The NAIC may ask the jurisdiction under consideration for the opportunity to perform an on-site review of the jurisdiction’s reinsurance supervisory system. Factors that the Qualified Jurisdiction Working Group will consider in determining whether an on-site review is appropriate include the completeness of the information provided by the jurisdiction under review, the general familiarity of the jurisdiction by the NAIC staff or other state regulators participating in the review based on prior conduct or dealings with the jurisdiction, and the results of other evaluations performed by other regulatory or supervisory organizations. If the review is performed, it will be coordinated through the NAIC, utilizing personnel with the appropriate

\(^1\) The U.S. financial solvency framework is understood to refer to the key elements provided in the NAIC Financial Regulation Standards and Accreditation Program. Appendix A and Appendix B are derived from this framework.
knowledge, experience and expertise. Individual states may also request that representatives from their state be added to the review team.

b. The review team will communicate with the supervisory authority in advance of the on-site visit to clearly identify the objectives, expectations and procedures with respect to the review, as well as any significant issues or concerns identified within the review of the Evaluation Materials. Information to be considered during the on-site review includes, but is not limited to, the following:

   i. Interviews with supervisory authority personnel.
   
   ii. Review of organizational and personnel practices.
   
   iii. Any additional information beneficial to gaining an understanding of document and communication flows.

c. Upon completing the on-site review, the reviewer(s) will report initial findings to the Qualified Jurisdiction Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation.

5. Standard of Review

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

6. Additional Information to be Considered as Part of Evaluation

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

a. Documents, reports and information from appropriate international, U.S. federal and U.S. state authorities.

b. Public comments from interested parties.

c. Rating agency information.

d. Any other relevant information.

7. Preliminary Evaluation Report

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

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


a. The Qualified Jurisdiction Working Group’s review of the Preliminary Evaluation Report will be held in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings.

b. The Qualified Jurisdiction Working Group will make a preliminary determination as to whether the jurisdiction under consideration satisfies the Standard of Review and is deemed acceptable to be included on the NAIC List of Qualified Jurisdictions. If the preliminary determination is that the jurisdiction should not be included on the NAIC List of Qualified Jurisdictions, the Qualified Jurisdiction Working Group will set forth its specific findings and identify those areas of concern with respect to this determination.

c. The results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review.


a. Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. This is not intended to be a formal appeals process that would initiate U.S. state administrative due process requirements.

b. The Qualified Jurisdiction Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Qualified Jurisdiction Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings. This report will be approved upon an affirmative vote of a majority of the members in attendance at this meeting.

c. Upon approval of the Final Evaluation Report, the Qualified Jurisdiction Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the summary for public comment. The detailed report will be a confidential, regulator-only document. The report may be shared with any state indicating that it is considering relying on the NAIC List of Qualified Jurisdictions and has entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction.
10. NAIC Determination regarding List of Qualified Jurisdictions

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

b. In the event that a jurisdiction is not approved as a Qualified Jurisdiction, the supervisory authority will be eligible for reapplication at the discretion of the NAIC.

c. Upon final adoption of the Qualified Jurisdiction Working Group’s determination with respect to a jurisdiction, the Final Evaluation Report will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential.

11. Memorandum of Understanding (MOU)

a. A Qualified Jurisdiction must agree to share information and cooperate on a confidential basis with the U.S. state insurance regulatory authority with respect to all certified reinsurers domiciled within that jurisdiction.

b. The International Association of Insurance Supervisors (IAIS) Multilateral Memorandum of Understanding (MMoU) is the recommended method under which a Qualified Jurisdiction will agree to share information and cooperate with U.S. state insurance regulatory authorities. However, until such time as a state has been approved as a signatory to the MMoU by the IAIS, the state may rely on an MOU entered into by a “Lead State” designated by the NAIC. This Lead State will act as a conduit for information between the Qualified Jurisdiction and other states that have certified a reinsurer domiciled and licensed in that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of information included in the applicable IAIS MMoU or bilateral MOU between the Lead State and the Qualified Jurisdiction and pursuant to the NAIC Master Information Sharing and Confidentiality Agreement. The jurisdiction must also confirm in writing that it is willing to permit this Lead State to act as the contact for purposes of obtaining information concerning its certified reinsurers, provided the Lead State share that information with the other states requesting the information consistent with the terms governing the further sharing of information included in the applicable IAIS MMoU or bilateral MOU between the Lead State and the Qualified Jurisdiction.

c. If a Qualified Jurisdiction has not been approved by the IAIS for use of the MMoU, it must enter into an MOU with a Lead State. The MOU will also provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions.

d. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.
12. Process for Evaluation after Initial Approval

a. The process for determining whether a non-U.S. jurisdiction is a Qualified Jurisdiction is ongoing and subject to periodic review. The Qualified Jurisdiction Working Group will perform a yearly due diligence review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. This yearly review shall follow such abbreviated process as may be determined by the Qualified Jurisdiction Working Group to be appropriate.

b. Qualified Jurisdictions must provide the Qualified Jurisdiction Working Group with notice of any material change in the applicable reinsurance supervisory system that may affect the status of the Qualified Jurisdiction. A U.S. jurisdiction should also notify the Qualified Jurisdiction Working Group if it receives notice of any material change in the applicable reinsurance supervisory system, or any adverse developments with respect to enforcement of final U.S. judgments, that may affect the status of the Qualified Jurisdiction. Upon receipt of any such notice, the Qualified Jurisdiction Working Group will consider whether it is necessary to re-evaluate the status of the Qualified Jurisdiction.

c. If the Qualified Jurisdiction Working Group finds the jurisdiction to be out of compliance at any time with the requirements to be a Qualified Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review, and the status as a Qualified Jurisdiction may be placed on probation, suspended or revoked. The Qualified Jurisdiction Working Group will perform a yearly due diligence review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. This yearly review shall follow such abbreviated process as may be determined by the Qualified Jurisdiction Working Group to be appropriate.

d. The Qualified Jurisdiction Working Group will monitor those jurisdictions that have been approved as Qualified Jurisdictions by individual states, but are not included on the NAIC List of Qualified Jurisdictions.

13. Review of Qualified Jurisdictions as Reciprocal Jurisdictions

a. In undertaking the evaluation of a Qualified Jurisdiction as a Reciprocal Jurisdiction, the Qualified Jurisdiction Working Group shall utilize such processes and procedures as outlined in the immediately-preceding paragraphs 1 – 12 of Section III. Procedure for Evaluation of Non-U.S. Jurisdictions such as the Qualified Jurisdiction Working Group deems is appropriate. Specifically, the Qualified Jurisdiction Working Group will use processes and procedures outlined in paragraph 1 (Initiation of Evaluation of the Reinsurance Supervisory System of an Individual Jurisdiction), paragraph 3 (NAIC Review of Evaluation Materials), paragraph 7 (Preliminary Evaluation Report), paragraph 8 (Review of Preliminary Evaluation Report), paragraph 9 (Opportunity to Respond to Preliminary Evaluation Report), paragraph 10 (NAIC Determination regarding List of Qualified Jurisdictions), paragraph 11 (Memorandum of Understanding) and paragraph 12 (Process for Evaluation after Initial Approval), as modified for use with Reciprocal Jurisdictions.

b. A Qualified Jurisdiction may not be reviewed for inclusion on the NAIC List of Reciprocal Jurisdictions, unless it has undergone the Evaluation Methodology outlined in Section IV, and remains in good standing with the NAIC as a Qualified Jurisdiction. The Qualified Jurisdiction Working Group may, if it determines an extended review period to be appropriate after its initial approval of a new Qualified Jurisdiction, defer consideration of that jurisdiction as a possible Reciprocal Jurisdiction until there has been sufficient United States experience with that jurisdiction and its Certified Reinsurers that the Working Group believes it is appropriate to progress from collateral reduction to collateral elimination. Nothing in this process requires
a finding that a Qualified Jurisdiction meets the standards for recognition as a Reciprocal Jurisdiction, and the Qualified Jurisdiction Working Group may base such recommendation on factors not specifically included in this process.

c. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the NAIC List of Reciprocal Jurisdictions. In making its recommendation with respect to whether a Qualified Jurisdiction should be added to the NAIC List of Reciprocal Jurisdictions, the Qualified Jurisdiction Working Group shall undergo the following analysis in making its evaluation:

i. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in that jurisdiction is received by United States ceding insurers;

ii. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

iii. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurers and insurance groups that are domiciled or maintain their worldwide headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision, including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the Qualified Jurisdiction;

iv. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

v. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction, and has been granted an exemption from state collateral requirements under Section 9 of Model #786, continues to comply with the requirements set forth in Section 9C(2) and (3) of Model #786; i.e., must maintain minimum capital and surplus of no less than $250,000,000, and maintains on an ongoing basis the required minimum solvency or capital ratio, as applicable.
d. In order to satisfy the requirements of subsection (c) above, the chief insurance supervisor of the Qualified Jurisdiction being evaluated as a Reciprocal Jurisdiction may provide the NAIC with a written letter confirming, as follows:

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

- An insurer which has its head office or is domiciled in [Jurisdiction] shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in [Jurisdiction] is received by United States ceding insurers. [Jurisdiction] does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by [Jurisdiction] or as a condition to allow the ceding insurer to recognize credit for such reinsurance.

- [Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that insurers and insurance groups that are domiciled or maintain their worldwide headquarters in jurisdictions accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision, including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the [Jurisdiction].

- [Jurisdiction] confirms that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the [Jurisdiction].

- [Jurisdiction] will annually provide to the states confirmation that applicable assuming insurers domiciled in [Jurisdiction] maintain minimum capital and surplus of no less than $250,000,000, and maintain on an ongoing basis the required minimum solvency or capital ratio, as applicable.

- Finally, I confirm that [Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

e. The Qualified Jurisdiction Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate, and will prepare for the review by the Reinsurance Task Force a Summary of Findings and Determination recommending that the Qualified Jurisdiction be recognized as a Reciprocal Jurisdiction. Upon approval by the Task Force, the Summary of Findings and Determination must be adopted by a vote of the NAIC Executive (EX) Committee and Plenary for inclusion on the List of Reciprocal Jurisdictions.
f. The Qualified Jurisdiction Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable equivalency assessment conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

g. Except for Reciprocal Jurisdictions entitled to automatic recognition, a jurisdiction’s status as a Reciprocal Jurisdiction may be placed on probation, suspended or revoked for good cause in the same manner as provided for Qualified Jurisdictions under paragraph 12. If cause is found to question the fitness of a Reciprocal Jurisdiction that is subject to an in-force covered agreement, or its compliance with applicable requirements of the covered agreement, the Qualified Jurisdiction Working Group shall promptly bring the matter to the attention of the applicable dispute resolution mechanism under the covered agreement.
IV. Evaluation Methodology

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

The Evaluation Methodology consists of the following:

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

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

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

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

1. Confirmation of the jurisdiction’s most recent FSAP Report, including relevant updates with respect to descriptions or elements of the FSAP Report in which changes have occurred since the assessment or where information might otherwise be outdated.

2. Confirmation of the jurisdiction’s ROSC, including relevant updates with respect to descriptions or elements of the ROSC in which changes have occurred since the report was completed or where information might otherwise be outdated.

3. If materials responsive to the topics under review have been provided in response to information exchanges between the jurisdiction under review and the NAIC, such prior responses may be cross-referenced provided updates are submitted, if required to address changes in laws or procedures.

4. Any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC’s evaluation process in order to address, on an outcomes basis, the key elements described within Appendix A.

The NAIC will review the information provided by the applicant jurisdiction and determine whether it is adequate to reasonably conclude whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. After reviewing the initial submission, the NAIC may request that the applicant jurisdiction

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2 The basic considerations under this section are derived from Model #786, Section 8C(2), which include: (a) the framework under which the assuming reinsurer is regulated; (b) the structure and authority of the jurisdiction’s reinsurance supervisory authority with regard to solvency regulation requirements and financial surveillance; (c) the substance of financial and operating standards for reinsurers domiciled in the jurisdiction; and (d) the form and substance of financial reports required to be filed or made publicly available by reinsurers domiciled in the jurisdiction and the accounting principles used.
submit supplemental information as necessary in order to make this determination. An applicant jurisdiction is
strongly encouraged to provide thorough, detailed and current information in its initial submission in order to
minimize the number and extent of supplemental information requests from the NAIC with respect to Section A of
this Evaluation Methodology. The NAIC will provide a complete description in the Final Evaluation Report of the
information provided in the Evaluation Materials, and any updates or other information that have been provided by
the applicant jurisdiction.

Section B: Regulatory Practices and Procedures

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

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

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

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

Section D: Regulatory Cooperation and Information-Sharing

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

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

a. Number of reinsurers domiciled in the jurisdiction, and a list of any reinsurers domiciled in the jurisdiction that have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, of no less than $250,000,000.

b. Up to a 10-year history of any regulatory actions taken against specific reinsurers.

c. Up to a 10-year history listing any reinsurers that have gone through insolvency proceedings, including the size of each insolvency and a description of the related outcomes (e.g., reinsurer rehabilitated or liquidated, payout percentage of claims to priority classes, payout percentage of claims to domestic and foreign claimants).

d. Up to a 10-year history of any significant industry-wide fluctuations in capital or profitability with respect to domestic reinsurers.

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

Section F: Enforcement of Final U.S. Judgments

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

Section G: Solvent Schemes of Arrangement

The jurisdiction is requested to provide a description of any legal framework that allows reinsurers domiciled in the jurisdiction to propose or participate in any solvent scheme of arrangement or similar procedure. In addition, the jurisdiction is requested to provide a description of any solvent scheme of arrangement or similar procedure that a domestic reinsurer has proposed or participated in and the outcome of such procedure.
V. Appendices: Specific Guidance with Respect to Section A and Section B

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

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

1. Examination Authority

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

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

2. Capital and Surplus Requirement

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

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

3. Accounting Practices and Procedures

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

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

4. Corrective Action

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

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

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

a. Whether the jurisdiction has the authority to require a diversified investment portfolio for all domestic reinsurers as to type, issue and liquidity.

b. Whether the jurisdiction has the authority to establish acceptable practices and procedures under which investments owned by reinsurers must be valued, including standards under which reinsurers are required to value securities/investments.

6. **Holding Company Systems**

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

a. Whether the jurisdiction has access to information via the parent or other regulated group entities about activities or transactions within the group involving other regulated or non-regulated entities that could have a material impact on the operations of the reinsurer.

b. Whether the jurisdiction has access to consolidated financial information of a reinsurer’s ultimate controlling person.

c. Whether the jurisdiction has the authority to review integrity and competency of management.

d. Whether the jurisdiction has approval and intervention powers for material transactions and events involving reinsurers.

e. Whether the jurisdiction has authority to monitor, or has prior approval authority over:
   i. Change in control of domestic reinsurers.
   ii. Dividends and other distributions to shareholders of the reinsurer.
   iii. Material transactions with affiliates.

7. **Risk Management**

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

a. Whether the jurisdiction has Own Risk and Solvency Assessment (ORSA) requirements and reporting.

b. Any requirements regarding the maximum net amount of risk to be retained by a reinsurer for an individual risk based on the reinsurer’s capital and surplus.

c. Whether the jurisdiction has authority to monitor enterprise risk, including any activity, circumstance, event (or series of events) involving one or more affiliates of a reinsurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the reinsurer or its insurance holding company system as a whole.

d. Whether the jurisdiction has corporate governance requirements for reinsurers.
8. **Liabilities and Reserves**

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

a. Liabilities incurred under reinsurance contracts for policy reserves, unearned premium, claims and losses unpaid, and incurred but not reported (IBNR) claims (including whether discounting is allowed for reserve calculation/reporting).

b. Liabilities related to catastrophic occurrences.

c. Whether the jurisdiction requires an opinion on reserves and loss and loss adjustment expense reserves by a qualified actuary or specialist for all domestic reinsurers, and the frequency of such reports.

9. **Reinsurance Ceded**

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

a. Credit for reinsurance requirements applicable to reinsurance retroceded to domestic and non-domestic reinsurers.

b. Collateral requirements applicable to reinsurance contracts.

c. Whether the jurisdiction requires a reinsurance agreement to provide for insurance risk transfer (i.e., transfer of both underwriting and timing risk).

d. Requirements applicable to special purpose reinsurance vehicles and insurance securitizations.

e. Affiliated reinsurance transactions and concentration risk.

f. Disclosure requirements specific to reinsurance transactions, agreements and counterparties, if such information is not provided under another item.

10. **Independent Audits**

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

a. Requirements for the filing of audited financial statements prepared in conformity with accounting practices prescribed or permitted by the supervisory authority.

b. Contents of annual audited financial reports.

c. Requirements for selection of auditor.

d. Allowance of audited consolidated or combined financial statements.

e. Notification of material misstatements of financial condition.

f. Supervisor’s access to auditor’s workpapers.

g. Audit committee requirements.

h. Requirements for reporting of internal control-related matters.

11. **Receivership**

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

12. Filings with Supervisory Authority

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

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

13. Reinsurance Intermediaries

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

14. Other Regulatory Requirements with respect to Reinsurers

Any other information necessary to adequately describe the effectiveness of the jurisdiction’s laws and regulations with respect to its reinsurance supervisory system.
Appendix B: Regulatory Practices and Procedures

1. Financial Analysis

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

a. Qualified Staff and Resources
   The resources employed to effectively review the financial condition of all domestic reinsurers, including a description of the educational and experience requirements for staff responsible for financial analysis.

b. Communication of Relevant Information to/from Financial Analysis Staff
   The process under which relevant information and data received by the supervisory authority are provided to the financial analysis staff and the process under which the findings of the financial analysis staff are communicated to the appropriate person(s).

c. Supervisory Review
   How the jurisdiction’s internal financial analysis process provides for supervisory review and comment.

d. Priority-Based Analysis
   How the jurisdiction’s financial analysis procedures are prioritized in order to ensure that potential problem reinsurers are reviewed promptly.

e. Depth of Review
   How the jurisdiction’s financial analysis procedures ensure that domestic reinsurers receive an appropriate level or depth of review commensurate with their financial strength and position.

f. Analysis Procedures
   How the jurisdiction has documented its financial analysis procedures and/or guidelines to provide for consistency and continuity in the process and to ensure that appropriate analysis procedures are being performed on each domestic reinsurer.

g. Reporting of Material Adverse Findings
   The process for reporting material adverse indications, including the determination and implementation of appropriate regulatory action.

h. Early Warning System/Stress Testing
   Whether the jurisdiction has an early warning system and/or stress testing methodology that is utilized with respect to its domestic reinsurers.

2. Financial Examinations

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

a. Qualified Staff and Resources
   The resources employed to effectively examine all domestic reinsurers. This should include whether the jurisdiction prioritizes examination scheduling and resource allocation commensurate with the financial strength and position of each reinsurer, and a description of the educational and experience requirements for staff responsible for financial examinations.
b. **Communication of Relevant Information to/from Examination Staff**
   The process under which relevant information and data received by the supervisory authority are provided to the examination staff and the process under which the findings of the examination staff are communicated to the appropriate person(s).

c. **Use of Specialists**
   Whether the supervisory authority’s examination staff includes specialists with appropriate training and/or experience or whether the supervisory authority otherwise has available qualified specialists that will permit the supervisory authority to effectively examine any reinsurer.

d. **Supervisory Review**
   Whether the supervisory authority’s procedures for examinations provide for supervisory review.

e. **Examination Guidelines and Procedures**
   Description of the policies and procedures the supervisory authority employs for the conduct of examinations, including whether variations in methods and scope are commensurate with the financial strength and position of the reinsurer.

f. **Risk-Focused Examinations**
   Does the supervisory authority perform and document risk-focused examinations and, if so, what guidance is utilized in conducting the examinations? Are variations in method and scope commensurate with the financial strength and position of the reinsurer?

g. **Scheduling of Examinations**
   Whether the supervisory authority’s procedures provide for the periodic examination of all domestic reinsurers, including how the system prioritizes reinsurers that exhibit adverse financial trends or otherwise demonstrate a need for examination.

h. **Examination Reports**
   Description of the format in which the supervisory authority’s reports of examinations are prepared, and how the reports are shared with other jurisdictions under information-sharing agreements.

i. **Action on Material Adverse Findings**
   What are the jurisdiction’s procedures regarding supervisory action in response to the reporting of any material adverse findings.

3. **Information Sharing**

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

4. **Procedures for Troubled Reinsurers**

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

5. **Organization, Licensing and Change of Control of Reinsurers**

   What processes does the supervisory authority use to identify unlicensed or fraudulent activities? The description should address the following:
a. **Licensing Procedure**  
Whether the supervisory authority has documented licensing procedures that include a review and/or analysis of key pieces of information included in a primary licensure application.

b. **Staff and Resources**  
The educational and experience requirements for staff responsible for evaluating company licensing.

c. **Change in Control of a Domestic Reinsurer**  
Procedures for the review of key pieces of information included in filings with respect to a change in control of a domestic reinsurer.
Summary of Findings and Determination

France: Autorité de Contrôle Prudentiel et de Résolution (ACPR)

Re-Evaluation of Qualified Jurisdiction

Issued for Public Comment By:

Qualified Jurisdiction (E) Working Group

September 4, 2019

Updated: October 16, 2019
I. Re-Evaluation of France as a Qualified Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to its re-evaluation of the Autorité de Contrôle Prudentiel et de Résolution (ACPR), the lead insurance regulatory supervisor for France. It is the recommendation of the Working Group that the NAIC re-approve the ACPR as a Qualified Jurisdiction and continue its designation on the *NAIC List of Qualified Jurisdictions*, to be effective as of January 1, 2020. Further, the Working Group recommends that New York and Delaware be the Lead State for purposes of regulatory cooperation and information sharing with the ACPR. These recommendations are based on the following analysis.

II. Procedural History

The NAIC adopted the *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions* (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.1

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved the ACPR as a Qualified Jurisdiction and placed it on the *NAIC List of Qualified Jurisdictions*, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the ACPR would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

> Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the *NAIC List of Qualified Jurisdictions*. The Working Group met in regulator-to-regulator session on August 22, 2019, and heard a presentation by NAIC staff.

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1 The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. Because the ACPR’s status as a Reciprocal Jurisdiction arises under a covered agreement under the Dodd-Frank Wall Street Reform and Consumer Protection Act, it is not affected by this re-evaluation of the ACPR as a Qualified Jurisdiction.
on whether the ACPR should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of the ACPR:


3. Summary of Findings and Determination France: Autorité de Contrôle Prudentiel et de Résolution (ACPR) approved by NAIC Executive (EX) Committee and Plenary on December 16, 2014.

4. NAIC Staff Workpapers on Initial Review and Findings dated August 7, 2014 (Confidential).

III. Standard of Review

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other documentation that the Working Group would consider to be relevant to this determination. In addition, the Working Group would consider its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

IV. Summary of Findings and Recommendation

Upon review of the available information, the Working Group has reached the conclusion that the ACPR’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency regulation that is acceptable for purposes of reinsurance collateral reduction, that the ACPR’s demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize the ACPR as a Qualified Jurisdiction and place it on the *NAIC List of Qualified Jurisdictions*, with such re-evaluation to be effective as of January 1, 2020.
Summary of Findings and Determination

Germany: Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin)

Re-Evaluation of Qualified Jurisdiction

Issued for Public Comment By:

Qualified Jurisdiction (E) Working Group

September 4, 2019

Updated: October 16, 2019
I. Re-Evaluation of Germany as a Qualified Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to its re-evaluation of the Bundesanstalt für FinanzdienstleistungsAufsicht (BaFin), the lead insurance regulatory supervisor for Germany. It is the recommendation of the Working Group that the NAIC re-approve BaFin as a Qualified Jurisdiction and continue its designation on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that California be the Lead State for purposes of regulatory cooperation and information sharing with BaFin. These recommendations are based on the following analysis.

II. Procedural History

The NAIC adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.1

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved BaFin as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which BaFin would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the NAIC List of Qualified Jurisdictions. The Working Group met in regulator-to-regulator session on August 22, 2019, and heard a presentation by NAIC staff.

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1 The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. Because BaFin’s status as a Reciprocal Jurisdiction arises under a covered agreement under the Dodd-Frank Wall Street Reform and Consumer Protection Act, it is not affected by this re-evaluation of BaFin as a Qualified Jurisdiction.
on whether BaFin should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of BaFin:


3. Summary of Findings and Determination Germany: Federal Financial Supervisory Authority (BaFin) approved by NAIC Executive (EX) Committee and Plenary on December 16, 2014.


5. BaFin Comment Letter (Sept. 30, 2019): “The planned amendment of § 67 (1) VAG with respect to the exemption from the license requirement in cases where the EU has concluded an agreement is now part of another legislative procedure (implementation of the Money Laundering Directive)...the leaflet describes the situation for US reinsurers with the sufficient legal clarity”:
   https://www.bafin.de/dok/13008940

III. Standard of Review

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other documentation that the Working Group would consider to be relevant to this determination. In addition, the Working Group would consider its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

IV. Summary of Findings and Recommendation

Upon review of the available information, the Working Group has reached the conclusion that BaFin’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency regulation that is acceptable for purposes of reinsurance collateral reduction, that BaFin’s demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.
Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize BaFin as a Qualified Jurisdiction and place it on the *NAIC List of Qualified Jurisdictions*, with such re-evaluation to be effective as of January 1, 2020.
Summary of Findings and Determination

Ireland: Central Bank of Ireland

Re-Evaluation of Qualified Jurisdiction

Issued for Public Comment By:

Qualified Jurisdiction (E) Working Group

September 4, 2019
I. Re-Evaluation of Ireland as a Qualified Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to its re-evaluation of the Central Bank of Ireland (Central Bank), the lead insurance regulatory supervisor for Ireland. It is the recommendation of the Working Group that the NAIC re-approve the Central Bank as a Qualified Jurisdiction and continue its designation on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that Delaware be the Lead State for purposes of regulatory cooperation and information sharing with the Central Bank. These recommendations are based on the following analysis.

II. Procedural History

The NAIC adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.1

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved the Central Bank as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the Central Bank would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

> Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the NAIC List of Qualified Jurisdictions. The Working Group met in regulator-to-regulator session on August 22, 2019, and heard a presentation by NAIC staff

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1 The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. Because the Central Banks’s status as a Reciprocal Jurisdiction arises under a covered agreement under the Dodd-Frank Wall Street Reform and Consumer Protection Act, it is not affected by this re-evaluation of the Central Bank as a Qualified Jurisdiction.
on whether the Central Bank should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of the Central Bank:

1. *International Monetary Fund (IMF), Ireland: Report on Observance of Standards and Codes (ROSC), May, 2015 (IMF Country Report No. 15/117).*


4. *Summary of Findings and Determination Central Bank of Ireland approved by NAIC Executive (EX) Committee and Plenary on December 16, 2014.*

5. *NAIC Staff Workpapers on Initial Review and Findings dated July 25, 2014 (Confidential).*

**III. Standard of Review**

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other documentation that the Working Group would consider to be relevant to this determination. In addition, the Working Group would consider its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

**IV. Summary of Findings and Recommendation**

Upon review of the available information, the Working Group has reached the conclusion that the Central Bank’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency regulation that is acceptable for purposes of reinsurance collateral reduction, that the Central Bank’s demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.
Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize the Central Bank as a Qualified Jurisdiction and place it on the *NAIC List of Qualified Jurisdictions*, with such re-evaluation to be effective as of January 1, 2020.
Summary of Findings and Determination

United Kingdom (UK):
Prudential Regulation Authority of the
Bank of England

Re-Evaluation of Qualified Jurisdiction

Issued for Public Comment By:
Qualified Jurisdiction (E) Working Group

September 4, 2019
I. Re-Evaluation of the United Kingdom as a Qualified Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to its re-evaluation of the Prudential Regulation Authority of the Bank of England (PRA), the lead insurance regulatory supervisor for the United Kingdom (UK). It is the recommendation of the Working Group that the NAIC re-approve the PRA as a Qualified Jurisdiction and continue its designation on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that New York be the Lead State for purposes of regulatory cooperation and information sharing with the PRA. These recommendations are based on the following analysis.

II. Procedural History

The NAIC adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.1

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved the PRA as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the PRA would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the NAIC List of Qualified Jurisdictions. The Working Group met in regulator-to-regulator session on August 22, 2019, and heard a presentation by NAIC staff

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1 The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. Because the PRA’s status as a Reciprocal Jurisdiction arises under a covered agreement under the Dodd-Frank Wall Street Reform and Consumer Protection Act, it is not affected by this re-evaluation of the PRA as a Qualified Jurisdiction.
on whether the PRA should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of the PRA:


4. *NAIC Staff Workpapers on Initial Review and Findings dated July 22, 2014 (Confidential).*

### III. Standard of Review

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other documentation that the Working Group would consider to be relevant to this determination. In addition, the Working Group would consider its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

### IV. Summary of Findings and Recommendation

Upon review of the available information, the Working Group has reached the conclusion that the PRA’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency regulation that is acceptable for purposes of reinsurance collateral reduction, that the PRA’s demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize the PRA as a Qualified Jurisdiction and place it on the *NAIC List of Qualified Jurisdictions,* with such re-evaluation to be effective as of January 1, 2020.
October 11, 2019

Mr. Jake Stultz
Senior Accounting and Reinsurance Policy Advisor
and
Mr. Dan Schelp
Chief Counsel, Regulatory Affairs
National Association of Insurance Commissioners
1100 Walnut St.
Kansas City, MO  64106
(via email)

Re: Reciprocal Jurisdiction Accreditation Standard Exposure

Dear Messrs. Stultz and Schelp:

The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers' financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers' products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. ACLI also represents all professional life reinsurers assuming mortality and morbidity risks in the United States.

We appreciate the opportunity to comment on the exposure draft updating the reciprocal jurisdiction accreditation standard. Our review did not find any concerns or edits to suggest. We do appreciate that the Reinsurance Task Force members have decided to encourage the expedited adoption of this update to become part of the accreditation standard. ACLI supports this exposure.

Sincerely,

Steven M. Clayburn, FSA, MAAA

Mariana Gomez-Vock
October 4, 2019

Via Email

The Honorable Chlora Lindley-Myers
Director of the Missouri Department of Commerce & Insurance
Chair, NAIC Reinsurance Task Force

Re: Exposure of Revisions to Credit for Reinsurance Accreditation Standard

Dear Director Lindley-Myers,

This comment letter is submitted on behalf of Underwriters at Lloyd’s, London (“Lloyd’s”). Lloyd’s is one of the largest non-US domiciled providers of reinsurance capacity to the US insurance industry. In 2018, the Lloyd’s market assumed over $5.6 billion in reinsurance premiums from the US. We appreciate the opportunity to provide these comments on the Reinsurance Task Force’s proposal to make the covered agreement implementation an accreditation standard.

As the Reinsurance Task Force knows, Lloyd’s has been one of the main advocates for reinsurance collateral reform for more than a decade. Over the last several years, we have worked with a number of state insurance departments and legislatures to achieve enactment of the certified reinsurer regime. That experience helped impress upon us the value of making crucial reforms like this part of the NAIC accreditation program. We believe the certified reinsurer regime would not have been enacted in all 50 states if it had not been made an accreditation requirement. Often state legislators are faced with a daunting number of topics to cover in a very limited timeframe. The knowledge that the state insurance regulators who make up the NAIC – the experts in insurance regulatory standard setting – have deemed a particular standard important enough to be part of the accreditation program can go a long way towards convincing state legislators that a particular piece of legislation is a priority.

Given the important role that accreditation can play at the state level, Lloyd’s strongly supports the Reinsurance Task Force’s proposal to make the covered agreement implementation an accreditation standard effective October 1, 2022. Aligning the accreditation standard deadline with the covered agreement deadline will help to encourage all states to adopt the changes in a timely manner. We applaud the Reinsurance Task Force’s work on this important issue.

Regards,

[Signature]
BY E-MAIL

October 7, 2019

Todd E. Kiser
Chair, NAIC Financial Regulation Standards and Accreditation (F) Committee
Attention: Becky Meyer (bmeyer@naic.org)

Chlora Lindley-Myers
Chair, NAIC Reinsurance (E) Task Force
Attention: Jake Stultz (jstultz@naic.org)
Dan Schelp (dschelp@naic.org)

Re: Credit for Reinsurance Model Accreditation Decisions

Dear Commissioner Kiser and Director Lindley-Myers:

New York Life and Northwestern Mutual are writing in response to the current exposure by the Reinsurance (E) Task Force of draft revisions to the NAIC Accreditation Program Manual intended to incorporate the 2019 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) to implement the US-EU Covered Agreement.

Our comments are not with respect to those revisions, but rather to urge that the NAIC follow through on prior recommendations and set the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) as an accreditation standard in parallel with the Covered Agreement revisions. Our companies have long advocated that Model #787 should be an accreditation requirement, which is consistent with the prior recommendation by the Reinsurance Task Force.

By way of background, the NAIC adopted Model #787 in 2016 as the permanent method to implement the NAIC’s XXX/AXXX Reinsurance Framework that it spent years developing. Model #787 establishes the credit for reinsurance that a ceding company may be allowed for a subject captive reinsurance transaction. The requirements for Primary Security and Other Security in Model #787 are substantively the same as those in Actuarial Guideline 48, the NAIC’s interim tool to implement its XXX/AXXX Reinsurance Framework. However, whereas Model #787 binds the ceding company’s allowed credit for reinsurance, AG 48 can only impose requirements on the ceding company’s appointed actuary.

On March 20, 2017, the Reinsurance Task Force recommended to the F Committee that Model #787 be made an accreditation standard on an expedited basis, so that it would become an accreditation requirement by January 1, 2020. This was consistent with the NAIC’s recognition that (1) uniformity in implementation of the XXX/AXXX Reinsurance Framework is critical to its success; and (2) AG 48 was intended from the start as only an interim solution until the ultimate credit for reinsurance mechanism could be implemented. On August 24, 2017, the Reinsurance Task Force recommended the elements of Model #787 to be included in the accreditation standard.
However, as progress was being made toward an expedited accreditation action for Model #787, the need arose to amend Models #785 and #786 to address the Covered Agreement. Not wanting states to face multiple rulemaking processes, the F Committee decided at the 2017 Fall National Meeting to defer adoption of Model #787 as an accreditation requirement until the changes to Models #785 and #786 to implement the Covered Agreement had been completed. Our companies agreed that the NAIC’s announced process made sense.

Now that the Covered Agreement changes to Models #785 and #786 have been adopted and are being considered for accreditation on an expedited basis, we strongly urge that the F Committee move forward as originally contemplated and complete the accreditation decisions on Model #787 in synch with the Model #785 and #786 changes. Doing so will make state implementation of the credit for reinsurance changes more efficient. Moreover, since the Reinsurance Task Force has already done the work to identify the accreditation elements for Model #787, moving in parallel should not delay the NAIC’s efforts on Models #785 and #786.

It is important to remember that the NAIC has already made compliance with its XXX/AXXX Reinsurance Framework an accreditation requirement. That was decided in 2015, when the NAIC revised the Part A Preamble to the 2016 Accreditation Program Manual to subject the regulation of XXX/AXXX captives to the Part A accreditation requirements, and deemed regulation according to the NAIC’s XXX/AXXX Reinsurance Framework to meet those requirements. What remains to be done is to solidify that earlier conclusion by making Model #787 itself an accreditation requirement.

While AG 48 has served as a critical interim measure to implement the XXX/AXXX Reinsurance Framework, it was never intended to be nor is it an adequate permanent substitute for Model #787. Only Model #787 embeds the Primary Security and Other Security requirements directly into the determination of reinsurance credit. AG 48, by contrast, relies upon an indirect enforcement approach: requiring a ceding company’s appointed actuary to perform an analysis and, in the event the Primary Security or Other Security requirements are not met, deliver a qualified actuarial opinion. The allowance, or not, of reinsurance credit as a matter of law under Model #787 serves as a more direct and consequential incentive for compliance and uniformity than can the actuarial opinion requirements of AG 48. While some may question the need to make Model #787 an accreditation standard in light of the existence of AG 48, we would note that the intent of the accreditation program is to ensure uniformity among accredited jurisdictions with respect to solvency regulation. That uniformity can be best achieved by making Model #787 an accreditation standard, thereby ensuring uniform consequences and enforcement with respect to this aspect of the XXX/AXXX Reinsurance Framework. Moreover, it was recognized from the beginning that utilizing an actuarial opinion requirement as a tool for enforcement of the NAIC’s XXX/AXXX Reinsurance Framework puts the actuarial opinion requirement to a novel use going beyond what is ordinarily contemplated as the purpose of the Actuarial Opinion and Memorandum Regulation.

For these reasons, the NAIC has always described AG 48 as the interim method to implement its XXX/AXXX Reinsurance Framework, and the credit for reinsurance changes set forth in
Model #787 as the permanent implementation method. This is also reflected in the fact that AG 48 itself includes sunset provisions to apply in individual states as they adopt Model #787.

There is no longer any reason for delay in the NAIC’s action to make Model #787 an accreditation requirement. We again urge that the F Committee take this up and move forward in parallel with the Covered Agreement changes to Models #785 and #786. Doing so will allow the NAIC to finally complete the important work of uniformly implementing its XXX/AXXX Reinsurance Framework.

We appreciate the opportunity to comment on this important topic. Please let us know if you need any additional information or would like to discuss our comments.

Sincerely,

Douglas A. Wheeler
Senior Vice President, Office of Governmental Affairs
New York Life Insurance Company

Andrew T. Vedder
Vice President – Solvency Policy & Risk Management
The Northwestern Mutual Life Insurance Company
Dear Director Lindley-Myers:

The Reinsurance Association of America (RAA), the American Property and Casualty Insurance Association (APCIA) and the National Association of Mutual Insurance Companies (NAMIC) appreciate the opportunity to submit comments on the NAIC’s Exposure Draft of Accreditation Standard Relating to the Credit for Reinsurance Model Law/Regulation.1

Swift implementation of the 2019 changes to the NAIC Credit for Reinsurance Model Law and Regulation is critical to the U.S.’s commitments under the U.S./EU and U.S./UK covered agreements, as well as to provide the opportunity to extend equal collateral treatment to other reinsurers from other jurisdictions that meet the requirements specified in the revised Model Law/Regulation. We support prompt action by the NAIC to make the 2019 Credit for Reinsurance Model Law/Regulation accreditation requirements. Accreditation is an important tool to support efforts to spur legislative action. Where there is a looming threat of federal preemption as the result of the commitments in the two in-force covered agreements, the NAIC should use every available resource to urge implementation by the states within the required time frame.

1 The Reinsurance Association of America (RAA) is a national trade association representing reinsurance companies doing business in the United States. RAA membership is diverse, including reinsurance underwriters and intermediaries licensed in the U.S. and those that conduct business on a cross-border basis. The RAA also has life reinsurance affiliates.

Representing nearly 60 percent of the U.S. property casualty insurance market, the American Property Casualty Insurance Association (APCIA) promotes and protects the viability of private competition for the benefit of consumers and insurers. APCIA represents the broadest cross-section of home, auto, and business insurers of any national trade association. APCIA members represent all sizes, structures, and regions, which protect families, communities, and businesses in the U.S. and across the globe.

NAMIC membership includes more than 1,400 member companies. The association supports regional and local mutual insurance companies on main streets across America and many of the country’s largest national insurers. NAMIC member companies write $268 billion in annual premiums. Our members account for 59 percent of homeowners, 46 percent of automobile, and 29 percent of the business insurance markets. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.
The proposed changes to the accreditation standard appear to fully incorporate the 2019 changes to the NAIC Credit for Reinsurance Model Law and Regulation. In addition, we understand the Task Force recommendation setting October 1, 2022 as the effective date for this accreditation standard, with reviews of this part of the accreditation standard to begin on January 1, 2023. October 1, 2022 is the date on which preemption of U.S. state laws may begin in accordance with the U.S/EU and U.S./UK covered agreements. However, we ask the Task Force to consider whether an expedited process and an earlier date that would allow some review before the deadline for preemption arrives is more appropriate in this context. This is particularly true because the Federal Insurance Office must begin a preemption analysis 42 months after the date of signature of the U.S./EU covered agreement, or April 2, 2021. For this reason, we suggest that the effective date for the accreditation standard should be April 2, 2021.

Conclusion

We appreciate the opportunity to offer comments and work with the NAIC on the Accreditation Standard Relating to the Credit for Reinsurance Model Law/Regulation. Please do not hesitate to contact us with any questions or concerns.

Sincerely,

Reinsurance Association of America (RAA)
American Property Casualty Insurance Association (APCIA)
National Association of Mutual Insurance Companies (NAMIC)
October 2, 2019

via email: jstultz@naic.org
dschelp@naic.org

Chair Chlora Lindley-Myers (MO)
Vice-Chair Raymond G. Farmer (SC)
Reinsurance (E) Task Force
c/o Jake Stultz and Daniel Schelp
National Association of Insurance Commissioners

Dear Ms. Lindley-Myers and Mr. Farmer:

Texas submits the following comment regarding the effective date of the new reinsurance ceded section of the accreditation standard. Texas agrees with October 1, 2022 as the effective date for the accreditation standard, with reviews of this part of the accreditation standard beginning on January 1, 2023.

Sincerely,

Amy Garcia
Chief Analyst – Associate Commissioner
10. Reinsurance Ceded

State law should contain the NAIC Credit for Reinsurance Model Law (#785), the NAIC’s Credit for Reinsurance Model Regulation (#786) and the NAIC Life and Health Reinsurance Agreements Model Regulation (#791) or substantially similar laws.

**Changes to the Accreditation Standard:**

*NOTE: For both full reviews and interim annual reviews, this standard must be completed in its entirety. Please include all applicable citations in the reference column for each of the questions in this particular standard.

The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Regulation (#786), or a substantially similar law, was adopted as an update to the accreditation standard effective January 1, 2019.

Please provide a copy of the statute or regulation that specifically addresses the newly applicable sections.

Additionally, if there were any other changes that would impact one of the significant elements of this standard, please place an asterisk (*) in the reference column on the right-hand side of the page by each citation that has been changed and include below a brief description of the nature or reason for the change. Please also attach a copy of the statutes or regulations that had a change and ensure that they are clearly marked for the changes that have been made (i.e., highlight the changes, redlined version, etc.).

**REFERENCE**

<table>
<thead>
<tr>
<th>Credit for Reinsurance Model Law (#785)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Credit allowed for reinsurance ceded to a licensed insurer?</td>
</tr>
<tr>
<td>b. Credit allowed for reinsurance ceded to an accredited insurer who meets requirements similar to those in Section 2B and 2I2J of the model law?</td>
</tr>
<tr>
<td>c. Credit allowed for reinsurance ceded to an insurer domiciled and licensed in a state which employs substantially similar standards regarding credit for reinsurance and who maintains capital and surplus of at least $20,000,000 and submits to this states authority to examine its books and records?</td>
</tr>
<tr>
<td>d. Credit allowed for reinsurance ceded to an insurer who maintains a trust fund, established in a form approved by the commissioner, in a qualified U.S. financial institution for the payment of the valid claims of its U.S. policyholders and ceding insurers, their assigns and successors in interest and who reports financial information annually to the commissioner to determine the sufficiency of the trust fund?</td>
</tr>
<tr>
<td>e. In instances where reinsurance is ceded to insurers maintaining a trust fund, trustees of the trust required to report to the department annually, on or before February 28, the balance of the trust and a listing of the trust’s assets as of the end of the year and a certification of the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31?</td>
</tr>
</tbody>
</table>
f. Credit for reinsurance allowed under c. or d. above only permitted where assuming insurer agrees in the reinsurance agreements: 1) that in the event of a failure of the assuming insurer to perform its obligations, the assuming insurer shall submit to the jurisdiction of any court of competent jurisdiction in any state of the U.S.; and 2) to designate the commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process instituted by or on behalf of the ceding company?

REFERENCE

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g. Credit allowed for reinsurance ceded to an insurer not meeting the requirements of a., b., c., or d. above, or with respect to a certified reinsurer described below, in an amount not exceeding the liabilities carried by the ceding insurer and only in the amount of funds held by or on behalf of the ceding insurer in the form of cash, securities listed by the Securities Valuation Office of the NAIC, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets, clean, irrevocable, unconditional letters of credit, and other forms of security acceptable to the commissioner?

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h. Ceding insurers must be subject to notification requirements with respect to reinsurance concentration risk substantially similar to those in Section 2J2K of Model #785.

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Life and Health Reinsurance Agreements Model Regulation (#791)

i. Scope similar to Section 3?

---

j. No insurer, for reinsurance ceded establishes any asset or reduces any liability due to the terms of the reinsurance agreement, in substance or effect if any of the conditions in Section 4A exist?

---

k. Agreements entered into after the effective date of this regulation which involve the reinsurance of business issued prior to the effective date of agreements, along with subsequent amendments shall be filed by the ceding company with the commissioner within 30 days from the execution date along with attachments noted in Section 4C(1)?

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l. Any increase in surplus net of federal income tax resulting from arrangements described in Section 4C(1) to be reported as described in Section 4C(2)?

---

m. Written agreements with provisions similar to Section 5?

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n. Insurers required to reduce to zero any reserve credits or assets established with respect to existing reinsurance agreements entered into prior to the effective date of this regulation which would not be recognized under the provisions of this regulation?
### Reinsurance Ceded – continued

**Credit for Reinsurance Model Regulation (#786)**

- **o.** Credit for reinsurance allowed for reinsurance ceded by domestic insurers to assuming insurers that were licensed in the state as of the last date of the ceding insurers’ statutory financial statement?

- **p.** Credit for reinsurance provisions for accredited reinsurer similar to Section 5?

- **q.** Credit for reinsurance provisions for reinsurers licensed and domiciled in other states similar to Section 6?

- **r.** Credit for reinsurance provisions for reinsurers maintaining trust funds similar to Section 7?

- **s.** Credit for reinsurance required by law similar to Section 910?

- **t.** Reduction from liability for reinsurance ceded to an unauthorized assuming insurer similar to Section 1011?

- **u.** Provisions for trust agreements similar to Section 1112?

- **v.** Provisions for letters of credit similar to Section 1213?

- **w.** Provisions for unencumbered funds similar to Section 1314?

- **x.** Provisions for reinsurance contracts similar to Section 1415?

- **y.** The adoption of Form AR-1—Certificate of Assuming Insurer.

### Reinsurance Ceded to Certified Reinsurers

- **z.** A state’s laws and regulations shall allow credit for reinsurance ceded to a certified reinsurer, including affiliated reinsurance transactions. Its laws and regulations shall contain provisions that are substantially similar to those applicable to certified reinsurers contained in Section 2E of Model #785 and Section 8 of Model #786.

  - **i.** The credit allowed is based upon the security held by or on behalf of the ceding insurer in accordance with the rating assigned to the certified reinsurer by the commissioner? The amount of security required in order for full credit to be allowed shall not be less than that required under Section 8A(1) of Model #786.

  - **ii.** The security provided by the certified reinsurer is in a form consistent with the provisions of Section 2E(5) of Model #785 and Section 8A of Model #786?

  - **iii.** The commissioner requires the certified reinsurer to post 100% security upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer?
iv. A state’s laws or regulations shall include provisions for granting a certified reinsurer a deferral period for posting security applicable to catastrophe recoverables, substantially similar to Section 8A(4) of Model #786. The deferral period shall not exceed one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the commissioner, and shall not apply to lines of business other than those provided in Section 8A(4) of Model #786.

v. Credit for reinsurance ceded to a certified reinsurer shall apply only to reinsurance contracts meeting requirements substantially similar to Section 8A(5) of Model #786?

aa. In order to be a certified reinsurer, an assuming insurer must be certified by the commissioner in accordance with the process similar to Section 8B of Model #786?

i. The commissioner is required to post notice upon receipt of any application for certification substantially similar to the requirements of Section 8B(1) of Model #786?

ii. The commissioner is required to publish a list of all certified reinsurers and their ratings substantially similar to the requirements in Section 2E(4) of Model #785 and Section 8B(2) of Model #786?

iii. A certified reinsurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner?

iv. A certified reinsurer must maintain capital and surplus, or its equivalent, of no less than $250,000,000, calculated in accordance with Section 8B(4)(h) of Model #786? This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

v. A certified reinsurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner, and the maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as set forth in Section 8B(4)(a) of Model #786? These ratings must be based on interactive communication between the rating agency and the assuming insurer and not based solely on publicly available information.
Reinsurance Ceded – continued

vi. A certified reinsurer is rated by the commissioner on a legal entity basis, with consideration given to the group rating where appropriate (an association including incorporated and individual unincorporated underwriters that have been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating)? Factors may be considered in the evaluation process similar to those provided under Section 8B(4) and (5) of Model #786.

vii. A certified reinsurer must submit a properly executed Form CR-1 as evidence of its submission to the jurisdiction of the state, appointment of the commissioner as an agent for service of process in the state, and agreement to provide security for one hundred percent (100%) of its liabilities attributable to reinsurance ceded by ceding insurers if it resists enforcement of a final U.S. judgment? The commissioner must not certify any assuming insurer that is domiciled in a jurisdiction that the commissioner has determined does not adequately and promptly enforce final U.S. judgments or arbitration awards.

viii. A certified reinsurer must agree to meet applicable information filing requirements substantially similar to those provided under Section 8B(7) of Model #786, both with respect to an initial application for certification and on an ongoing basis?

ix. Changes in rating or revocation of certification of a certified reinsurer are applied by the commissioner in a manner substantially similar to the provisions of Section 2I2J of Model #785 and Section 8B(8) of Model #786?

x. A certified reinsurer must file audited financial statements, regulatory filings and actuarial opinion (as filed with the certified reinsurer’s supervisor, with a translation into English) consistent with the requirements set forth in Section 8B(4)(h) and Section 8B(7)(d) of Model #786? Upon the initial application for certification, the commissioner will consider audited financial statements for the last two (2) years filed with its non-U.S. jurisdiction supervisor?

bb. The commissioner is required to create and publish a list of qualified jurisdictions, under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer?

i. In determining whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner evaluates the reinsurance supervisory system of the non-U.S. jurisdiction, both initially and on an ongoing basis, under criteria substantially similar to those provided under Section 8C(2) of the model regulation?
ii. The commissioner shall consider the list of qualified jurisdictions published by the NAIC in determining qualified jurisdictions? If the commissioner approves a jurisdiction as qualified that does not appear on the NAIC list of qualified jurisdictions, the commissioner must provide thoroughly documented justification with respect to criteria substantially similar to that provided under Section 8C(2) of Model #786.

iii. U.S. jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program are recognized as qualified jurisdictions?

c. A state’s laws and regulations shall allow a commissioner to defer to the certification and rating of a certified reinsurer issued by another NAIC accredited jurisdiction. Recognition of certification is made in accordance with provisions substantially similar to Section 8D of Model #786?

d. Reinsurance contracts entered into or renewed with a certified reinsurer must include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer for reinsurance ceded to the certified reinsurer?

Reciprocal Jurisdictions

e. A state’s laws and regulations shall allow credit for reinsurance ceded to an assuming insurer that has its head office or is domiciled in, and is licensed in, a Reciprocal Jurisdiction. Its laws and regulations shall contain provisions that are substantially similar to those contained in Section 2F of Model #785 and Section 9 of Model #786. Its laws and regulations must provide that a Reciprocal Jurisdiction is a jurisdiction that meets one of the following:

i. A non-U.S. jurisdiction that is subject to an in-force covered agreement meeting the requirements of Section 2F(1)(a)(i) of Model #785 and Section 9B(1) of Model #786?

ii. A U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Standards and Accreditation Program pursuant to Section 2F(1)(a)(ii) of Model #785 and Section 9B(2) of Model #786?

iii. A Qualified Jurisdiction that meets all of the requirements of Section 2F(1)(a)(iii) of Model #785 and Section 9B(3) of Model #786?

ff. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact reinsurance by, and has its head office or is domiciled in, a Reciprocal Jurisdiction, and which meets each of the conditions set forth in Section 2F(1)(b) – (g) of Model #785 and Section 9C of Model #786;
i. The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction of no less than $250,000,000 similar to Section 2F(1)(b) of Model #785 and Section 9C(2) of Model #786? This minimum capital and surplus requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) or own funds of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

ii. The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, as set forth in Section 2F(1)(c) of Model #785 and Section 9C(3) of Model #786?

iii. The assuming insurer must submit a properly executed Form RJ-1 consistent with Section 2F(1)(d) of Model #785 and Section 9C(4) of Model #786:

- The assuming insurer must agree to provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in this subsection, or if any regulatory action is taken against it for serious noncompliance with applicable law pursuant to Section 2F(1)(d)(i) of Model #785 and Section 9C(4)(a) of Model #786?

- The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process pursuant to Section 2F(1)(d)(ii) of Model #785 and Section 9C(4)(b) of Model #786? The commissioner may also require that such consent be provided and included in each reinsurance agreement under the commissioner’s jurisdiction.

- The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained pursuant to Section 2F(1)(d)(iii) of Model #785 and Section 9C(4)(c) of Model #786?
Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the assuming insurer’s liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its estate, if applicable pursuant to Section 2F(1)(d)(iv) of Model #785 and Section 9C(4)(d) of Model #786?

The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement, which involves this state’s ceding insurers, and agrees to notify the ceding insurer and the commissioner and to provide one hundred percent (100%) security to the ceding insurer consistent with the terms of the scheme, should the assuming insurer enter into such a solvent scheme of arrangement pursuant to Section 2F(1)(d)(v) of Model #785 and Section 9C(4)(e) of Model #786?

The assuming insurer must agree in writing to meet the applicable information filing requirements pursuant to Section 9C(4)(f) of Model #786?

iv. The assuming insurer or its legal successor must provide, if requested by the commissioner, on behalf of itself and any legal predecessors, the documentation to the commissioner as outlined in Section 2F(1)(e) of Model #785 and Section 9C(5) of Model #786:

For the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer’s annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report pursuant to Section 9C(5)(a) of Model #786?

For the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer’s supervisor pursuant to Section 9C(5)(b) of Model #786?

Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States pursuant to Section 9C(5)(c) of Model #786?
• Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer’s assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer pursuant to Section 9C(5)(d) of Model #786?

v. The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements consistent with Section 2F(1)(f) of Model #785 and Section 9C(6) of Model #786?

vi. The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with the minimum capital and surplus requirements and the minimum solvency or capital ratio requirements as required under Section 2F(1)(g) of Model #785 and Section 9C(7) of Model #786?

gg. The commissioner is required to timely create and publish a list of Reciprocal Jurisdictions similar to Section 2F(2) of Model #786 and Section 9D of Model #786?

i. If the commissioner approves a jurisdiction that does not appear on the NAIC list of Reciprocal Jurisdictions, the commissioner must provide thoroughly documented justification in accordance with criteria published through the NAIC Committee Process pursuant to Section 2F(2)(a) of Model #785 and Section 9D(1) of Model #786?

ii. The commissioner may remove a jurisdiction from the list of Reciprocal Jurisdictions upon a determination that the jurisdiction no longer meets one or more of the requirements of a Reciprocal Jurisdiction pursuant to Section 2F(2)(b) of Model #785 and Section 9D(2) of Model #786, except that the commissioner shall not remove from the list a Reciprocal Jurisdiction as defined under Section 9B(1) and (2) of Model #786?

hh. The commissioner shall timely create and publish a list of assuming insurers to which cessions shall be granted credit consistent with Section 2F(3) of Model #785 and Section 9E of Model #786? Such assuming insurer must submit a properly executed Form RJ-1 and additional information as the commissioner may require.

i. If an NAIC accredited jurisdiction has determined that the conditions set forth in Section 2F of Model #785 and Section 9 of Model #786 have been met, the commissioner has the discretion to defer to that jurisdiction’s determination and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit in accordance pursuant to Section 2F(3) of Model #785 and Section 9E(1) of Model #786? The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC with respect to such reinsurer.
ii. When requesting that the commissioner defer to another NAIC accredited jurisdiction’s determination, an assuming insurer must submit a properly executed Form RJ-1 and additional information as the commissioner may require pursuant to Section 9E(2) of Model #786?

ii. If the commissioner determines that an assuming insurer no longer meets one or more of the requirements set forth in Section 2F of Model #786 and Section 9 of Model #786, the commissioner may revoke or suspend the eligibility of the assuming insurer consistent with Section 2F(4) of Model #785 and Section 9F of Model #786?

i. While an assuming insurer’s eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer’s obligations under the contract are otherwise secured pursuant to Section 2F(4)(a) of Model #785 and Section 9F(1) of Model #786?

ii. If an assuming insurer’s eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer’s obligations under the contract are otherwise secured in a form acceptable to the commissioner pursuant to Section 2F(4)(b) of Model #785 and Section 9F(2) of Model #786?

iii. Before denying statement credit or imposing a requirement to post security or adopting any similar requirement that will have substantially the same regulatory impact as security, the commissioner shall follow the process set forth in Section 9G of Model #786?

jj. If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding liabilities in accordance with Section 2F(5) of Model #785 and Section 9H of Model #786?

kk. Nothing shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by other applicable law or regulation similar to Section 2F(6) of Model #785?
II. Credit may be taken only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal consistent with the provisions of Section 2F(7) of Model #785?
Summary of Findings and Determination

BERMUDA MONETARY AUTHORITY

Re-Evaluation of Qualified Jurisdiction

Approved By:

Qualified Jurisdiction (E) Working Group          October 7, 2019
Reinsurance (E) Task Force                       December 8, 2019
Executive (EX) Committee and Plenary             December 10, 2019
I. Re-Evaluation of Bermuda Monetary Authority

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to the Bermuda Monetary Authority (BMA), the lead insurance regulatory supervisor for Bermuda. It is the recommendation of the Working Group that the NAIC re-approve the BMA as a Qualified Jurisdiction and continue its designation on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that the BMA’s status as a Qualified Jurisdiction only be applicable to (re)insurers of Class 3A, Class 3B and Class 4, and long-term insurers of Class C, Class D and Class E, which is consistent with the original approval of the BMA as a Qualified Jurisdiction. Finally, the Working Group recommends that Florida be the Lead State for purposes of regulatory cooperation and information sharing with the BMA. These recommendations are based on the following analysis:

II. Procedural History

The NAIC adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.1

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved the BMA as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the BMA would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

1 The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. A Qualified Jurisdiction which meets certain additional requirements described in the Credit for Reinsurance Models may be determined to be a Reciprocal Jurisdiction under a separate evaluation by the Working Group.
The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the *NAIC List of Qualified Jurisdictions*. The Working Group met in regulator-to-regulator session on October 7, 2019, and received a presentation from NAIC staff on whether the BMA should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of the BMA:

2. BMA Power Point Presentation on Group and Commercial Insurer Supervision (Confidential).
3. BMA Power Point Presentation on Legal Entity/Group Supervision Framework (Confidential).
4. BMA NAIC Qualified Jurisdiction Assessment: Summary of Appendices A & B, September 30, 2019 (Confidential).
5. Bermuda Response to Section D—Regulatory Cooperation and Information Sharing (Confidential).
8. Bermuda Response to Section G—Solvent Schemes of Arrangement (Confidential).
9. International Association of Insurance Supervisors Thematic Self-Assessment and Peer Review on Reinsurance and Macroprudential Surveillance (ICPs 13 and 24), September 19, 2016 (Confidential).

### III. Standard of Review

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other public documentation that the Working Group would consider to be relevant to this determination. It should be noted that the BMA’s last FSAP report was in 2008; therefore, the BMA supplied additional information (described above) to provide the Working...
Group with an accurate understanding of its supervisory regulatory regime deemed equal to the level of an IMF FSAP report. The Working Group also reviewed a confidential self-assessment and peer review on the BMA prepared by the International Association of Insurance Supervisors. In addition, the Working Group considered its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

IV. Summary of Findings and Recommendation

Upon review of the available information, the Working Group has reached the conclusion that the BMA’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency regulation that is acceptable for purposes of reinsurance collateral reduction, that the BMA’s demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize the BMA as a Qualified Jurisdiction and place it on the *NAIC List of Qualified Jurisdictions*, with such re-evaluation to be effective as of January 1, 2020. Further, the Working Group recommends that the BMA’s status as a Qualified Jurisdiction continues to be only applicable to (re)insurers of Class 3A, Class 3B and Class 4, and long-term insurers of Class C, Class D and Class E.
Summary of Findings and Determination

Japan:
Financial Services Agency (FSA)

Re-Evaluation of Qualified Jurisdiction

Approved By:

Qualified Jurisdiction (E) Working Group          October 7, 2019
Reinsurance (E) Task Force                          December 8, 2019
Executive (EX) Committee and Plenary          December 10, 2019
I. Re-Evaluation of Financial Services Agency of Japan

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to its re-evaluation of the Financial Services Agency (FSA), the lead insurance regulatory supervisor for Japan. It is the recommendation of the Working Group that the NAIC re-approve the FSA as a Qualified Jurisdiction and continue its designation on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that California continue to be the Lead State for purposes of regulatory cooperation and information sharing with the FSA. These recommendations are based on the following analysis.

II. Procedural History

The NAIC adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.1

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved the FSA as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the FSA would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the NAIC List of Qualified Jurisdictions. The Working Group met in regulator-to-regulator session on October 7, 2019, and heard a presentation by NAIC staff

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1 The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. A Qualified Jurisdiction which meets certain additional requirements described in the Credit for Reinsurance Models may be determined to be a Reciprocal Jurisdiction under a separate evaluation by the Working Group.
on whether the FSA should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of the FSA:


6. *Summary of Findings and Determination Japan: Financial Services Agency (FSA) approved by NAIC Executive (EX) Committee and Plenary on December 16, 2014.*

7. *NAIC Staff Workpapers on Initial Review and Findings dated September 30, 2014 (Confidential).*

### III. Standard of Review

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other documentation that the Working Group would consider to be relevant to this determination. In addition, the Working Group would consider its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

### IV. Summary of Findings and Recommendation

Upon review of the available information, the Working Group has reached the conclusion that the JSA’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency
regulation that is acceptable for purposes of reinsurance collateral reduction, that the JSA’s
demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent
with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of
Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize the JSA
as a Qualified Jurisdiction and place it on the **NAIC List of Qualified Jurisdictions**, with such re-
evaluation to be effective as of January 1, 2020.
Summary of Findings and Determination

Switzerland: Financial Market Supervisory Authority (FINMA)

Re-Evaluation of Qualified Jurisdiction

Approved By:

Qualified Jurisdiction (E) Working Group October 7, 2019
Reinsurance (E) Task Force December 8, 2019
Executive (EX) Committee and Plenary December 10, 2019
I. Re-Evaluation of Switzerland: Financial Market Supervisory Authority

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to its re-evaluation of the Financial Market Supervisory Authority (FINMA), the lead insurance regulatory supervisor for Switzerland. It is the recommendation of the Working Group that the NAIC re-approve FINMA as a Qualified Jurisdiction and continue its designation on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that Missouri be the Lead State for purposes of regulatory cooperation and information sharing with FINMA. These recommendations are based on the following analysis.

II. Procedural History

The NAIC adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (Qualified Jurisdiction Process) on August 27, 2013 (which was further amended on August 19, 2014). The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a Qualified Jurisdiction in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.¹

On December 16, 2014, the NAIC Executive (EX) Committee and Plenary approved FINMA as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which FINMA would be re-evaluated under the provisions of the Qualified Jurisdiction Process. Specifically, paragraph III(12)(c) of the Qualified Jurisdiction Process currently provides, as follows:

> Once approved, a Qualified Jurisdiction is subject to a re-evaluation every five years. The Periodic Evaluation may follow a similar process as that set forth above, or such abbreviated process as the Qualified Jurisdiction Working Group may deem appropriate. [Emphasis added].

The Working Group has determined that it would follow such an abbreviated process in its re-evaluations of the jurisdictions currently on the NAIC List of Qualified Jurisdictions. The Working Group met in regulator-to-regulator session on October 7, 2019, and heard a presentation by NAIC staff.

¹ The Credit for Reinsurance Models were further revised on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. A Qualified Jurisdiction which meets certain additional requirements described in the Credit for Reinsurance Models may be determined to be a Reciprocal Jurisdiction under a separate evaluation by the Working Group.
on whether FINMA should be re-approved as a Qualified Jurisdiction. The Working Group considered the following information with respect to the re-evaluation of FINMA:

1. **International Monetary Fund (IMF), Switzerland: Financial Sector Assessment Program, June 2019 (IMF Country Report No. 19/183).**


5. **Switzerland: Enforcement of Foreign Judgments 2019 (International Comparative Legal Guide, Global Legal Group, 2019).**

6. **Summary of Findings and Determination Switzerland: Financial Market Supervisory Authority (FINMA) approved by NAIC Executive (EX) Committee and Plenary on December 16, 2014.**

7. **NAIC Staff Workpapers on Initial Review and Findings dated August 5, 2014 (Confidential).**

### III. Standard of Review

The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction. In addition, the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system and the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

This same standard was deemed appropriate by the Working Group with respect to the re-evaluation of a Qualified Jurisdiction under the abbreviated process. Specifically, the Working Group determined that it would be appropriate to review a jurisdiction’s most recent IMF report prepared under its Financial Sector Assessment Program (FSAP), and any other documentation that the Working Group would consider to be relevant to this determination. In addition, the Working Group would consider its past experience in working with the Qualified Jurisdiction and any certified reinsurers domiciled in the Qualified Jurisdiction.

### IV. Summary of Findings and Recommendation

Upon review of the available information, the Working Group has reached the conclusion that FINMA’s reinsurance supervisory system continues to achieve a level of effectiveness in financial solvency
regulation that is acceptable for purposes of reinsurance collateral reduction, that FINMA’s demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

Therefore, it is the recommendation of the Working Group that the NAIC continue to recognize FINMA as a Qualified Jurisdiction and place it on the *NAIC List of Qualified Jurisdictions*, with such re-evaluation to be effective as of January 1, 2020.
November 6, 2019

Mr. Jake Stultz
Senior Accounting and Reinsurance Policy Advisor
and
Mr. Dan Schelp
Chief Counsel, Regulatory Affairs
National Association of Insurance Commissioners
1100 Walnut St.
Kansas City, MO 64106 (via email)

Re: Reciprocal Jurisdiction Accreditation Standard Exposure

Dear Messrs. Stultz and Schelp:

The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. ACLI also represents all professional life reinsurers assuming mortality and morbidity risks in the United States.

We appreciate the opportunity to review and comment on the three Summary of Findings and Determination exposures regarding the re-evaluations of the Bermuda Monetary Authority (Bermuda), the Financial Services Agency (Japan), and the Financial Market Supervisory Authority (Switzerland). With all three Qualified Jurisdictions needing review prior to their December 31, 2019 expiration date, we are pleased that all three jurisdictions continue to meet the requirements as Qualified Jurisdictions. Furthermore, we appreciate the timely reviews and look forward to these jurisdictions being reviewed to qualify as Reciprocal Jurisdictions.

Sincerely,

Steven M. Clayburn, FSA, MAAA
Mariana Gomez-Vock
Summary of Findings and Determination

BERMUDA MONETARY AUTHORITY

Evaluation of Reciprocal Jurisdiction

Issued for Public Comment By:

Qualified Jurisdiction (E) Working Group

November 5, 2019
I. Evaluation of Bermuda Monetary Authority as Reciprocal Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to the evaluation of the Bermuda Monetary Authority (BMA), the lead insurance regulatory supervisor for Bermuda, as a Reciprocal Jurisdiction. It is the recommendation of the Working Group that the NAIC approve the BMA as a Reciprocal Jurisdiction and place it on the NAIC List of Reciprocal Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that the BMA’s status as a Reciprocal Jurisdiction only be applicable to (re)insurers of Class 3A, Class 3B and Class 4, and long-term (re)insurers of Class C, Class D and Class E, which is consistent with the approval of the BMA as a Qualified Jurisdiction. Finally, the Working Group recommends that Florida be the Lead State for purposes of regulatory cooperation and information sharing with the BMA. These recommendations are based on the following analysis:

II. Procedural History

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

The NAIC adopted revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. A Qualified Jurisdiction which meets certain additional requirements described in the Credit for Reinsurance Models may be determined to be a Reciprocal Jurisdiction under the revised Credit for Reinsurance Models.

A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models.

On October 22, 2019, the Reinsurance (E) Task Force updated and revised the Process for Evaluating Qualified and Reciprocal Jurisdictions to specify how Qualified Jurisdictions that recognize key NAIC solvency initiatives, including group supervision and group capital standards, and also meet the other
requirements under the revised Credit for Reinsurance Models, will be recognized as Reciprocal Jurisdictions and receive similar treatment as that provided under the EU and UK Covered Agreements, including the elimination of reinsurance collateral and local presence requirements by the states.

III. BMA’s Status of a Qualified Jurisdiction

A Qualified Jurisdiction may not be reviewed for inclusion on the NAIC List of Reciprocal Jurisdictions unless it remains in good standing with the NAIC as a Qualified Jurisdiction. The NAIC originally designated the BMA as a Conditional Qualified Jurisdiction effective January 1, 2014, with the designation to continue for one year. On December 16, 2014, the NAIC approved the BMA as a Qualified Jurisdiction and placed it on the NAIC List of Qualified Jurisdictions, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the BMA would be re-evaluated.

The Working Group met in regulator-to-regulator session on October 7, 2019 and re-approved the BMA as a Qualified Jurisdiction. The Reinsurance (E) Task Force is expected to approve the re-evaluation of the BMA as a Qualified Jurisdiction, which is expected to be confirmed by the NAIC Executive (EX) Committee and Plenary at its 2019 Fall National Meeting. This Summary of Findings and Determination with respect to the BMA as a Reciprocal Jurisdiction is expressly made contingent upon the NAIC’s re-approval of the BMA as a Qualified Jurisdiction.

IV. Written Confirmation

In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the NAIC List of Reciprocal Jurisdictions, the Qualified Jurisdiction Working Group shall undertake the following analysis in making its evaluation:

1. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in that jurisdiction is received by United States ceding insurers;

2. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

3. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision, including worldwide group supervision.
governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the Qualified Jurisdiction;

4. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMOU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

5. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in in Section 9C(2) and (3) of Model #786; i.e., must maintain minimum capital and surplus of no less than $250,000,000, and maintains on an ongoing basis the required minimum solvency or capital ratio, as applicable.

The BMA provided the NAIC and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories with this written confirmation by letter dated October 30, 2019. The Qualified Jurisdiction Working Group performed a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate on November 5, 2019.

V. Minimum Solvency or Capital Ratio

The Qualified Jurisdiction Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable equivalency decision made by the European Commission (EC) based on assessments conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

In a Note dated September 27, 2019, the BMA advised the NAIC that Bermuda’s risk-based solvency regime for commercial (re)insurers (Bermuda Enhanced Regime) reached full Solvency II equivalence on 24th March 2016. The regulatory capital requirement for the Bermuda Enhanced Regime is designated Enhanced Capital Requirement (ECR). Full Solvency II equivalence means that the EC and
EIOPA recognize the Bermuda Enhanced Regime as producing equivalent outcomes to Solvency II, namely that a 100% Enhanced Capital Requirement (ECR) ratio is equivalent on an outcome basis to a 100% Solvency II SCR ratio. The BMA also advised the NAIC that it considers a 100% ECR ratio produces results equivalent to a 300% RBC ratio on an outcomes basis. Furthermore, the BMA advised that it had made some enhancements to certain aspects of its Bermuda Enhanced Regime in 2018, which became effective on January 1, 2019. The BMA further reported that in July 2018, the BMA engaged with EIOPA in a series of meetings as part of the monitoring of its Solvency II equivalence status. The overall assessment was “positive” which means that EIOPA confirmed that the Bermuda Enhanced Regime remains fully Solvency II equivalent and that a 100% ECR ratio as calculated under the revised rules remains equivalent on an outcome basis to a 100% Solvency II SCR ratio.

The Qualified Jurisdiction Working Group approved 100% ECR as the minimum solvency or capital ratio for reinsurers domiciled in Bermuda, and the Reinsurance Financial Analysis (E) Working Group approved 100% ECR as the minimum solvency or capital ratio on October 11, 2019.

VI. Summary of Findings and Recommendation

Therefore, it is the recommendation of the Qualified Jurisdiction Working Group that the NAIC recognize the BMA as a Reciprocal Jurisdiction and place it on the NAIC List of Reciprocal Jurisdictions, with such evaluation to be effective as of January 1, 2020. Further, the Working Group recommends that the BMA’s status as a Reciprocal Jurisdiction only apply to (re)insurers of Class 3A, Class 3B and Class 4, and long-term (re)insurers of Class C, Class D and Class E. Finally, the Working Group recommends that the minimum solvency or capital ratio for eligible reinsurers domiciled in Bermuda to be a 100% ECR ratio.

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Summary of Findings and Determination

Japan:
Financial Services Agency (FSA)

Evaluation of Reciprocal Jurisdiction

Issued for Public Comment By:
Qualified Jurisdiction (E) Working Group
November 5, 2019
I. Evaluation of Japan as Reciprocal Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to the evaluation of the Financial Services Agency (FSA), the lead insurance regulatory supervisor for Japan, as a Reciprocal Jurisdiction. It is the recommendation of the Working Group that the NAIC approve the FSA as a Reciprocal Jurisdiction and place it on the NAIC List of Reciprocal Jurisdictions, to be effective as of January 1, 2020. Further, the Working Group recommends that California be the Lead State for purposes of regulatory cooperation and information sharing with the FSA. These recommendations are based on the following analysis:

II. Procedural History

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

The NAIC adopted revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. A Qualified Jurisdiction which meets certain additional requirements described in the Credit for Reinsurance Models may be determined to be a Reciprocal Jurisdiction under the revised Credit for Reinsurance Models.

A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models.

On October 22, 2019, the Reinsurance (E) Task Force updated and revised the Process for Evaluating Qualified and Reciprocal Jurisdictions to specify how Qualified Jurisdictions that recognize key NAIC solvency initiatives, including group supervision and group capital standards, and also meet the other requirements under the revised Credit for Reinsurance Models, will be recognized as Reciprocal Jurisdictions and receive similar treatment as that provided under the EU and UK Covered Agreements, including the elimination of reinsurance collateral and local presence requirements by the states.
III. Japan’s Status of a Qualified Jurisdiction

A Qualified Jurisdiction may not be reviewed for inclusion on the *NAIC List of Reciprocal Jurisdictions* unless it remains in good standing with the NAIC as a Qualified Jurisdiction. On December 16, 2014, the NAIC approved the FSA as a Qualified Jurisdiction and placed it on the *NAIC List of Qualified Jurisdictions*, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which the FSA would be re-evaluated.

The Working Group met in regulator-to-regulator session on October 7, 2019 and re-approved the FSA as a Qualified Jurisdiction. The Reinsurance (E) Task Force is expected to approve the re-evaluation of the FSA as a Qualified Jurisdiction, which is expected to be confirmed by the NAIC Executive (EX) Committee and Plenary at its 2019 Fall National Meeting. This *Summary of Findings and Determination* with respect to the FSA as a Reciprocal Jurisdiction is expressly made contingent upon the NAIC’s re-approval of the FSA as a Qualified Jurisdiction.

IV. Written Confirmation

In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the *NAIC List of Reciprocal Jurisdictions*, the Qualified Jurisdiction Working Group shall undertake the following analysis in making its evaluation:

1. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in that jurisdiction is received by United States ceding insurers;

2. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

3. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision, including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the Qualified Jurisdiction;

4. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if
applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

5. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in in Section 9C(2) and (3) of Model #786; i.e., must maintain minimum capital and surplus of no less than $250,000,000, and maintains on an ongoing basis the required minimum solvency or capital ratio, as applicable.

The FSA provided the NAIC and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories with this written confirmation by letter dated October 31, 2019. The Qualified Jurisdiction Working Group performed a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate on November 5, 2019.

V. Minimum Solvency or Capital Ratio

The Qualified Jurisdiction Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable equivalency assessment conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

In the 2015 EIOPA Advice to the European Commission: Equivalence assessment of the Japanese supervisory system in relation to Article 172 of the Solvency II Directive (EIOPA-CP-14/043), EIOPA made the following observations on the FSA’s capital requirements:

JFSA regulation defines a capital requirement that is named the ‘total risk’ in Ministry of Finance Notice No. 50 “Calculation methods...”. This capital requirement broadly corresponds to the Solvency II Solvency Capital Requirement (SCR) (see below)…JFSA regulation defines a ‘Solvency Margin Ratio’ (hereunder SMR), which equates to double the own funds divided by the ‘total risk’.

JFSA regulation defines three levels of supervisory intervention:
• Even when the SMR is **above 200%**, the JFSA may require insurers to adopt ‘improvement measures’, notably on profitability, credit risk (including a reduction to their credit concentration risk), stability (reduction to their market and interest rate risks) and liquidity risk. The JFSA refers to this ‘early’ supervisory intervention as the “early warning system”.

• When the SMR is **between 100% and 200%**, the JFSA may order insurers to submit and implement an improvement plan for ensuring managerial soundness.

• When the SMR is **between 0% and 100%**, the JFSA may order a series of measures such as reduction of dividends to shareholders, reduction of dividends to policyholders, and contraction of business operations.

• When the SMR is **below 0%**, JFSA may order the total or partial suspension of business.

…From the above description, it follows that in terms of supervisory action the JFSA system has at least one supplementary level of intervention, compared to the Solvency II system. It also follows that supervisory actions taken at 200% of the SMR would, broadly speaking, correspond to those taken at the Solvency II SCR level of intervention—even though JFSA may intervene in a legally binding manner even if the SMR is more than 200%—, while supervisory actions taken at 0% of the SMR along with actions taken at the level of 100% of the SMR would, broadly speaking, correspond to possible actions under the Solvency II MCR.

In its consultation e-mail to the NAIC dated October 3, 2019, the FSA advised as follows: “an SMR of 200 percent triggers early remedial action such as submission of a management plan to restore the SMR, as an SCR of 100 percent triggers supervisory action such as submission of a realistic recovery plan. In this regard, we understand supervisory actions taken at 200% of the SMR would correspond to those taken at the Solvency II SCR level of intervention, even though the FSA may take supervisory actions in a proactive manner even if the SMR is more than 200%.”

The Qualified Jurisdiction Working Group approved 200 percent of the SMR as the minimum solvency or capital ratio for reinsurers domiciled in Japan, and the Reinsurance Financial Analysis (E) Working Group approved 200 percent of the SMR as the minimum solvency or capital ratio on October 11, 2019.

**VI. Summary of Findings and Recommendation**

Therefore, it is the recommendation of the Qualified Jurisdiction Working Group that the NAIC recognize the FSA as a Reciprocal Jurisdiction and place it on the *NAIC List of Reciprocal Jurisdictions*, with such evaluation to be effective as of January 1, 2020. Further, the Working Group recommends that the minimum solvency or capital ratio for eligible reinsurers domiciled in Japan to be 200 percent of the SMR.
Summary of Findings and Determination

Switzerland:
Financial Market Supervisory Authority (FINMA)

_Evaluation of Reciprocal Jurisdiction_

Issued for Public Comment By:
Qualified Jurisdiction (E) Working Group
November 5, 2019
I. Evaluation of Switzerland as Reciprocal Jurisdiction

The Qualified Jurisdiction (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this *Summary of Findings and Determination* with respect to the evaluation of the Swiss Financial Market Supervisory Authority FINMA, the lead insurance regulatory supervisor for Switzerland, as a Reciprocal Jurisdiction. It is the recommendation of the Working Group that the NAIC approve FINMA as a Reciprocal Jurisdiction and place it on the *NAIC List of Reciprocal Jurisdictions*, to be effective as of January 1, 2020. Further, the Working Group recommends that Missouri be the Lead State for purposes of regulatory cooperation and information sharing with FINMA. These recommendations are based on the following analysis:

II. Procedural History

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

The NAIC adopted revisions to the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786) (collectively, the “Credit for Reinsurance Models”) on June 25, 2019, to recognize a new designation of “Reciprocal Jurisdiction” under which certain reinsurers licensed and domiciled in Reciprocal Jurisdictions are not required to post reinsurance collateral. A Qualified Jurisdiction which meets certain additional requirements described in the Credit for Reinsurance Models may be determined to be a Reciprocal Jurisdiction under the revised Credit for Reinsurance Models.

A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models.

On October 22, 2019, the Reinsurance (E) Task Force updated and revised the *Process for Evaluating Qualified and Reciprocal Jurisdictions* to specify how Qualified Jurisdictions that recognize key NAIC solvency initiatives, including group supervision and group capital standards, and also meet the other requirements under the revised Credit for Reinsurance Models, will be recognized as Reciprocal Jurisdictions and receive similar treatment as that provided under the EU and UK Covered Agreements, including the elimination of reinsurance collateral and local presence requirements by the states.
III. FINMA’s Status of a Qualified Jurisdiction

A Qualified Jurisdiction may not be reviewed for inclusion on the *NAIC List of Reciprocal Jurisdictions* unless it remains in good standing with the NAIC as a Qualified Jurisdiction. The NAIC originally designated FINMA as a Conditional Qualified Jurisdiction effective January 1, 2014, with the designation to continue for one year. On December 16, 2014, the NAIC approved FINMA as a Qualified Jurisdiction and placed it on the *NAIC List of Qualified Jurisdictions*, to be effective as of January 1, 2015. This designation as a Qualified Jurisdiction was to be valid for five years (absent a material change in circumstances) ending on December 31, 2019, after which FINMA would be re-evaluated.

The Working Group met in regulator-to-regulator session on October 7, 2019 and re-approved FINMA as a Qualified Jurisdiction. The Reinsurance (E) Task Force is expected to approve the re-evaluation of FINMA as a Qualified Jurisdiction, which is expected to be confirmed by the NAIC Executive (EX) Committee and Plenary at its 2019 Fall National Meeting. This *Summary of Findings and Determination* with respect to FINMA as a Reciprocal Jurisdiction is expressly made contingent upon the NAIC’s re-approval of FINMA as a Qualified Jurisdiction.

IV. Written Confirmation

In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the *NAIC List of Reciprocal Jurisdictions*, the Qualified Jurisdiction Working Group shall undertake the following analysis in making its evaluation:

1. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance assumed by insurers domiciled in that jurisdiction is received by United States ceding insurers;

2. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

3. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision, including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the Qualified Jurisdiction;
4. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

5. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in in Section 9C(2) and (3) of Model #786; i.e., must maintain minimum capital and surplus of no less than $250,000,000, and maintains on an ongoing basis the required minimum solvency or capital ratio, as applicable.

FINMA provided the NAIC and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories with this written confirmation by letter dated October 29, 2019. The Qualified Jurisdiction Working Group performed a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate on November 5, 2019.

V. Minimum Solvency or Capital Ratio

The Qualified Jurisdiction Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable equivalency assessment conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

In the 2015 EIOPA Advice to the European Commission: Equivalence assessment of the Swiss supervisory system in relation to Articles 172, 227 and 260 of the Solvency II Directive (EIOPA-BoS-15/041), EIOPA made the following observations on Switzerland’s ladder of supervisory intervention:

Under the Swiss Solvency Test (SST), the capital requirement which is more commonly referred to as the Target Capital (TC) under the SST, is calculated to cover unexpected losses arising from existing business that correspond to the Tail Value-at Risk (Tail-VaR) of the Risk Bearing Capital (RBC) subject to a confidence level of 99% over a one-year period.
The SST ratio of an insurer determines its supervisory zone (green, yellow, amber or red) and the corresponding degree of supervisory intervention:

- **If the SST ratio is 100% or more, there will be no supervisory intervention – i.e. the insurer will be subject to normal supervisory monitoring. [Emphasis added].**

- If the SST ratio falls below 100%, the intensity of supervisory intervention and the intrusiveness of supervisory actions will increase as the SST ratio decreases.

- If the SST ratio falls below 33%, the insurer will be required to take immediate actions to restore the SST ratio, the failure of which will trigger FINMA to revoke its license.

In its consultation letter to the NAIC dated October 2, 2019, FINMA advised as follows:

FINMA would consider in principle 100% SST to be comparable to some extent to 100% SCR under Solvency II. In addition, we would like to make the following comments:

- There is a significant degree of commonalities between the two solvency regimes, but also some different approaches applied.
- The application for the tail value-at-risk with a confidence level of 99% under the SST as opposed to the value-at-at risk with a confidence level of 99.5% leads in the case of a reinsurer typically to more conservative results, i.e. to a higher insurance target capital.
- In this context, one can also refer to recent IMF FSAP Reports.

The Qualified Jurisdiction Working Group approved 100% SST as the minimum solvency or capital ratio for reinsurers domiciled in Switzerland, and the Reinsurance Financial Analysis (E) Working Group approved 100% SST as the minimum solvency or capital ratio on October 11, 2019.

**VI. Summary of Findings and Recommendation**

Therefore, it is the recommendation of the Qualified Jurisdiction Working Group that the NAIC recognize FINMA as a Reciprocal Jurisdiction and place it on the **NAIC List of Reciprocal Jurisdictions**, with such evaluation to be effective as of January 1, 2020. Further, the Working Group recommends that the minimum solvency or capital ratio for eligible reinsurers domiciled in Switzerland to be a 100% SST ratio.
Steven Clayburn  
Senior Actuary, Health Insurance & Reinsurance  
steveclayburn@acli.com

Mariana Gomez-Vock  
Associate General Counsel  
marianagomez-voack@acli.com

November 26, 2019

Mr. Jake Stultz  
Senior Accounting and Reinsurance Policy Advisor  
and  
Mr. Dan Schelp  
Chief Counsel, Regulatory Affairs  
National Association of Insurance Commissioners  
1100 Walnut St.  
Kansas City, MO  64106 (via email)

Re: Evaluation of Reciprocal Jurisdictions Exposures

Dear Messrs. Stultz and Schelp:

The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. ACLI also represents all professional life reinsurers assuming mortality and morbidity risks in the United States.

We appreciate the opportunity to review and comment on the three Summary of Findings and Determination exposures regarding the evaluations of the Bermuda Monetary Authority (Bermuda), the Financial Services Agency (Japan), and the Financial Market Supervisory Authority (Switzerland) as Reciprocal Jurisdictions. We are pleased that the Qualified Jurisdiction Working Group has deemed all three jurisdictions to meet the requirements as Reciprocal Jurisdictions. ACLI supports those findings.

Sincerely,

Steven M. Clayburn, FSA, MAAA  
Mariana Gomez-Vock
### NAIC BLANKS (E) WORKING GROUP

**Blanks Agenda Item Submission Form**

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Jake Stultz</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE:</td>
<td>816-783-8481</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:jstultz@naic.org">jstultz@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>Chlora Lindley-Myers</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Chair, Reinsurance (E) Task Force</td>
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**Date:** 11/14/2019

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**FOR NAIC USE ONLY**

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<tr>
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<td>New Reporting Requirement</td>
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**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

| No Impact | [ X ] |
| Modifies Required Disclosure | [ ] |

**DISPOSITION**

| [ ] Rejected For Public Comment |
| [ ] Referred To Another NAIC Group |
| [ ] Received For Public Comment |
| [ ] Adopted Date [ ] |
| [ ] Rejected Date [ ] |
| [ ] Deferred Date [ ] |
| [ ] Other (Specify) [ ] |

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**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [ X ] ANNUAL STATEMENT
- [ X ] QUARTERLY STATEMENT
- [ X ] Instructions
- [ ] CROSSCHECKS
- [ X ] BLANK
- [ X ] Separated Accounts
- [ ] Protected Cell
- [ X ] Health
- [ X ] Health (Life Supplement)

Anticipated Effective Date: Annual 2020

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**IDENTIFICATION OF ITEM(S) TO CHANGE**

See next page for details.

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**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

See next page for details.

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**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date:__________________________________________

Other Comments:__________________________________________

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**This section must be completed on all forms.**

© 2019 National Association of Insurance Commissioners 1

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Attachment Ten
Reinsurance (E) Task Force
12/8/19
On June 25, 2019, NAIC Executive (EX) Committee and Plenary adopted revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) to incorporate the relevant provisions from the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement). Under the revisions, credit for reinsurance is allowed for domestic ceding insurers for reinsurance that has been ceded to reinsurers from Reciprocal Jurisdictions, and that those reinsurers are not required to post collateral. As a result, it is necessary to consider revisions to the appropriate reinsurance schedules and instructions in order to collect the relevant information with respect to these reinsurance transactions.

IDENTIFICATION OF ITEM(S) TO CHANGE

Annual Statement Instructions

Life/Fraternal and Health

Schedule S General Instructions
- Modify instructions to include section on numbers for Reciprocal Jurisdiction Companies.
- Modify note on applying Reciprocal Jurisdiction.
- Add Reciprocal Jurisdiction to the instruction for determining status.
- Reference in certified reinsurer number paragraph.

Schedule S, Part 1, Section 1
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

Schedule S, Part 1, Section 2
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

Schedule S, Part 2
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

Schedule S, Part 3, Section 1
- Add category lines for Reciprocal Jurisdiction Companies.
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

Schedule S, Part 3, Section 2
- Add category lines for Reciprocal Jurisdiction Companies.
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

Schedule S, Part 4
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

Schedule S, Part 5
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

Life/Fraternal

Workers’ Compensation Cave-out Supplement
- Schedule F General Instructions
  - Modify instructions to include section on numbers for Reciprocal Jurisdiction Companies.
  - Modify note on applying Reciprocal Jurisdiction.
  - Add Reciprocal Jurisdiction to the instruction for determining status.
  - Reference in certified reinsurer number paragraph.
Schedule F, Part 1
   • Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Schedule F, Part 2
   • Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Supplemental term and Universal Life Insurance Reinsurance Exhibit
   Part 1
   • Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

   Part 2A
   • Add Reciprocal Jurisdiction to list of type of reinsurers for Column 3.

   Part 2B
   • Add Reciprocal Jurisdiction to list of type of reinsurers for Column 3.

Trusteed Surplus Statement
   • Add instructions for Line 4.4 Reciprocal Jurisdiction Companies

Property

Schedule F General Instructions
   • Modify instructions to include section on numbers for Reciprocal Jurisdiction Companies.
   • Modify note on applying Reciprocal Jurisdiction.
   • Add Reciprocal Jurisdiction to the instruction for determining status.
   • Reference in certified reinsurer number paragraph.

Schedule F, Part 1
   • Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Schedule F, Part 2
   Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Schedule F, Part 3
   • Add category lines for Reciprocal Jurisdiction Companies.
   • Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.
   • Modify category lines references for the list of lines for Reciprocal Jurisdiction Companies for Columns 28 through 36.
   • Modify category lines references for the list of lines for Reciprocal Jurisdiction Companies for Columns 71 and 72.
   • Modify category lines references for the list of lines for Reciprocal Jurisdiction Companies for Columns 73 and 74.

Supplemental Schedule for Reinsurance Counterparty Reporting Acceptations – Asbestos and Pollution Contracts
   • Add category lines for Reciprocal Jurisdiction Companies.
   • Add Reciprocal Jurisdiction to list of type of reinsurers for Columns 1 and 5.

Notes to Financial Statement 23F(1)f
   • Add section to illustration for Reciprocal Jurisdiction Companies

Trusteed Surplus Statement
   • Add instructions for Line 7.4 Reciprocal Jurisdiction Companies
Title

Schedule F General Instructions
- Modify instructions to include section on numbers for Reciprocal Jurisdiction Companies.
- Modify note on applying Reciprocal Jurisdiction.
- Add Reciprocal Jurisdiction to the instruction for determining status.
- Reference in certified reinsurer number paragraph.

Schedule F, Part 1
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Schedule F, Part 2
- Add category lines for Reciprocal Jurisdiction Companies.
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Schedule F, Part 3
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Schedule F, Part 4
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Operations and Investments Exhibit – Part 2B
- For Line 2 remove the references to authorized, unauthorized and certified. Line is for all types of reinsurers so specifying is not needed.

Notes to Financial Statement 23F(1)f
- Add section to illustration for Reciprocal Jurisdiction Companies

Life/Fraternal, Health, Property, Title

Schedule Y, Part 1A
- Add Reciprocal Jurisdiction to the list of ID numbers provided in Column 4

Schedule Y, Part 2
- Add Reciprocal Jurisdiction to the list of ID numbers provided in Column 2

Schedule D, Part 6, Section 1
- Add Reciprocal Jurisdiction to the list of ID numbers provided in Column 5

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<th>Quarterly Statement Instructions</th>
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<tr>
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<tr>
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<tr>
<td>- Add instructions for Line 4.4 Reciprocal Jurisdiction Companies</td>
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<td><strong>Property</strong></td>
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<tr>
<td><strong>Trusted Surplus Statement</strong></td>
</tr>
<tr>
<td>- Add instructions for Line 7.4 Reciprocal Jurisdiction Companies</td>
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</table>
Life/Fraternal and Health

Schedule S
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 7.
- Modify instructions to include section on numbers for Reciprocal Jurisdiction Companies.

Property and Title

Schedule F
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 5.
- Modify instructions to include section on numbers for Reciprocal Jurisdiction Companies.

Life/Fraternal, Health, Property, Title

Schedule Y, Part 1A
- Add Reciprocal Jurisdiction to the list of ID numbers provided in Column 4.

Annual Statement Blank

Property

Schedule F, Part 3
- Add the word Reciprocal Jurisdiction to the column descriptions for Columns 73, 74, and 75.

Title

Operations and Investments Exhibit – Part 2B
- For Line 2 remove the references to authorized, unauthorized and certified. Line is for all types of reinsurers so specifying is not needed.

Life/Fraternal and Property

Trusted Surplus Statement
- Add Line 7.4 for Reciprocal Jurisdiction Companies

Quarterly Statement Blank

Life/Fraternal and Property

Trusted Surplus Statement
- Add Line 7.4 for Reciprocal Jurisdiction Companies
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL AND HEALTH (INCLUDES HEALTH LIFE SUPPLEMENT)

SCHEDULE S – REINSURANCE

These parts (except Part 1, which shows reinsurance assumed) provide an analysis by reinsurance carrier of reinsurance ceded data shown in total in various parts of the statement. Information is included on all reinsurance ceded to other entities authorized as well as unauthorized or certified in the state of domicile of the reporting entity. Additional data for unauthorized companies is displayed in Part 4; additional data for certified reinsurers is displayed in Part 5.

NOTE: Certified reinsurer status applies on a prospective basis and is determined by the state of domicile of the ceding insurer. Reciprocal Jurisdiction reinsurer status applies on a prospective basis and is for reinsurance agreements entered into, amended, or renewed on or after the effective date of the domiciliary state of the ceding entity enacting the 2019 revisions to the Credit for Reinsurance Models, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal. As such, it is possible that a ceding insurer will report reinsurance balances applicable to a single assuming insurer under multiple classifications within Schedule S. For example, with respect to a certified reinsurer that was considered unauthorized prior to certification, balances attributable to contracts entered into prior to the assuming insurer’s certification would be reported in the unauthorized classification, while balances attributable to contracts entered into or renewed on or after the assuming insurer’s certification would be reported in the certified classification. This will also be the case for Reciprocal Jurisdiction reinsurance, which may have been classified as certified reinsurance prior to the enactment of the 2019 revisions to the Credit for Reinsurance Models by the domiciliary state of the ceding entity. Proper classification of such balances is essential to ensure accurate reporting of collateral requirements applicable to specific balances and the corresponding calculation of the liability for unauthorized and/or certified reinsurance.

Effective date as used in this schedule is the date the contract originally went into effect.

Index to Schedule S

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<td>Reinsurance Recoverable on Paid and Unpaid Losses</td>
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<td>Part 7</td>
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<td>Restatement of Balance Sheet to Identify Net Credit for Ceded Reinsurance</td>
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</table>

ID Number

Most parts of Schedule S require that the “ID Number” be reported for assuming or ceding entities.

Reinsurance intermediaries should not to be listed, because Schedule S is intended to identify the risk-bearing entities.
A ceding insurer can have unauthorized reinsurance, certified reinsurance and Reciprocal Jurisdiction reinsurance with the same reinsurer, based on when the contract became effective. It is important that the ceding insurer report all types correctly. The same reinsurer may be listed on the same Schedule S by the ceding insurer with an AIIN for unauthorized reinsurance, a CRIN for certified reinsurance, and a RJIN for Reciprocal Jurisdiction reinsurance.

**Use of Federal Employer Identification Number**

The Federal Employer Identification Number (FEIN) must be reported for each U.S.-domiciled insurer and U.S. branch of an alien insurer. The FEIN should not be reported as the “ID Number” for other alien insurers even if the federal government has issued such a number.

**Alien Insurer Identification Number (AIIN)**

In order to report transactions involving alien companies correctly, the appropriate Alien Insurer Identification Number (AIIN) must be included on Schedule S instead of the FEIN. The AIIN number is assigned by the NAIC and is listed in the NAIC *Listing of Companies*. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**Pool and Association Numbers**

In order to report transactions involving non-risk bearing pools or associations consisting of nonaffiliated companies correctly, the company must include on Schedule S the appropriate Pool/Association Identification Number. These numbers are listed in the NAIC *Listing of Companies*. The Pool/Association Identification Number should be used instead of any FEIN that may have been assigned. If a pool or association does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**Certified Reinsurer Identification Number (CRIN)**

In order to report transactions involving certified reinsurers correctly, the appropriate Certified Reinsurer Identification Number (CRIN) must be included on Schedule S instead of the FEIN, AIIN or Reciprocal Jurisdiction Reinsurer Identification Number (RJIN). The CRIN is assigned by the NAIC and is listed in the NAIC *Listing of Companies*. If a certified reinsurer does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)**

In order to report transactions involving Reciprocal Jurisdiction reinsurers correctly, the appropriate Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) must be included on Schedule S instead of the FEIN, AIIN or CRIN. The RJIN number is assigned by the NAIC and is listed in the NAIC *Listing of Companies*. If a company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company...
Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**NAIC Company Code**

Company codes are assigned by the NAIC and are listed in the NAIC Listing of Companies. The NAIC does not assign a company code to insurers domiciled outside of the U.S. or to non-risk bearing pools or associations. The “NAIC Company Code” field should be zero-filled for those organizations. Non-risk bearing pools or associations are assigned a Pool/Association Identification Number. See the “Pool and Association Numbers” section above for details on assignment of Pool/Association Identification Numbers. Risk-bearing pools or associations are assigned a company code. If a reinsurer or reinsured has merged with another entity, report the company code of the surviving entity.

If a risk-bearing entity (e.g., risk-bearing pools or associations) does not appear in the NAIC Listing of Companies, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned. Newly assigned company codes are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

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**Determination of Authorized Status**

The determination of the authorized, reciprocal jurisdiction, unauthorized or certified status of an insurer or reinsurer listed in any part of Schedule S shall be based on the status of that insurer or reinsurer in the reporting entity’s state of domicile.
SCHEDULE S – PART 1 – SECTION 1
REINSURANCE ASSUMED LIFE INSURANCE, ANNUITIES, DEPOSIT FUNDS AND OTHER LIABILITIES WITHOUT LIFE OR DISABILITY CONTINGENCIES, AND RELATED BENEFITS LISTED BY REINSURED COMPANY AS OF DECEMBER 31, CURRENT YEAR

This section should include data on all reinsurance assumed for life insurance, annuities, deposit fund and other liabilities without life or disability contingencies, and related benefits by reinsured company as of December 31, current year.

Detail Eliminated to Conserve Space

Column 2 – ID Number
Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

Federal Employer Identification Number (FEIN)
Alien Insurer Identification Number (AIIN)
Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
Certified Reinsurer Identification Number (CRIN)
Pool/Association Identification Number

Detail Eliminated to Conserve Space

SCHEDULE S – PART 1 – SECTION 2
REINSURANCE ASSUMED ACCIDENT AND HEALTH INSURANCE LISTED BY REINSURED COMPANY AS OF DECEMBER 31, CURRENT YEAR

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total line and number:

Detail Eliminated to Conserve Space

Column 2 – ID Number
Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

Federal Employer Identification Number (FEIN)
Alien Insurer Identification Number (AIIN)
Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
Certified Reinsurer Identification Number (CRIN)
Pool/Association Identification Number

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SCHEDULE S – PART 2

REINSURANCE RECOVERABLE ON PAID AND UNPAID LOSSES LISTED BY REINSURING COMPANY
AS OF DECEMBER 31, CURRENT YEAR

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total line and number:

Column 2 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number
SCHEDULE S – PART 3 – SECTION 1

REINSURANCE CEDED LIFE INSURANCE, ANNUITIES, DEPOSIT FUNDS AND OTHER LIABILITIES
WITHOUT LIFE OR DISABILITY CONTINGENCIES, AND RELATED BENEFITS LISTED BY REINSURING
COMPANY AS OF DECEMBER 31, CURRENT YEAR

NOTE: This schedule is to include Exhibit 7 cessions. Include actual reinsurance ceded on group cases but exclude jointly underwritten group contracts.

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total line and number:

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<tr>
<th>Group or Category</th>
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<td>Authorized Affiliates</td>
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<td>U.S.</td>
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<tr>
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<th>Total Certified Non-Affiliates</th>
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</thead>
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| Total Certified Affiliates | 2999999 |

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| Total Reciprocal Jurisdiction Affiliates | 4099999 |

| Total Reciprocal Jurisdiction Affiliates | 4099999 |

<table>
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<tr>
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<tr>
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<tr>
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| Total Authorized Affiliates | 4199999 |

| Total Authorized Affiliates | 4199999 |

| Total Authorized Affiliates | 4199999 |

<p>| Total Authorized Affiliates | 4199999 |</p>
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<tr>
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<tr>
<td>Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.</td>
<td></td>
</tr>
<tr>
<td>Federal Employer Identification Number (FEIN)</td>
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<tr>
<td>Alien Insurer Identification Number (AIIN)</td>
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<td>Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)</td>
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<td>Certified Reinsurer Identification Number (CRIN)</td>
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</tr>
<tr>
<td>Pool/Association Identification Number</td>
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</tr>
</tbody>
</table>

**SCHEDULE S – PART 3 – SECTION 2**

**REINSURANCE CEDED ACCIDENT AND HEALTH INSURANCE LISTED BY REINSURING COMPANY AS OF DECEMBER 31, CURRENT YEAR**

Include actual reinsurance ceded on group cases but exclude jointly underwritten group contracts.

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total line and number:

<table>
<thead>
<tr>
<th>Group or Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorized Affiliates</td>
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</table>

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<table>
<thead>
<tr>
<th>Category</th>
<th>U.S. Non-Affiliates</th>
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<td>Total General Account Authorized, Unauthorized and Certified</td>
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Separate Accounts

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<td>Non-U.S. Non-Affiliates</td>
<td>43999995499999</td>
<td>46999995799999</td>
</tr>
<tr>
<td>Total Authorized Non-Affiliates</td>
<td>44999995599999</td>
<td>47999995899999</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unauthorized Affiliates</th>
<th>Total Unauthorized Affiliates</th>
<th>Total Separate Accounts Unauthorized</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Captive</td>
<td>46999995799999</td>
<td>53999996499999</td>
</tr>
<tr>
<td>Other</td>
<td>47999995899999</td>
<td>54999996599999</td>
</tr>
<tr>
<td>Total</td>
<td>48999995999999</td>
<td>55999996699999</td>
</tr>
</tbody>
</table>

| Total Unauthorized Affiliates       | 52999996399999                             | 56999996799999                                |

<table>
<thead>
<tr>
<th>Non-Affiliates</th>
<th>Total Unauthorized Non-Affiliates</th>
<th>Total Separate Accounts Unauthorized</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Non-Affiliates</td>
<td>53999996499999</td>
<td>56999996799999</td>
</tr>
<tr>
<td>Non-U.S. Non-Affiliates</td>
<td>54999996599999</td>
<td>57999996899999</td>
</tr>
<tr>
<td>Total Unauthorized Non-Affiliates</td>
<td>55999996699999</td>
<td>58999996999999</td>
</tr>
</tbody>
</table>

| Total Separate Accounts Unauthorized| 56999996799999                             | 59999997099999                                |

<table>
<thead>
<tr>
<th>Certified Affiliates</th>
<th>Total Separate Accounts Unauthorized</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Captive</td>
<td>57999996899999</td>
</tr>
<tr>
<td>Other</td>
<td>58999996999999</td>
</tr>
<tr>
<td>Total</td>
<td>59999997099999</td>
</tr>
</tbody>
</table>

<p>| Non-U.S.                           | 60999997199999                             |
| Captive                            | 61999997299999                             |
| Other                              | 62999997399999                             |</p>
<table>
<thead>
<tr>
<th>Total Certified Affiliates</th>
<th>63999997499999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Affiliates</td>
<td></td>
</tr>
<tr>
<td>U.S. Non-Affiliates</td>
<td>64999997599999</td>
</tr>
<tr>
<td>Non-U.S. Non-Affiliates</td>
<td>65999997699999</td>
</tr>
<tr>
<td>Total Certified Non-Affiliates</td>
<td>66999997799999</td>
</tr>
<tr>
<td>Total Separate Accounts Certified</td>
<td>67999997899999</td>
</tr>
<tr>
<td>Reciprocal Jurisdiction</td>
<td></td>
</tr>
<tr>
<td>Affiliates</td>
<td></td>
</tr>
<tr>
<td>U.S.</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>7999999</td>
</tr>
<tr>
<td>Other</td>
<td>8099999</td>
</tr>
<tr>
<td>Total</td>
<td>8199999</td>
</tr>
<tr>
<td>Non-U.S.</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>8299999</td>
</tr>
<tr>
<td>Other</td>
<td>8399999</td>
</tr>
<tr>
<td>Total</td>
<td>8499999</td>
</tr>
<tr>
<td>Total Reciprocal Jurisdiction Affiliates</td>
<td>8599999</td>
</tr>
<tr>
<td>Non-Affiliates</td>
<td></td>
</tr>
<tr>
<td>U.S. Non-Affiliates</td>
<td>8699999</td>
</tr>
<tr>
<td>Non-U.S. Non-Affiliates</td>
<td>8799999</td>
</tr>
<tr>
<td>Total Reciprocal Jurisdiction Non-Affiliates</td>
<td>8899999</td>
</tr>
<tr>
<td>Total Separate Accounts Reciprocal Jurisdiction</td>
<td>8999999</td>
</tr>
<tr>
<td>Total U.S. (Sum of 0399999, 0899999, 1499999, 1999999, 2599999, 3099999, 37999993699999, 42999994199999, 4899999, 5399999, 5999999, 6499999, 7099999, 7599999, 8199999 and 64999998699999)</td>
<td>68999999099999</td>
</tr>
<tr>
<td>Total Non-U.S. (Sum of 0699999, 0999999, 1799999, 2099999, 2899999, 3199999, 40999993999999, 43999994299999, 5199999, 5499999, 6299999, 6599999, 7399999, 7699999, 8499999 and 65999998799999)</td>
<td>70999999299999</td>
</tr>
<tr>
<td>Total (Sum of 3499999 and 6899999)</td>
<td>9999999</td>
</tr>
</tbody>
</table>

**Column 2 – ID Number**

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

---

**Detail Eliminated to Conserve Space**
SCHEDULE S – PART 4

REINSURANCE CEDED TO UNAUTHORIZED COMPANIES

Contains data on life and accident and health insurance in force that is reinsured with companies not authorized in the state of domicile of the reporting insurance company. The purpose of this schedule is to display reinsurance ceded data used in the development of the liability for reinsurance in unauthorized companies. This liability serves to offset those assets and liability reductions that reflect the result of reinsurance ceded with unauthorized companies.

Column 2 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

SCHEDULE S – PART 5

REINSURANCE CEDED TO CERTIFIED REINSURERS

NOTE: This schedule is to be completed by those reporting entities whose domiciliary state has enacted the Credit for Reinsurance Model Law (#785) and/or Credit for Reinsurance Model Regulation (#786) with the defined certified reinsurer provisions.

Column 2 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

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ANNUAL STATEMENT INSTRUCTIONS – PROPERTY

SCHEDULE F – REINSURANCE

Index to Schedule F

Part 1 – Assumed Reinsurance
Part 2 – Portfolio Reinsurance
Part 3 – Ceded Reinsurance
Part 4 – Issuing or Confirming Banks for Letters of Credit from Schedule F, Part 3
Part 5 – Interrogatories for Schedule F, Part 3
Part 6 – Restatement of Balance Sheet to Identify Net Credit for Ceded Reinsurance

NOTE: Certified reinsurer status applies on a prospective basis and is determined by the state of domicile of the ceding insurer. Reciprocal Jurisdiction reinsurer status applies on a prospective basis and is for reinsurance agreements entered into, amended, or renewed on or after the effective date of the domiciliary state of the ceding entity enacting the 2019 revisions to the Credit for Reinsurance Models, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal. As such, it is possible that a ceding insurer will report reinsurance balances applicable to a single assuming insurer under multiple classifications within Schedule F. For example, with respect to a certified reinsurer that was considered unauthorized prior to certification, balances attributable to contracts entered into prior to the assuming insurer’s certification would be reported in the unauthorized classification, while balances attributable to contracts entered into or renewed on or after the assuming insurer’s certification would be reported in the certified classification. This will also be the case for Reciprocal Jurisdiction reinsurance, which may have been classified as certified reinsurance prior to the enactment of the 2019 revisions to the Credit for Reinsurance Models by the domiciliary state of the ceding entity. Proper classification of such balances is essential to ensure accurate reporting of collateral requirements applicable to specific balances and the corresponding calculation of the liability for unauthorized and/or certified reinsurance.

Due Date

All parts of Schedule F are to be filed with the annual statement.

Please note that Parts 1, 3, 4 and 5 of this schedule are reported with thousands omitted. Parts 2 and 6 are reported in whole dollars.

ID Number

Most parts of Schedule F require that the “ID Number” be reported for assuming or ceding entities.

Reinsurance intermediaries should not be listed, because Schedule F is intended to identify only risk-bearing entities.

A ceding insurer can have unauthorized reinsurance, certified reinsurance and Reciprocal Jurisdiction reinsurance with the same reinsurer, based on when the contract became effective. It is important that the ceding insurer report all types correctly. The same reinsurer may be listed on the same Schedule F by the ceding insurer with an AIIN for unauthorized reinsurance, a CRIN for certified reinsurance, and a RJIN for Reciprocal Jurisdiction reinsurance.
Use of Federal Employer Identification Number

The Federal Employer Identification Number (FEIN) must be reported for each U.S.-domiciled insurer and U.S. branch of an alien insurer. The FEIN should not be reported as the “ID Number” for other alien insurers, even if the federal government has issued such a number.

Alien Insurer Identification Number (AIIN)

In order to report transactions involving alien companies correctly, the appropriate Alien Insurer Identification Number (AIIN) must be included on Schedule F instead of the FEIN. The AIIN number is assigned by the NAIC and is listed in the NAIC Listing of Companies. If an alien company does not appear in that publication, contact with the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Pool and Association Numbers

In order to report transactions involving non-risk bearing pools or associations consisting of non-affiliated companies correctly, the company must include on Schedule F the appropriate Pool/Association Identification Number. These numbers are listed in the NAIC Listing of Companies. The Pool/Association Identification Number should be used instead of any FEIN that may have been assigned. If a pool or association does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Alien pools and associations should be reported on Schedule F under the category “Other Non-U.S. Insurers” rather than under “Pools, Associations and Similar Facilities.” Pools and associations consisting of affiliated companies should be listed by individual company names rather than by pool or association identification.

Certified Reinsurer Identification Number (CRIN)

In order to report transactions involving certified reinsurers correctly, the appropriate Certified Reinsurer Identification Number (CRIN) must be included on Schedule F instead of the FEIN or Alien Insurer Identification Number (AIIN) or Reciprocal Jurisdiction Reinsurer Identification Number (RJIN). The CRIN is assigned by the NAIC and is listed in the NAIC Listing of Companies. If a certified reinsurer does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.
**Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)**

In order to report transactions involving alien companies correctly, the appropriate Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) must be included on Schedule F instead of the FEIN, Alien Insurer Identification Number (AIIN) or Certified Reinsurer Identification Number (CRIN). The RJIN number is assigned by the NAIC and is listed in the NAIC *Listing of Companies*. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**NAIC Company Code**

Company codes are assigned by the NAIC and are listed in the NAIC *Listing of Companies*. The NAIC does not assign a company code to insurers domiciled outside of the U.S. or to non-risk bearing pools or associations. The “NAIC Company Code” field should be zero-filled for those organizations. Non-risk bearing pools or associations are assigned a Pool/Association Identification Number. See the “Pool and Association Numbers” section above for details on assignment of Pool/Association Identification Numbers. Risk-bearing pools or associations are assigned a company code. If a reinsurer or reinsured has merged with another entity, report the company code of the surviving entity.

If a risk-bearing entity (e.g., risk-bearing pools or associations) does not appear in the NAIC *Listing of Companies*, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned. Newly assigned company codes are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

**Determination of Authorized Status**

The determination of the authorized, reciprocal jurisdiction, unauthorized or certified status of an insurer or reinsurer listed in any part of Schedule F shall be based on the status of that insurer or reinsurer in the reporting entity’s state of domicile.
**SCHEDULE F – PART 1**

ASSUMED REINSURANCE
AS OF DECEMBER 31, CURRENT YEAR

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal of the corresponding group, category, or subcategory, with the specified subtotal line appearing in the same manner and location as the pre-printed total or grand total line and number:

<table>
<thead>
<tr>
<th>Column 1</th>
<th>ID Number</th>
</tr>
</thead>
</table>

**Detail Eliminated to Conserve Space**

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

**SCHEDULE F – PART 2**

PREMIUM PORTFOLIO REINSURANCE EFFECTED OR (CANCELED)
DURING CURRENT YEAR

This schedule should list by portfolio any original premiums and reinsurance premiums for portfolio reinsurance transactions affected or canceled during the year. Portfolio reinsurance is the transfer of the entire liability of a reporting entity for in force policies as respects a described segment of the reporting entity’s business.

<table>
<thead>
<tr>
<th>Column 1</th>
<th>ID Number</th>
</tr>
</thead>
</table>

**Detail Eliminated to Conserve Space**

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number
**SCHEDULE F – PART 3**

**CEDED REINSURANCE**

**AS OF DECEMBER 31, CURRENT YEAR**

If a reporting entity has amounts reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

<table>
<thead>
<tr>
<th>Group or Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Authorized Affiliates</strong></td>
<td>0199999</td>
</tr>
<tr>
<td>U.S. Intercompany Pooling</td>
<td>0199999</td>
</tr>
<tr>
<td>U.S. Non-Pool Captive</td>
<td>0299999</td>
</tr>
<tr>
<td>U.S. Non-Pool Other</td>
<td>0399999</td>
</tr>
<tr>
<td>U.S. Non-Pool Total</td>
<td>0499999</td>
</tr>
<tr>
<td>Other (Non-U.S.) Captive</td>
<td>0599999</td>
</tr>
<tr>
<td>Other (Non-U.S.) Other</td>
<td>0699999</td>
</tr>
<tr>
<td>Other (Non-U.S.) Total</td>
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</tr>
<tr>
<td><strong>Total Authorized – Affiliates</strong></td>
<td>0899999</td>
</tr>
<tr>
<td>Other U.S. Unaffiliated Insurers Pools</td>
<td>0999999</td>
</tr>
<tr>
<td>Mandatory Pools*@</td>
<td>1099999</td>
</tr>
<tr>
<td>Voluntary Pools*%</td>
<td>1199999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td>1299999</td>
</tr>
<tr>
<td>Protected Cells</td>
<td>1399999</td>
</tr>
<tr>
<td><strong>Total Authorized Excluding Protected Cells (Sum of 0899999, 0999999, 1099999, 1199999 and 1299999)</strong></td>
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</tr>
<tr>
<td><strong>Total Unauthorized Affiliates</strong></td>
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</tr>
<tr>
<td>U.S. Intercompany Pooling</td>
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</tr>
<tr>
<td>U.S. Non-Pool Captive</td>
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</tr>
<tr>
<td>U.S. Non-Pool Other</td>
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</tr>
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<td>U.S. Non-Pool Total</td>
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</tr>
<tr>
<td>Other (Non-U.S.) Captive</td>
<td>1999999</td>
</tr>
<tr>
<td>Other (Non-U.S.) Other</td>
<td>2099999</td>
</tr>
<tr>
<td>Other (Non-U.S.) Total</td>
<td>2199999</td>
</tr>
<tr>
<td><strong>Total Unauthorized – Affiliates</strong></td>
<td>2299999</td>
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<tr>
<td>Other U.S. Unaffiliated Insurers Pools</td>
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</tr>
<tr>
<td>Mandatory Pools*@</td>
<td>2499999</td>
</tr>
<tr>
<td>Voluntary Pools*%</td>
<td>2599999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td>2699999</td>
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<td>Protected Cells</td>
<td>2799999</td>
</tr>
<tr>
<td><strong>Total Unauthorized Excluding Protected Cells (Sum of 2299999, 2399999, 2499999, 2599999 and 2699999)</strong></td>
<td>2899999</td>
</tr>
</tbody>
</table>
Total Certified Affiliates

<table>
<thead>
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<th>Category</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>U.S. Non-Pool</td>
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</tr>
<tr>
<td>Captive</td>
<td>3099999</td>
</tr>
<tr>
<td>Other</td>
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</tr>
<tr>
<td>Total</td>
<td>3299999</td>
</tr>
<tr>
<td>Other (Non-U.S.)</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>3399999</td>
</tr>
<tr>
<td>Other</td>
<td>3499999</td>
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<tr>
<td>Total</td>
<td>3599999</td>
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<tr>
<td>Total Certified – Affiliates</td>
<td>3699999</td>
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<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td>3799999</td>
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</tbody>
</table>

Pools

<table>
<thead>
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<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Voluntary Pools</td>
<td>3999999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers</td>
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</tr>
<tr>
<td>Protected Cells</td>
<td>4199999</td>
</tr>
<tr>
<td>Total Certified Excluding Protected Cells</td>
<td>4299999</td>
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</tbody>
</table>

Total Reciprocal Jurisdiction

<table>
<thead>
<tr>
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<th>Total</th>
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<tr>
<td>U.S. Intercompany Pooling</td>
<td>4399999</td>
</tr>
<tr>
<td>U.S. Non-Pool</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>4499999</td>
</tr>
<tr>
<td>Other</td>
<td>4599999</td>
</tr>
<tr>
<td>Total</td>
<td>4699999</td>
</tr>
<tr>
<td>Other (Non-U.S.)</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
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</tr>
<tr>
<td>Other</td>
<td>4899999</td>
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<tr>
<td>Total</td>
<td>4999999</td>
</tr>
<tr>
<td>Total Reciprocal Jurisdiction – Affiliates</td>
<td>5099999</td>
</tr>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
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</table>

Pools

<table>
<thead>
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<th>Category</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory Pools</td>
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<tr>
<td>Voluntary Pools</td>
<td>5399999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers</td>
<td>5499999</td>
</tr>
<tr>
<td>Protected Cells</td>
<td>5599999</td>
</tr>
<tr>
<td>Total Reciprocal Jurisdiction Excluding</td>
<td>5699999</td>
</tr>
<tr>
<td>Protected Cells</td>
<td></td>
</tr>
</tbody>
</table>

Total Authorized, Reciprocal Jurisdiction, Unauthorized and Certified Excluding Protected Cells

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Authorized, Reciprocal Jurisdiction,</td>
<td>4399999</td>
</tr>
<tr>
<td>Unauthorized and Certified Excluding</td>
<td></td>
</tr>
<tr>
<td>Protected Cells</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4399999</td>
</tr>
</tbody>
</table>

Total Protected Cells

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>4499999</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
</tr>
</tbody>
</table>

* - Pools and Associations consisting of affiliated companies should be listed by individual company names.

@ - Include in Mandatory Pools all U.S. Government programs (e.g., National Flood Insurance, National Crop Insurance Corporation), all state residual market mechanisms, the Workers Compensation Reinsurance Pool, and the National Council on Compensation Insurance.

% - Include in Voluntary Pools all pool participation that is voluntary on the part of the reporting entity. Include participation in any state program for which participation is not mandatory.

# - Alien Pools and Associations should be reported on Schedule F under the category “Other Non-U.S. Insurers.”
Column 1 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

Detail Eliminated to Conserve Space

Ceded Reinsurance Credit Risk – Columns 28 Through 36

Only complete columns 28 through 36 for the following required groups, categories or subcategories (Line Numbers); otherwise leave blank.

<table>
<thead>
<tr>
<th>Group or Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Authorized</td>
<td></td>
</tr>
<tr>
<td>Affiliates</td>
<td></td>
</tr>
<tr>
<td>Other (Non-U.S.)</td>
<td></td>
</tr>
<tr>
<td>Captive ..................................................................</td>
<td>0599999</td>
</tr>
<tr>
<td>Other ......................................................................</td>
<td>0699999</td>
</tr>
<tr>
<td>Total .....................................................................</td>
<td>0799999</td>
</tr>
<tr>
<td>Total Authorized – Affiliates</td>
<td></td>
</tr>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td></td>
</tr>
<tr>
<td>Pools</td>
<td></td>
</tr>
<tr>
<td>Voluntary Pools*%</td>
<td>1199999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td>1299999</td>
</tr>
<tr>
<td>Total Authorized Excluding Protected Cells (Sum of 0899999, 0999999, 1099999, 1199999 and 1299999)</td>
<td>1499999</td>
</tr>
<tr>
<td>Total Unauthorized</td>
<td></td>
</tr>
<tr>
<td>Affiliates</td>
<td></td>
</tr>
<tr>
<td>Other (Non-U.S.)</td>
<td></td>
</tr>
<tr>
<td>Captive ..................................................................</td>
<td>1999999</td>
</tr>
<tr>
<td>Other ......................................................................</td>
<td>2099999</td>
</tr>
<tr>
<td>Total .....................................................................</td>
<td>2199999</td>
</tr>
<tr>
<td>Total Unauthorized – Affiliates</td>
<td></td>
</tr>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td></td>
</tr>
<tr>
<td>Pools</td>
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<tr>
<td>Voluntary Pools*%</td>
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</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
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<tr>
<td>Total Unauthorized Excluding Protected Cells (Sum of 2299999, 2399999, 2499999, 2599999 and 2699999)</td>
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</tr>
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### Total Certified

<table>
<thead>
<tr>
<th>Affiliates</th>
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</thead>
<tbody>
<tr>
<td>Other (Non-U.S.)</td>
<td>3399999</td>
</tr>
<tr>
<td>Captive</td>
<td></td>
</tr>
<tr>
<td>Other</td>
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</tr>
<tr>
<td>Total Certified – Affiliates</td>
<td>3699999</td>
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<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td>3799999</td>
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<tr>
<td>Pools</td>
<td></td>
</tr>
<tr>
<td>Voluntary Pools*%</td>
<td>3999999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
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</tr>
<tr>
<td>Total</td>
<td>4299999</td>
</tr>
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</table>

### Total Reciprocal Jurisdiction

<table>
<thead>
<tr>
<th>Affiliates</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (Non-U.S.)</td>
<td>4799999</td>
</tr>
<tr>
<td>Captive</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>4899999</td>
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<tr>
<td>Total</td>
<td>4999999</td>
</tr>
<tr>
<td>Total Reciprocal Jurisdiction – Affiliates</td>
<td>5099999</td>
</tr>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td>5199999</td>
</tr>
<tr>
<td>Pools</td>
<td></td>
</tr>
<tr>
<td>Voluntary Pools*%</td>
<td>5399999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td>5499999</td>
</tr>
<tr>
<td>Total Reciprocal Jurisdiction Excluding Protected Cells (Sum of 5099999, 5199999, 5299999, 5399999 and 5499999)</td>
<td>5699999</td>
</tr>
</tbody>
</table>

Total Authorized, Reciprocal Jurisdiction, Unauthorized and Certified Excluding Protected Cells (Sum of 1499999, 2899999, 4299999 and 5699999) | 43999999

### Totals (Sum of 1499999, 2899999, 4299999, 43999999, 44999999, 45999999 and 46999999) | 9999999

---

**Provision for Certified Reinsurance – Columns 54 Through 69**

**NOTE:** Columns 54 through 69 are to be completed by those reporting entities whose domiciliary state has enacted the *Credit for Reinsurance Model Law* (#785) and/or *Credit for Reinsurance Model Regulation* (#786) with the defined certified reinsurer provisions.

Only complete columns 54 through 69 for the following required groups, categories, or subcategories (Line Numbers); otherwise leave blank.

<table>
<thead>
<tr>
<th>Group or Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Certified</td>
<td></td>
</tr>
<tr>
<td>Affiliates</td>
<td></td>
</tr>
<tr>
<td>U.S. Intercompany Pooling</td>
<td>2999999</td>
</tr>
<tr>
<td>U.S. Non-Pool</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>3099999</td>
</tr>
<tr>
<td>Other</td>
<td>3199999</td>
</tr>
<tr>
<td>Total</td>
<td>3299999</td>
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<tr>
<td>Group or Category</td>
<td>Line Number</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Total Unauthorized Affiliates</td>
<td></td>
</tr>
<tr>
<td>U.S. Intercompany Pooling</td>
<td>1599999</td>
</tr>
<tr>
<td>U.S. Non-Pool</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>1699999</td>
</tr>
<tr>
<td>Other</td>
<td>1799999</td>
</tr>
<tr>
<td>Total</td>
<td>1899999</td>
</tr>
<tr>
<td>Other (Non-U.S.)</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>1999999</td>
</tr>
<tr>
<td>Other</td>
<td>2099999</td>
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<tr>
<td>Total</td>
<td>2199999</td>
</tr>
<tr>
<td>Total Unauthorized – Affiliates</td>
<td>2299999</td>
</tr>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td></td>
</tr>
<tr>
<td>Pools</td>
<td></td>
</tr>
<tr>
<td>Mandatory Pools*</td>
<td>2499999</td>
</tr>
<tr>
<td>Voluntary Pools*</td>
<td>2599999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td>2699999</td>
</tr>
<tr>
<td>Protected Cells</td>
<td>2799999</td>
</tr>
<tr>
<td>Total Unauthorized Excluding Protected Cells (Sum of 2299999, 2399999, 2499999, 2599999 and 2699999)</td>
<td>2899999</td>
</tr>
</tbody>
</table>

Provision for Unauthorized Reinsurance – Columns 71 and 72

Only complete columns 71 and 72 for the following required groups, categories or subcategories (Line Numbers); otherwise enter zero.
Provision for Overdue Authorized and Reciprocal Jurisdiction Reinsurance – Columns 73 and 74

Only complete columns 73 and 74 for the following required groups, categories or subcategories (Line Numbers); otherwise enter zero.

<table>
<thead>
<tr>
<th>Group or Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
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<tr>
<td>U.S. Non-Pool Captive</td>
<td>0299999</td>
</tr>
<tr>
<td>U.S. Non-Pool Other</td>
<td>0399999</td>
</tr>
<tr>
<td>U.S. Non-Pool Total</td>
<td>0499999</td>
</tr>
<tr>
<td>Other (Non-U.S.) Captive</td>
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</tr>
<tr>
<td>Other (Non-U.S.) Other</td>
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</tr>
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<td>Other (Non-U.S.) Total</td>
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</tr>
<tr>
<td>Total Authorized – Affiliates</td>
<td>0899999</td>
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<tr>
<td>Other U.S. Unaffiliated Insurers</td>
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</tr>
<tr>
<td>Pools</td>
<td></td>
</tr>
<tr>
<td>Mandatory Pools* @</td>
<td>1099999</td>
</tr>
<tr>
<td>Voluntary Pools* %</td>
<td>1199999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td>1299999</td>
</tr>
<tr>
<td>Protected Cells</td>
<td></td>
</tr>
<tr>
<td>Total Authorized Excluding Protected Cells (Sum of 0899999, 0999999, 1099999, 1199999 and 1299999)</td>
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</tr>
<tr>
<td>Total Reciprocal Jurisdiction</td>
<td></td>
</tr>
<tr>
<td>Affiliates</td>
<td></td>
</tr>
<tr>
<td>U.S. Intercompany Pooling</td>
<td>4399999</td>
</tr>
<tr>
<td>U.S. Non-Pool Captive</td>
<td>4499999</td>
</tr>
<tr>
<td>U.S. Non-Pool Other</td>
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</tr>
<tr>
<td>U.S. Non-Pool Total</td>
<td>4699999</td>
</tr>
<tr>
<td>Other (Non-U.S.) Captive</td>
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</tr>
<tr>
<td>Other (Non-U.S.) Other</td>
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</tr>
<tr>
<td>Other (Non-U.S.) Total</td>
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</tr>
<tr>
<td>Total Reciprocal Jurisdiction – Affiliates</td>
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<tr>
<td>Other U.S. Unaffiliated Insurers</td>
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</tr>
<tr>
<td>Pools</td>
<td></td>
</tr>
<tr>
<td>Mandatory Pools* @</td>
<td>5299999</td>
</tr>
<tr>
<td>Voluntary Pools* %</td>
<td>5399999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
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<tr>
<td>Protected Cells</td>
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</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Total Reciprocal Jurisdiction Excluding Protected Cells
(Sum of 5099999, 5199999, 5299999, 5399999, and 5499999) .................................................................................................................... 5699999

### Total Authorized, Reciprocal Jurisdiction, Unauthorized and Certified Excluding Protected Cells
(Sum of 1499999, 2899999, 4299999, and 4299999) .................................................................................................................... 43999995799999

### Total Protected Cells
(Sum of 1399999, 2799999, 4199999, and 4199999) .................................................................................................................... 44999995899999

### Totals
(Sum of 4399999 5799999 and 4499999 5899999) .................................................................................................................... 9999999

Columns 73 & 74 – Provisions for Overdue Authorized Reinsurance

Amounts reported in the detail lines cannot be less than 0. If the calculated amounts are less than 0, then enter 0.

Columns 75 through 78 – Total Provisions for Reinsurance

Amounts reported in the detail lines cannot be less than 0. If the calculated amounts are less than 0, then enter 0.

**SUPPLEMENTAL SCHEDULE FOR REINSURANCE COUNTERPARTY REPORTING EXCEPTION – ASBESTOS AND POLLUTION CONTRACTS**

**DETAIL OF ORIGINAL REINSURERS AGGREGATED ON SCHEDULE F AS OF DECEMBER 31, CURRENT YEAR**

<table>
<thead>
<tr>
<th>Group or Category</th>
<th>Line Number</th>
</tr>
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<tbody>
<tr>
<td>Total Authorized</td>
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<tr>
<td>Affiliates</td>
<td></td>
</tr>
<tr>
<td>U.S. Intercompany Pooling</td>
<td>0199999</td>
</tr>
<tr>
<td>U.S. Non-Pool</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
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</tr>
<tr>
<td>Total</td>
<td>0499999</td>
</tr>
<tr>
<td>Other (Non-U.S.)</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>0599999</td>
</tr>
<tr>
<td>Other</td>
<td>0699999</td>
</tr>
<tr>
<td>Total</td>
<td>0799999</td>
</tr>
<tr>
<td>Total Authorized – Affiliates</td>
<td>0899999</td>
</tr>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td>0999999</td>
</tr>
<tr>
<td>Pools</td>
<td></td>
</tr>
<tr>
<td>Mandatory Pools*@</td>
<td>1099999</td>
</tr>
<tr>
<td>Voluntary Pools*%</td>
<td>1199999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
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<tr>
<td>Protected Cells</td>
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<td>Description</td>
<td>Value</td>
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<tr>
<td>---------------------------------------------------------------------------</td>
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<td>Total Authorized Excluding Protected Cells (Sum of 0899999, 0999999, 1099999, 1199999 and 1299999)</td>
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</tr>
<tr>
<td>Total Unauthorized Affiliates</td>
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</tr>
<tr>
<td><strong>U.S. Intercompany Pooling</strong></td>
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<td><strong>U.S. Non-Pool</strong></td>
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</tr>
<tr>
<td>Captive</td>
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<tr>
<td>Other</td>
<td>1799999</td>
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<tr>
<td><strong>Total</strong></td>
<td>1899999</td>
</tr>
<tr>
<td><strong>Other (Non-U.S.)</strong></td>
<td></td>
</tr>
<tr>
<td>Captive</td>
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</tr>
<tr>
<td><strong>Total Unauthorized – Affiliates</strong></td>
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<tr>
<td><strong>Other U.S. Unaffiliated Insurers</strong></td>
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</tr>
<tr>
<td><strong>Pools</strong></td>
<td></td>
</tr>
<tr>
<td>Mandatory Pools*@</td>
<td>2499999</td>
</tr>
<tr>
<td>Voluntary Pools*%</td>
<td>2599999</td>
</tr>
<tr>
<td><strong>Other Non-U.S. Insurers#</strong></td>
<td>2699999</td>
</tr>
<tr>
<td><strong>Protected Cells</strong></td>
<td>2799999</td>
</tr>
<tr>
<td><strong>Total Unauthorized Excluding Protected Cells (Sum of 2299999, 2399999, 2499999, 2599999 and 2699999)</strong></td>
<td>2899999</td>
</tr>
<tr>
<td>Total Certified Affiliates</td>
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</tr>
<tr>
<td><strong>U.S. Intercompany Pooling</strong></td>
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<td><strong>U.S. Non-Pool</strong></td>
<td></td>
</tr>
<tr>
<td>Captive</td>
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</tr>
<tr>
<td>Other</td>
<td>3199999</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3299999</td>
</tr>
<tr>
<td><strong>Other (Non-U.S.)</strong></td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>3399999</td>
</tr>
<tr>
<td>Other</td>
<td>3499999</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3599999</td>
</tr>
<tr>
<td><strong>Total Certified – Affiliates</strong></td>
<td>3699999</td>
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<tr>
<td><strong>Other U.S. Unaffiliated Insurers</strong></td>
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<td><strong>Pools</strong></td>
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</tr>
<tr>
<td>Mandatory Pools*@</td>
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<tr>
<td>Voluntary Pools*%</td>
<td>3999999</td>
</tr>
<tr>
<td><strong>Other Non-U.S. Insurers#</strong></td>
<td>4099999</td>
</tr>
<tr>
<td><strong>Protected Cells</strong></td>
<td>4199999</td>
</tr>
<tr>
<td><strong>Total Certified Excluding Protected Cells (Sum of 3699999, 3799999, 3899999, 3999999 and 4099999)</strong></td>
<td>4299999</td>
</tr>
</tbody>
</table>
## Total Reciprocal Jurisdiction

### Affiliates

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</thead>
<tbody>
<tr>
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<tr>
<td>U.S. Non-Pool</td>
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</tr>
<tr>
<td>Captive</td>
<td>4499999</td>
</tr>
<tr>
<td>Other</td>
<td>4599999</td>
</tr>
<tr>
<td>Total</td>
<td>4699999</td>
</tr>
<tr>
<td>Other (Non-U.S.)</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>4799999</td>
</tr>
<tr>
<td>Other</td>
<td>4899999</td>
</tr>
<tr>
<td>Total</td>
<td>4999999</td>
</tr>
</tbody>
</table>

Total Reciprocal Jurisdiction – Affiliates: 5099999

### Other U.S. Unaffiliated Insurers

<table>
<thead>
<tr>
<th>Pools</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory Pools*@</td>
<td>5299999</td>
</tr>
<tr>
<td>Voluntary Pools*%</td>
<td>5399999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td>5499999</td>
</tr>
<tr>
<td>Protected Cells</td>
<td>5599999</td>
</tr>
</tbody>
</table>

Total Reciprocal Jurisdiction Excluding Protected Cells (Sum of 5099999, 5199999, 5299999, 5399999 and 5499999): 5699999

Total Authorized, Reciprocal Jurisdiction, Unauthorized and Certified Excluding Protected Cells (Sum of 1499999, 2899999, 4299999 and 42999995699999): 43999995799999

Total Protected Cells (Sum of 1399999, 2799999, 4199999 and 41999995599999): 44999995899999

Totals (Sum of 4399999, 5799999 and 44999995899999): 9999999

* – Pools and Associations consisting of affiliated companies should be listed by individual company names.

@ – Include in Mandatory Pools all U.S. Government programs (e.g., National Flood Insurance, National Crop Insurance Corporation), all state residual market mechanisms, the Workers Compensation Reinsurance Pool, and the National Council on Compensation Insurance.

% – Include in Voluntary Pools all pool participation that is voluntary on the part of the reporting entity. Include participation in any state program for which participation is not mandatory.

# – Alien Pools and Associations should be reported on Schedule F under the category “Other Non-U.S. Insurers.”

### Column 1 – ID Number (Original Reinsurer)

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number
Column 5 – ID Number (Retroactive Reinsurer)

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number
ID Number

Schedule F requires that the “ID Number” be reported for assuming or ceding entities.

Reinsurance intermediaries should not be listed, because Schedule F is intended to identify only risk-bearing entities.

A ceding insurer can have unauthorized reinsurance, certified reinsurance and Reciprocal Jurisdiction reinsurance with the same reinsurer, based on when the contract became effective. It is important that the ceding insurer report all types correctly. The same reinsurer may be listed on the same Schedule S by the ceding insurer with an AIIN for unauthorized reinsurance, a CRIN for certified reinsurance, and a RJIN for Reciprocal Jurisdiction reinsurance.

Use of Federal Employer Identification Number

The Federal Employer Identification Number (FEIN) must be reported for each U.S.-domiciled insurer and U.S. branch of an alien insurer. The FEIN should not be reported as the “ID Number” for other alien insurers even if the federal government has issued such a number.

Alien Insurer Identification Number (AIIN)

In order to report transactions involving alien companies correctly, the appropriate Alien Insurer Identification Number (AIIN) must be included on Schedule F instead of the FEIN. The AIIN number is assigned by the NAIC and is listed in the NAIC Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Pool and Association Numbers

In order to report transactions involving non-risk bearing pools or associations consisting of non-affiliated companies correctly, the company must include on Schedule F the appropriate Pool/Association Identification Number. These numbers are listed in the NAIC Listing of Companies. The Pool/Association Identification Number should be used instead of any FEIN that may have been assigned. If a pool or association does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Alien pools and associations should be reported on Schedule F under the category “Other Non-U.S. Insurers” rather than under “Pools, Associations and Similar Facilities.” Pools and associations consisting of affiliated companies should be listed by individual company names rather than by pool or association identification.

Certified Reinsurer Identification Number (CRIN)

In order to report transactions involving certified reinsurers correctly, the appropriate Certified Reinsurer Identification Number (CRIN) must be included on Schedule F instead of the FEIN, or Alien Insurer Identification Number (AIIN) or Reciprocal Jurisdiction Reinsurer Identification Number (RJIN). The CRIN is assigned by the NAIC and is listed in the NAIC Listing of Companies. If a certified reinsurer does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.
Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)**

In order to report transactions involving alien companies correctly, the appropriate Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) must be included on Schedule F instead of the FEIN, Alien Insurer Identification Number (AIIN) or Certified Reinsurer Identification Number (CRIN). The RJIN is assigned by the NAIC and is listed in the NAIC *Listing of Companies*. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**NAIC Company Code**

Company codes are assigned by the NAIC and are listed in the NAIC *Listing of Companies*. The NAIC does not assign a company code to insurers domiciled outside of the U.S. or to non-risk bearing pools or associations. The “NAIC Company Code” field should be zero-filled for those organizations. Non-risk bearing pools or associations are assigned a Pool/Association Identification Number. See the “Pool and Association Numbers” section above for details on assignment of Pool/Association Identification Numbers. Risk-bearing pools or associations are assigned a company code. If a reinsurer or reinsured has merged with another entity, report the company code of the surviving entity.

If a risk-bearing entity (e.g., risk-bearing pools or associations) does not appear in the NAIC *Listing of Companies*, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned. Newly assigned company codes are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

**Determination of Authorized Status**

The determination of the authorized, reciprocal jurisdiction, unauthorized or certified status of an insurer or reinsurer listed in any part of Schedule F shall be based on the status of that insurer or reinsurer in the reporting entity’s state of domicile.
SCHEDULE F – PART 1

ASSUMED REINSURANCE AS OF DECEMBER 31, CURRENT YEAR

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal of the corresponding group, category, or subcategory, with the specified subtotal line appearing in the same manner and location as the pre-printed total or grand total line and number:

---

Column 1 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

---

SCHEDULE F – PART 2

CEDED REINSURANCE AS OF DECEMBER 31, CURRENT YEAR

If a reporting entity has amounts reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

---

Group or Category

<table>
<thead>
<tr>
<th>Total Authorized Affiliates</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Intercompany Pooling ................................................................. 0199999</td>
</tr>
<tr>
<td>U.S. Non-Pool</td>
</tr>
<tr>
<td>Captive .......................................................... 0299999</td>
</tr>
<tr>
<td>Other .......................................................... 0399999</td>
</tr>
<tr>
<td>Total .......................................................... 0499999</td>
</tr>
<tr>
<td>Other (Non-U.S.)</td>
</tr>
<tr>
<td>Captive .......................................................... 0599999</td>
</tr>
<tr>
<td>Other .......................................................... 0699999</td>
</tr>
<tr>
<td>Total .......................................................... 0799999</td>
</tr>
<tr>
<td>Total Authorized – Affiliates .............................................................. 0899999</td>
</tr>
</tbody>
</table>
### Total Authorized Affiliates

<table>
<thead>
<tr>
<th>Category</th>
<th>Pools</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td>Mandatory Pools*</td>
<td>1099999</td>
</tr>
<tr>
<td></td>
<td>Voluntary Pools*</td>
<td>1199999</td>
</tr>
<tr>
<td></td>
<td>Total Authorized</td>
<td>1299999</td>
</tr>
</tbody>
</table>

### Total Unauthorized Affiliates

<table>
<thead>
<tr>
<th>Category</th>
<th>Pools</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td>Mandatory Pools*</td>
<td>1099999</td>
</tr>
<tr>
<td></td>
<td>Voluntary Pools*</td>
<td>1199999</td>
</tr>
<tr>
<td></td>
<td>Total Authorized</td>
<td>1299999</td>
</tr>
</tbody>
</table>

### Total Certified Affiliates

<table>
<thead>
<tr>
<th>Category</th>
<th>Pools</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td>Mandatory Pools*</td>
<td>2399999</td>
</tr>
<tr>
<td></td>
<td>Voluntary Pools*</td>
<td>2499999</td>
</tr>
<tr>
<td></td>
<td>Total Authorized</td>
<td>2599999</td>
</tr>
</tbody>
</table>

### Total Unauthorized – Affiliates

- **U.S. Intercompany Pooling**: 1499999
- **U.S. Non-Pool Captive**: 1599999
- **U.S. Non-Pool Other**: 1699999
- **U.S. Non-Pool Total**: 1799999
- **Other (Non-U.S.) Captive**: 1899999
- **Other (Non-U.S.) Other**: 1999999
- **Other (Non-U.S.) Total**: 2099999

### Total Unauthorized – Other Non-U.S. Insurers

- **Total Unauthorized**: 2199999

### Total Unauthorized – Other Non-U.S. Insurers

- **Total Unauthorized**: 2299999

### Total Certified – Affiliates

- **Total Certified**: 2799999

### Total Certified – Affiliates

- **Total Certified**: 2899999

### Total Unauthorized – Other Non-U.S. Insurers

- **Total Unauthorized**: 3099999

### Total Unauthorized – Other Non-U.S. Insurers

- **Total Unauthorized**: 3199999

### Total Certified

- **Total Certified**: 3299999

### Total Certified

- **Total Certified**: 3399999

### Total Unauthorized

- **Total Unauthorized**: 3499999

### Total Unauthorized

- **Total Unauthorized**: 3599999

### Total Unauthorized

- **Total Unauthorized**: 3699999

### Total Unauthorized

- **Total Unauthorized**: 3799999

### Total Unauthorized

- **Total Unauthorized**: 3899999

### Total Unauthorized

- **Total Unauthorized**: 3999999
## Total Reciprocal Jurisdiction

### Affiliates

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<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Intercompany Pooling</td>
<td>4099999</td>
</tr>
<tr>
<td>U.S. Non-Pool</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>4199999</td>
</tr>
<tr>
<td>Other</td>
<td>4299999</td>
</tr>
<tr>
<td>Total</td>
<td>4399999</td>
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<tr>
<td>Other (Non-U.S.)</td>
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</tr>
<tr>
<td>Captive</td>
<td>4499999</td>
</tr>
<tr>
<td>Other</td>
<td>4599999</td>
</tr>
<tr>
<td>Total</td>
<td>4699999</td>
</tr>
</tbody>
</table>

Total Reciprocal Jurisdiction – Affiliates: 4799999

### Other U.S. Unaffiliated Insurers

<table>
<thead>
<tr>
<th>Category</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pools</td>
<td></td>
</tr>
<tr>
<td>Mandatory Pools*®</td>
<td>4999999</td>
</tr>
<tr>
<td>Voluntary Pools*®</td>
<td>5099999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td>5199999</td>
</tr>
<tr>
<td>Total</td>
<td>5299999</td>
</tr>
</tbody>
</table>

Total Reciprocal Jurisdiction: 5299999

Totals: 9999999

---

* Pools and Associations consisting of affiliated companies should be listed by individual company names.

# Alien Pools and Associations should be reported on Schedule F under the category “Other Non-U.S. Insurers.”

**NOTE:** Disclosure of the five largest provisional commission rates should exclude mandatory pools and joint underwriting associations.

**Column 1 – ID Number**

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- **Federal Employer Identification Number (FEIN)**
- **Alien Insurer Identification Number (AIIN)**
- **Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)**
- **Certified Reinsurer Identification Number (CRIN)**
- **Pool/Association Identification Number**
SCHEDULE F – PART 3

PROVISION FOR UNAUTHORIZED REINSURANCE AS OF DECEMBER 31, CURRENT YEAR

If a reporting entity has amounts reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

Column 1 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

SCHEDULE F – PART 4

PROVISION FOR REINSURANCE Ceded TO CERTIFIED REINSURERS AS OF DECEMBER 31, CURRENT YEAR

NOTE: This schedule is to be completed by those reporting entities whose domiciliary state has enacted the Credit for Reinsurance Model Law (#785) and/or Credit for Reinsurance Model Regulation (#786) with the defined certified reinsurer provisions.

Column 1 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number
This schedule reports unpaid loss and loss adjustment expenses on direct and agency operations. Affiliated agencies are those that meet the affiliation standards defined by SSAP No. 25—Affiliates and Other Related Parties. Refer to SSAP No. 57—Title Insurance, paragraphs 8–13, for accounting guidance.

Line 2 – Reinsurance Recoverable from Authorized, Unauthorized and Certified Companies

The amounts shown on this line represents reinsurance ceded recoverables (from authorized, unauthorized and certified companies) on unpaid losses of which notice has been received. This can be done through reinsurance ceded treaties, facultative reinsurance assumed agreements, or under transfer and assumption agreements.

The amounts shown on this line should reconcile to amounts reported in Schedule F, Part 2, Column 9, Total.

The amount shown in Column 1 should agree to Schedule P, Part 1A, Column 19, Line 12.

The amount shown in Column 2 plus the amount shown in Column 3 should as agree to Schedule P, Part 1B, Column 19, Line 12.
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

WORKERS’ COMPENSATION CARVE-OUT SUPPLEMENT

The Workers’ Compensation Carve-out Supplement shall be completed by those reporting entities that assume or cede workers’ compensation carve-out business.

Workers’ compensation carve-out business is defined as reinsurance (including retrocessional reinsurance) assumed by life and health insurers of medical, wage loss and death benefits of the occupational illness and accident exposures, but not the employer’s liability exposures, of business originally written as workers compensation insurance.

SCHEDULE F – REINSURANCE

NOTE: Certified reinsurer status applies on a prospective basis and is determined by the state of domicile of the ceding insurer. Reciprocal Jurisdiction reinsurer status applies on a prospective basis and is for reinsurance agreements entered into, amended, or renewed on or after the effective date of the domiciliary state of the ceding entity enacting the 2019 revisions to the Credit for Reinsurance Models, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal. As such, it is possible that a ceding insurer will report reinsurance balances applicable to a single assuming insurer under multiple classifications within Schedule FS. For example, with respect to a certified reinsurer that was considered unauthorized prior to certification, balances attributable to contracts entered into prior to the assuming insurer’s certification would be reported in the unauthorized classification, while balances attributable to contracts entered into or renewed on or after the assuming insurer’s certification would be reported in the certified classification. Proper classification of such balances is essential to ensure accurate reporting of collateral requirements applicable to specific balances and the corresponding calculation of the liability for unauthorized and/or certified reinsurance.

Index to Schedule F

| Part 1 | Assumed Reinsurance |
| Part 2 | Ceded Reinsurance |

ID Number

Schedule F requires that the “ID Number” be reported for assuming or ceding entities.

Reinsurance intermediaries should not be listed, because Schedule F is intended to identify only risk-bearing entities.

A ceding insurer can have unauthorized reinsurance, certified reinsurance and Reciprocal Jurisdiction reinsurance with the same reinsurer, based on when the contract became effective. It is important that the ceding insurer report all types correctly. The same reinsurer may be listed on the same Schedule S by the ceding insurer with an AIIN for unauthorized reinsurance, a CRIN for certified reinsurance, and a RJIN for Reciprocal Jurisdiction reinsurance.
Use of Federal Employer Identification Number

The Federal Employer Identification Number (FEIN) must be reported for each U.S.-domiciled insurer and U.S. branch of an alien insurer. The FEIN should not be reported as the “ID Number” for other alien insurers even if the federal government has issued such a number.

Alien Insurer Identification Number (AIIN)

In order to report transactions involving alien companies correctly, the appropriate Alien Insurer Identification Number (AIIN) must be included on Schedule F instead of the FEIN. The AIIN number is assigned by the NAIC and is listed in the NAIC Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Pools and Association Numbers

In order to report transactions involving non-risk bearing pools or associations consisting of non-affiliated companies correctly, the company must include on Schedule F the appropriate Pool/Association Identification Number. These numbers are listed in the NAIC Listing of Companies. The NAIC Pool/Association Identification Number should be used instead of any FEIN that may have been assigned. If a pool or association does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Alien pools and associations should be reported on Schedule F under the category “Other Non-U.S. Insurers” rather than under “Pools, Associations and Similar Facilities.” Pools and associations consisting of affiliated companies should be listed by individual company names rather than by pool or association identification.

Certified Reinsurer Identification Number (CRIN)

In order to report transactions involving certified reinsurers correctly, the appropriate Certified Reinsurer Identification Number (CRIN) must be included on Schedule F instead of the FEIN or Alien Insurer Identification Number (AIIN) or Reciprocal Jurisdiction Reinsurer Identification Number (RJIN). The CRIN is assigned by the NAIC and is listed in the NAIC Listing of Companies. If a certified reinsurer does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.
**Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)**

In order to report transactions involving alien companies correctly, the appropriate Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) must be included on Schedule F instead of the FEIN. The RJIN number is assigned by the NAIC and is listed in the NAIC *Listing of Companies*. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**NAIC Company Code**

Company codes are assigned by the NAIC and are listed in the NAIC *Listing of Companies*. The NAIC does not assign a company code to insurers domiciled outside of the U.S. or to non-risk bearing pools or associations. The “NAIC Company Code” field should be zero filled for those organizations. Non-risk bearing pools or associations are assigned a Pool/Association Identification Number. See the “Pool and Association Numbers” section above for details on assignment of Pool/Association Identification Numbers. Risk-bearing pools or associations are assigned a company code. If a reinsurer or reinsured has merged with another entity, report the company code of the surviving entity.

If a risk-bearing entity (e.g., risk-bearing pools or associations) does not appear in the NAIC *Listing of Companies*, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned. Newly assigned company codes are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

**Determination of Authorized Status**

The determination of the authorized, reciprocal jurisdiction, unauthorized or certified status of an insurer or reinsurer listed in any part of Schedule F shall be based on the status of that insurer or reinsurer in the reporting company’s state of domicile.
SCHEDULE F – PART 1

ASSUMED REINSURANCE

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal of the corresponding group, category, or subcategory, with the specified subtotal line appearing in the same manner and location as the pre-printed total or grand total line and number.

Detail Eliminated to Conserve Space

Column 1 — ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

Federal Employer Identification Number (FEIN)
Alien Insurer Identification Number (AIIN)
Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
Certified Reinsurer Identification Number (CRIN)
Pool/Association Identification Number

Detail Eliminated to Conserve Space

SCHEDULE F – PART 2

CEDED REINSURANCE

If a reporting entity has amounts reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, categories, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total line and number.

<table>
<thead>
<tr>
<th>Group or Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Authorized</td>
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</tr>
<tr>
<td>Affiliates</td>
<td></td>
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<tr>
<td>Affiliates – U.S. Intercompany Pooling</td>
<td>0199999</td>
</tr>
<tr>
<td>U.S. Non-Pool</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>0299999</td>
</tr>
<tr>
<td>Other</td>
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</tr>
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<td>Other</td>
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<tr>
<td>Total</td>
<td>0799999</td>
</tr>
<tr>
<td>Total Authorized – Affiliates</td>
<td>0899999</td>
</tr>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td>0999999</td>
</tr>
</tbody>
</table>
### Pools

<table>
<thead>
<tr>
<th>Pools</th>
<th>Total Unauthorized</th>
<th>Total Authorized Excluding Protected Cells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory Pools*</td>
<td>1099999</td>
<td>2799999</td>
</tr>
<tr>
<td>Voluntary Pools*</td>
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<td>2899999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td>1299999</td>
<td>1499999</td>
</tr>
<tr>
<td>Protected Cells</td>
<td>1399999</td>
<td></td>
</tr>
</tbody>
</table>

### Total Unauthorized Affiliates

| U.S. Intercompany Pooling | 1599999 |
| U.S. Non-Pool             |         |
| Captive                   | 1699999 |
| Other                     | 1799999 |
| Total                     | 1899999 |
| Other (Non-U.S.)          |         |
| Captive                   | 1999999 |
| Other                     | 2099999 |
| Total                     | 2199999 |
| Total Unauthorized – Affiliates | 2299999 |

### Other U.S. Unaffiliated Insurers

| Other U.S. Unaffiliated Insurers | 2399999 |
| Pools                             |         |
| Mandatory Pools*                 | 2499999 |
| Voluntary Pools*                 | 2599999 |
| Other Non-U.S. Insurers#         | 2699999 |
| Protected Cells                  | 2799999 |
| Total Unauthorized Excluding Protected Cells (Sum of 2299999, 2399999, 2499999, 2599999 and 2699999) | 2899999 |

### Total Certified Affiliates

| U.S. Intercompany Pooling | 2999999 |
| U.S. Non-Pool             |         |
| Captive                   | 3099999 |
| Other                     | 3199999 |
| Total                     | 3299999 |
| Other (Non-U.S.)          |         |
| Captive                   | 3399999 |
| Other                     | 3499999 |
| Total                     | 3599999 |
| Total Certified – Affiliates | 3699999 |

### Other U.S. Unaffiliated Insurers

| Other U.S. Unaffiliated Insurers | 3799999 |
| Pools                             |         |
| Mandatory Pools*                 | 3899999 |
| Voluntary Pools**                | 3999999 |
| Other Non-U.S. Insurers#         | 4099999 |
| Protected Cells                  | 4199999 |
| Total Certified Excluding Protected Cells (Sum of 3699999, 3799999, 3899999, 3999999 and 4099999) | 4299999 |
## Total Reciprocal Jurisdiction

### Affiliates

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<th>Category</th>
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<tbody>
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<td>Other</td>
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<td>Other</td>
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</table>

### Total Reciprocal Jurisdiction – Affiliates

<table>
<thead>
<tr>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>5099999</td>
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</tbody>
</table>

### Other U.S. Unaffiliated Insurers

<table>
<thead>
<tr>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>5199999</td>
</tr>
</tbody>
</table>

### Pools

<table>
<thead>
<tr>
<th>Category</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory Pools*®</td>
<td>5299999</td>
</tr>
<tr>
<td>Voluntary Pools*®</td>
<td>5399999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td>5499999</td>
</tr>
<tr>
<td>Protected Cells</td>
<td>5599999</td>
</tr>
</tbody>
</table>

### Total Reciprocal Jurisdiction Excluding Protected Cells (Sum of 5099999, 5199999, 5299999, 5399999, and 5499999)

<table>
<thead>
<tr>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>5699999</td>
</tr>
</tbody>
</table>

### Total Authorized Reciprocal Jurisdiction, Unauthorized and Certified Excluding Protected Cells (Sum of 1499999, 2899999, 4299999, and 4299999)

<table>
<thead>
<tr>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>4399999579999</td>
</tr>
</tbody>
</table>

### Total Protected Cells (Sum of 1399999, 2799999, 4199999, and 4199999)

<table>
<thead>
<tr>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>4499999589999</td>
</tr>
</tbody>
</table>

### Totals (Sum of 4399999, 5799999, and 4499999589999)

<table>
<thead>
<tr>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>9999999</td>
</tr>
</tbody>
</table>

* Pools and Associations consisting of affiliated companies should be listed by individual company names.

# Alien Pools and Associations should be reported on Schedule F under the category “Other Non-U.S. Insurers.”

### Column 1 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

---

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SUPPLEMENTAL TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE EXHIBIT

PART 1 – ALL CESSIONS OF TERM AND UNIVERSAL LIFE INSURANCE WITH SECONDARY GUARANTEES

<table>
<thead>
<tr>
<th>Column 2</th>
<th>ID Number</th>
</tr>
</thead>
</table>

Enter one of the following as appropriate for the assuming insurer reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)

SUPPLEMENTAL TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE EXHIBIT

PART 2A – TRANSACTIONS SUBJECT TO PART 2 DISCLOSURE (GRANDFATHERED OR SPECIAL EXEMPTION)

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Cession ID</th>
</tr>
</thead>
</table>

Enter a unique Cession ID for each line (01 – 99).

<table>
<thead>
<tr>
<th>Column 2</th>
<th>NAIC Company Code</th>
</tr>
</thead>
</table>

Provide the NAIC code of the assuming insurer.

<table>
<thead>
<tr>
<th>Column 3</th>
<th>ID Number</th>
</tr>
</thead>
</table>

Enter one of the following as appropriate for the assuming insurer being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
SUPPLEMENTAL TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE EXHIBIT

PART 2B – TRANSACTIONS SUBJECT TO PART 2 DISCLOSURE
(NON-GRANDFATHERED)

Column 1 – Cession ID

Enter a unique Cession ID for each line (01 – 99).

To differentiate between cessions that contain risks subject to the provisions of AG48 and those that contain risks subject to the provisions of a state regulation equivalent to Model #787, append an A or B after the cession ID.

In the event that a cession contains risks subject to both the provisions of AG48 and the provisions of a state regulation equivalent to Model #787, the reporting of the cession shall be bi-furcated accordingly and listed on two distinct lines.

Use “A” for cessions that contain risks subject to the provisions of AG48.

Use “B” for cessions that contain risks subject to the provisions of a state regulation.

Column 2 – NAIC Company Code

Provide the NAIC code of the assuming insurer.

Column 3 – ID Number

Enter one of the following as appropriate for the assuming insurer being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

Federal Employer Identification Number (FEIN)
Alien Insurer Identification Number (AIIN)
Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
Certified Reinsurer Identification Number (CRIN)

Detail Eliminated to Conserve Space
ANNUAL STATEMENT INSTRUCTIONS – PROPERTY AND TITLE

NOTES TO FINANCIAL STATEMENTS

Notes to the Annual Statement are to be filed on March 1.

Detail Eliminated to Conserve Space

23. Reinsurance

Instruction:

A. Unsecured Reinsurance Recoverables

If the company has with any individual reinsurers (authorized, reciprocal jurisdiction, unauthorized or certified), an unsecured aggregate recoverable for losses, paid and unpaid including IBNR, loss adjustment expenses, and unearned premium that exceeds 3% of the company’s policyholder surplus, list each individual reinsurer and the unsecured aggregate recoverable pertaining to that reinsurer. If the individual reinsurer is part of a group, list the individual reinsurers, each of its related group members having reinsurance with the reporting company, and the total unsecured aggregate recoverables for the entire group.

Include: The NAIC group code number, where appropriate, and the Federal Employer Identification Number for each individual company.

Detail Eliminated to Conserve Space

F. Retroactive Reinsurance

(1) Provide the following information for all retroactive reinsurance agreements that transfer liabilities for losses that have already occurred and that will generate special surplus transactions:

Detail Eliminated to Conserve Space

f. List the total Paid Loss/LAE amounts recoverable (for authorized, reciprocal jurisdiction, unauthorized and certified reinsurers), any amounts more than 90 days overdue (for authorized, reciprocal jurisdiction, unauthorized and certified reinsurers) and for amounts recoverable the collateral held (for unauthorized and certified reinsurers).

The insurer (assuming or ceding) shall assign a unique number to each retroactive reinsurance agreement and shall utilize this number for as long as the agreement exists. Do not report transactions utilizing deposit accounting in this note.
Illustration:

A. Unsecured Reinsurance Recoverables

The Company does not have an unsecured aggregate recoverable for losses, paid and unpaid including IBNR, loss adjustment expenses and unearned premium with any individual reinsurers, authorized or unauthorized, that exceeds 3% of the Company’s policyholder surplus.

**Detail Eliminated to Conserve Space**

**THIS EXACT FORMAT MUST BE USED IN THE PREPARATION OF THIS NOTE FOR THE TABLE BELOW. REPORTING ENTITIES ARE NOT PRECLUDED FROM PROVIDING CLARIFYING DISCLOSURE BEFORE OR AFTER THIS ILLUSTRATION.**

F. Retroactive Reinsurance

(1) Reported Company

**Detail Eliminated to Conserve Space**

f. Total Paid Loss/LAE amounts recoverable (for authorized, reciprocal jurisdiction, unauthorized and certified reinsurers), any amounts more than 90 days overdue (for authorized, reciprocal jurisdiction, unauthorized and certified reinsurers), and for amounts recoverable the collateral held (for authorized, reciprocal jurisdiction, unauthorized and certified reinsurers) as respects amounts recoverable from authorized, reciprocal jurisdiction, unauthorized and certified reinsurers:

1. Authorized Reinsurers

<table>
<thead>
<tr>
<th>Company</th>
<th>Total Paid/Loss/LAE Recoverable</th>
<th>Amounts Over 90 Days Overdue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>$</td>
<td>$</td>
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<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Total</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

2. Unauthorized Reinsurers

<table>
<thead>
<tr>
<th>Company</th>
<th>Total Paid/Loss/LAE Recoverable</th>
<th>Amounts Over 90 Days Overdue</th>
<th>Collateral Held</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
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<td>$</td>
</tr>
<tr>
<td>Total</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
### 3. Certified Reinsurers

<table>
<thead>
<tr>
<th>Company</th>
<th>Total Amounts Paid/Loss/LAE Recoverable</th>
<th>Amounts Over 90 Days Overdue</th>
<th>Collateral Held</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

### 4. Reciprocal Jurisdiction Reinsurers

<table>
<thead>
<tr>
<th>Company</th>
<th>Total Amounts Paid/Loss/LAE Recoverable</th>
<th>Amounts Over 90 Days Overdue</th>
<th>Collateral Held</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Detail Eliminated to Conserve Space
ANNUAL & QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY & TITLE

SCHEDULE Y

PART 1A – DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

All insurer and reporting entity members of the holding company system shall prepare a schedule for inclusion in each of the individual annual statements that is common for the group with the exception of Column 10, Relationship to Reporting Entity.

--- Detail Eliminated to Conserve Space ---

Column 4  –  ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F (Property and Title) or Schedule S (Life, Health and Fraternal) General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN) *
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) *
- Certified Reinsurer Identification Number (CRIN) *

* RJIN, AIINs or CRINs are only reported if the entity in Column 8 is a reinsurer that has had an RJIN, AIIN or CRIN number assigned or should have one assigned due to transactions being reported on Schedule F (Property and Title) or Schedule S (Life, Health and Fraternal) of another entity regardless of whether the entity in Column 8 is part of reporting entity’s group.

If not applicable for the entity in Column 8, leave blank.

--- Detail Eliminated to Conserve Space ---
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE Y

PART 2 – SUMMARY OF INSURER’S TRANSACTIONS WITH ANY AFFILIATES

This schedule was designed to provide an overview of transactions among insurance holding company system members. It is intended to demonstrate the scope and direction of major fund and/or surplus flows throughout the system. This schedule should be prepared on an accrual basis.

Detail Eliminated to Conserve Space

Column 2 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F (Property and Title) or Schedule S (Life, Health and Fraternal) General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN) *
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) *
- Certified Reinsurer Identification Number (CRIN) *

* RJIN, AIIN or CRIN numbers are only reported if the entity in Column 3 is a reinsurer that has had an RJIN, AIIN or CRIN number assigned or should have one assigned due to transactions being reported on Schedule F (Property and Title) or Schedule S (Life, Health and Fraternal) of another entity regardless of whether the entity in Column 3 is part of reporting entity’s group or not.

If not applicable for the entity in Column 3, leave blank.

Detail Eliminated to Conserve Space
SCHEDULE D – PART 6 – SECTION 1

VALUATION OF SHARES OF SUBSIDIARY, CONTROLLED OR AFFILIATED COMPANIES

If a reporting entity has any common stock or preferred stock reported for any of the following required categories or subcategories, it shall report the subtotal amount of the corresponding category or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

Column 5 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F (Property and Title) or Schedule S (Life, Health and Fraternal) General Instructions for more information on these identification numbers.

Federal Employer Identification Number (FEIN)
Alien Insurer Identification Number (AIIN) *
Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) *
Certified Reinsurer Identification Number (CRIN) *

* RJIN, AIINs or CRINs are only reported if the entity is a reinsurer that has had an RJIN, AIIN or CRIN number assigned or should have one assigned due to transactions being reported on Schedule F (Property and Title) or Schedule S (Life, Health and Fraternal) of another reporting entity.

If not applicable for the entity, leave blank.
ANNUAL AND QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

TRUSTEED SURPLUS STATEMENT

Page 3

Line 1 – Total Liabilities

Should agree with the amount reported on Page 3, Line 28 of the quarterly statement.

Line 4 – Amounts Recoverable From Reinsurers

Line 4.1 – Authorized Companies

Include: Any reinsurance recoverable on paid losses from authorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.

Line 4.2 – Unauthorized Companies

Include: Any reinsurance recoverables on paid losses from unauthorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.

Line 4.3 – Certified Companies

Include: Any reinsurance recoverable on paid losses from certified companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.

Line 4.4 – Reciprocal Jurisdiction Companies

Include: Any reinsurance recoverable on paid losses from Reciprocal Jurisdiction companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.
ANNUAL AND QUARTERLY STATEMENT INSTRUCTIONS – PROPERTY

TRUSTEED SURPLUS STATEMENT

Page 3

Line 1 – Total Liabilities

Should agree with the amount reported on Page 3, Line 28 of the quarterly statement.

Line 7 – Reinsurance Recoverable on Paid Losses and Loss Adjustment Expenses

Line 7.1 – Authorized Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from authorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.

Line 7.2 – Unauthorized Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from unauthorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.

Line 7.3 – Certified Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from certified companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.

Line 7.4 – Reciprocal Jurisdiction Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from reciprocal jurisdiction companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.
**QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL AND HEALTH**

**SCHEDULE S – CEDED REINSURANCE**

SHOWING ALL NEW REINSURANCE TREATIES – CURRENT YEAR TO DATE

<table>
<thead>
<tr>
<th>Column 1</th>
<th>NAIC Company Code</th>
</tr>
</thead>
</table>

Company codes are assigned by the NAIC and are listed in the NAIC *Listing of Companies*. The NAIC does not assign a company code to insurers domiciled outside of the U.S. or to non-risk bearing pools or associations. The “NAIC Company Code” field should be zero-filled for those organizations. Non-risk bearing pools or associations are assigned a Pool/Association Identification Number. See the instruction for Column 2 for details on assignment of Pool/Association Identification Numbers. Risk bearing pools or associations are assigned a company code. If a reinsurer or reinsured has merged with another entity, report the company code of the surviving entity.

If a risk bearing entity (e.g., risk bearing pools or associations) does not appear in the NAIC *Listing of Companies*, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned. Newly assigned company codes are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

<table>
<thead>
<tr>
<th>Column 2</th>
<th>ID Number</th>
</tr>
</thead>
</table>

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions in the annual statement instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

**Federal ID Number (FEIN)**

The Federal Employer Identification Number (FEIN) must be reported for each U.S.-domiciled insurer and U.S. branch of an alien insurer. The FEIN should not be reported as the “Federal ID Number” for other alien insurers even if the federal government has issued such a number.

**Alien Insurer Identification Number (AIIN)**

In order to report transactions involving alien companies correctly, the appropriate Alien Insurer Identification Number (AIIN) must be included on Schedule S instead of the FEIN. The AIIN number is assigned by the NAIC and is listed in the NAIC *Listing of Companies*. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.
Pool and Association Numbers

In order to report transactions involving non-risk bearing pools or associations consisting of non-affiliated companies correctly, the company must include on Schedule S the appropriate Pool/Association Identification Number. These numbers are listed in the NAIC Listing of Companies. The Pool/Association Identification Number should be used instead of any FEIN that may have been assigned. If a pool or association does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semiannually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

Certified Reinsurer Identification Number (CRIN)

In order to report transactions involving certified reinsurers correctly, the appropriate Certified Reinsurer Identification Number (CRIN) must be included on Schedule S instead of the FEIN, or Alien Insurer Identification Number (AIIN) or Reciprocal Jurisdiction Reinsurer Identification Number (RJIN). The CRIN is assigned by the NAIC and is listed in the NAIC Listing of Companies. If a certified reinsurer does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)

In order to report transactions involving alien companies correctly, the appropriate Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) must be included on Schedule S instead of the FEIN. The RJIN number is assigned by the NAIC and is listed in the NAIC Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Column 7 – Type of Reinsurer

The determination of the authorized, certified or unauthorized status of an insurer or reinsurer shall be based on the status of that insurer or reinsurer in the reporting company’s state of domicile.

Enter “Authorized” “Reciprocal Jurisdiction” “Certified” or “Unauthorized” to indicate the type of reinsurer.
QUARTERLY STATEMENT INSTRUCTIONS – PROPERTY AND TITLE

SCHEDULE F – CEDED REINSURANCE

SHOWING ALL NEW REINSURERS – CURRENT YEAR TO DATE

Detail Eliminated to Conserve Space

Column 1 – NAIC Company Code

Company codes are assigned by the NAIC and are listed in the NAIC Listing of Companies. The NAIC does not assign a company code to insurers domiciled outside of the U.S. or to non-risk bearing pools or associations. The “NAIC Company Code” field should be zero-filled for those organizations. Non-risk bearing pools or associations are assigned a Pool/Association Identification Number. See the instruction for Column 2 for details on assignment of Pool/Association Identification Numbers. Risk bearing pools or associations are assigned a company code. If a reinsurer or reinsured has merged with another entity, report the company code of the surviving entity.

If a risk bearing entity (e.g., risk bearing pools or associations) does not appear in the NAIC Listing of Companies, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned. Newly assigned company codes are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

Column 2 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions in the annual statement instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

Federal ID Number (FEIN)

The Federal Employer Identification Number (FEIN) must be reported for each U.S.-domiciled insurer and U.S. branch of an alien insurer. The FEIN should not be reported as the “ID Number” for other alien insurers even if the federal government has issued such a number.

Alien Insurer Identification Number (AIIN)

In order to report transactions involving alien companies correctly, the appropriate Alien Insurer Identification Number (AIIN) must be included on Schedule F instead of the FEIN. The AIIN number is assigned by the NAIC and is listed in the Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semiannually. The NAIC provides this information to annual statement software vendors for incorporation into the software.
Pool and Association Numbers

In order to report transactions involving non-risk bearing pools or associations consisting of non-affiliated companies correctly, the company must include on Schedule F the appropriate Pool/Association Identification Number. These numbers are listed in the NAIC Listing of Companies. The Pool/Association Identification Number should be used instead of any FEIN that may have been assigned. If a pool or association does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semiannually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

Certified Reinsurer Identification Number (CRIN)

In order to report transactions involving certified reinsurers correctly, the appropriate Certified Reinsurer Identification Number (CRIN) must be included on Schedule F instead of the FEIN or Alien Insurer Identification Number (AIIN) or Reciprocal Jurisdiction Reinsurer Identification Number (RJIN). The CRIN is assigned by the NAIC and is listed in the NAIC Listing of Companies. If a certified reinsurer does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)

In order to report transactions involving alien companies correctly, the appropriate Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) must be included on Schedule F instead of the FEIN. The RJIN number is assigned by the NAIC and is listed in the NAIC Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Column 5 — Type of Reinsurer

The determination of the authorized, certified or unauthorized status of an insurer or reinsurer shall be based on the status of that insurer or reinsurer in the reporting company’s state of domicile.

Enter “Authorized” “Reciprocal Jurisdiction” “Certified” or “Unauthorized” to indicate the type of reinsurer.
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NAIC Proceedings – Fall 2019
10-1015

Attachment Ten
Reinsurance (E) Task Force
12/8/19


## OPERATIONS AND INVESTMENT EXHIBIT

**PART 2B – UNPAID LOSSES AND LOSS ADJUSTMENT EXPENSES**

<table>
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<th>1. Loss and allocated LAE reserve for title and other losses of which notice has been received:</th>
<th>2. Deduct reinsurance recoverable from authorized, unauthorized and certified companies (Schedule P, Part 1, Line 12, Col. 19)</th>
<th>3. Known claims reserve net of reinsurance (Line 1.1 plus Line 1.2 minus Line 2)</th>
<th>4. Incurred But Not Reported:</th>
<th>5. Unallocated LAE reserve (Schedule P, Part 1, Line 12, Col. 23)</th>
<th>6. Less discount for time value of money, if allowed (Schedule P, Part 1, Line 12, Col. 33)</th>
<th>7. Total Schedule P reserves (Lines 3 + 4.4 + 5 - 6) (Schedule P, Part 1, Line 12, Col. 34)</th>
<th>8. Statutory premium reserve at year end (Part 1B, Line 2.6).</th>
<th>9. Aggregate of other reserves required by law (Page 3, Line 3)</th>
<th>10. Supplemental reserve (a) (Lines 7 - (3 + 8 + 9))</th>
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<td>Direct Operations</td>
<td>Non-Affiliated Agency Operations</td>
<td>Affiliated Agency Operations</td>
<td>Total Current Year (Cols. 1+2+3)</td>
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1.1 Direct (Schedule P, Part 1, Line 12, Col. 17) ........................................................  
1.2 Reinsurance assumed (Schedule P, Part 1, Line 12, Col. 18) ........................................................  
2. Net incurred but not reported (Line 4.1 plus Line 4.2 minus Line 4.3)  
4.3 Reinsurance ceded (Schedule P, Part 1, Line 12, Col. 22)  
4.4 Net incurred but not reported (Line 4.1 plus Line 4.2 minus Line 4.3)  
5. Unallocated LAE reserve (Schedule P, Part 1, Line 12, Col. 23)  
7. Total Schedule P reserves (Lines 3 + 4.4 + 5 - 6) (Schedule P, Part 1, Line 12, Col. 34)  
8. Statutory premium reserve at year end (Part 1B, Line 2.6).  
9. Aggregate of other reserves required by law (Page 3, Line 3)  
10. Supplemental reserve (a) (Lines 7 - (3 + 8 + 9))

(a) If the sum of Lines 3 + 8 + 9 is greater than Line 7, place a "0" in this Line.
## ANNUAL AND QUARTERLY STATEMENT BLANK – LIFE/FRATERNAL

### TRUSTEED SURPLUS STATEMENT

#### LIABILITIES AND TRUSTEED SURPLUS

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### ADDITIONS TO LIABILITIES:

1. Total Liabilities
2. Aggregate write-ins for additions to liabilities
3. Total (Lines 1 + 2)

### DEDUCTIONS FROM LIABILITIES:

4. Amounts Recoverable From Reinsurers:
   4.1 Authorized Companies
   4.2 Unauthorized Companies
   4.3 Certified Companies
   4.4 Reciprocal Jurisdiction Companies

5. Special State Deposits, not exceeding net liabilities carried:
   5.1 Special State Deposits (submit schedule)
   5.2 Accrued interest on special state deposits
   6. Life insurance premiums and annuity considerations deferred and uncollected
   7. Accident and health premiums due and unpaid
   8. Contract loans and premium notes:
      8.1 Contract loans not exceeding reserves carried on such policies
      8.2 Premium notes
      8.3 Interest due and accrued on contract loans and premium notes
   9. Aggregate write-ins for other deductions from liabilities

10. Total Deductions (Lines 4.1 thru 9)
11. Total Adjusted Liabilities (Line 3 minus Line 10)
12. Trusteed Surplus
13. Total

### DETAILS OF WRITE-INS

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<tr>
<td>0902.</td>
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<tr>
<td>0903.</td>
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<td>0998.</td>
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<tr>
<td>0999.</td>
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</tr>
</tbody>
</table>

### INTERROGATORIES:

1.1 Have there been any changes made to any of the trust indentures during the period? Yes [ ] No [ ]

1.2 If yes, has the domiciliary or entry state approved the change? Yes [ ] No [ ]
## TRUSTEED SURPLUS STATEMENT
### LIABILITIES AND TRUSTEED SURPLUS

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Liabilities</td>
<td></td>
</tr>
<tr>
<td>2. Ceded Reinsurance Balances Payable</td>
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</tr>
<tr>
<td>3. Agents' Credit Balances</td>
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<tr>
<td>4. Aggregate Write-ins For Other Additions to Liabilities</td>
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<tr>
<td>5. Total Additions (Lines 2 + 3 + 4)</td>
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<tr>
<td>6. Total (Lines 1 + 5)</td>
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<tr>
<td><strong>DEDUCTIONS FROM LIABILITIES:</strong></td>
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<tr>
<td>7. Reinsurance Recoverable on Paid Losses and Loss Adjustment Expenses:</td>
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<tr>
<td>7.1 Authorized Companies</td>
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<td>7.2 Unauthorized Companies</td>
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<tr>
<td>7.3 Certified Companies</td>
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</tr>
<tr>
<td>7.4 Reciprocal Jurisdiction Companies</td>
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</tr>
<tr>
<td>8. Special State Deposits, not exceeding net liabilities carried in this statement on business in each respective state:</td>
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</tr>
<tr>
<td>8.1 Special State Deposits (submit schedule)</td>
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<tr>
<td>8.2 Accrued interest on Special State Deposits</td>
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<tr>
<td>9. Agents' balances or uncollected premiums not more than ninety days past due, not exceeding unearned premium reserves carried thereon</td>
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</tr>
<tr>
<td>10. Unpaid Reinsurance Premiums Receivable, not exceeding losses and loss adjustment expenses due to reinsured:</td>
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</tr>
<tr>
<td>10.1 Authorized Companies</td>
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<td>10.2 Unauthorized Companies</td>
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<td>11. Aggregate write-ins for other deductions from liabilities</td>
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<td>12. Total Deductions (Lines 7 thru 11)</td>
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<td>13. Total Adjusted Liabilities (Line 6 minus Line 12)</td>
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<td>14. Trusted Surplus</td>
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<td>15. Total</td>
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### DETAILS OF WRITE-INS

<table>
<thead>
<tr>
<th>Item</th>
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<tr>
<td>0401.</td>
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<td>0402.</td>
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<td>0403.</td>
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<td>0498. Summary of remaining write-ins for Line 4 from overflow page</td>
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<td>1101.</td>
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<td>1102.</td>
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<td>1103.</td>
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<td>1198. Summary of remaining write-ins for Line 11 from overflow page</td>
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<td>1199. Totals (Lines 1101 thru 1103 plus 1198) (Line 11 above)</td>
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</tbody>
</table>

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Risk Retention Group (E) Task Force  
Austin, Texas  
December 7, 2019

The Risk Retention Group (E) Task Force met in Austin, TX, Dec. 7, 2019. The following Task Force members participated: Michael S. Pieciak, Chair, represented by Christine Brown (VT); Stephen C. Taylor, Vice Chair, represented by Sean O’Donnell (DC); Nancy G. Atkins represented by Sandy Batts (KY); James J. Donelson represented by Stewart Guerin (LA); Matthew Rosendale represented by Steve Matthews (MT); Glen Mulready represented by Eli Snowbarger (OK); and Raymond G. Farmer represented by Lee Hill (SC).

1. **Adopted its Oct. 7 Minutes**

Mr. Hill made a motion, seconded by Mr. O’Donnell, to adopt the Task Force’s Oct. 7 minutes (Attachment One). The motion passed unanimously.

2. **Adopted the FAQ Document and Best Practices Document**

Ms. Brown stated that over the past year, the Task Force has been working diligently to provide additional guidance to both state insurance regulators and industry regarding the registration process for risk retention groups (RRGs) in non-domestic states. The process started last year with a letter from the National Risk Retention Association (NRRA) citing concerns regarding fees and delays in the review of registration forms. The discussion that followed also raised concerns from non-domiciliary states, such as incomplete registration forms or potentially non-compliant RRGs.

As a result, a drafting group was formed to develop three documents: “Risk Retention Groups: Frequently Asked Questions” (FAQ document); “Best Practices: Risk Retention Groups” (Best Practices document); and the NAIC Uniform Risk Retention Group Registration Form (Registration Form). These documents were exposed for public comment at the Summer National Meeting, and several comment letters were received. The comment letters were discussed during the Task Force’s Oct. 7 conference call where there was agreement on many of the issues, but a few outstanding items were referred back to the drafting group for additional consideration.

The drafting group provided its input, and the FAQ document, the Best Practices document and the Registration Form were exposed again. During that exposure period, three comment letters were received from the District of Columbia (comments incorporated into Attachment Two and Attachment Three), the NRRA (Attachment Four) and the Vermont Captive Insurance Association (VCIA) (Attachment Five).

Becky Meyer (NAIC) summarized the recommendations from the drafting group, as noted in the FAQ document and the Best Practices document.

Mr. O’Donnell made a motion, seconded by Mr. Hill, to adopt the FAQ document (Attachment Two) and the Best Practices document (Attachment Three), including the suggestions as noted by comment bubbles in each document. The motion passed unanimously.

3. **Adopted a Referral to the Property and Casualty Insurance (C) Committee to Consider Proposed Revisions to the Registration Form**

Ms. Brown stated that the Registration Form is a little different than the FAQ document and the Best Practices document because the proposal is for changes to an existing document rather than creating something new. This document is housed in the Risk Retention and Purchasing Group Handbook (Handbook). This Handbook is overseen by the Property and Casualty Insurance (C) Committee. Therefore, any changes to the Registration Form adopted by the Task Force will be referred to the Property and Casualty Insurance (C) Committee for consideration.

Ms. Meyer summarized the recommendations from the drafting group as noted on the Registration Form.

Mr. Snowbarger made a motion, seconded by Mr. Matthews, to adopt the referral to the Property and Casualty Insurance (C) Committee to the Registration Form, including the revisions proposed by the drafting group (Attachment Six). The motion passed unanimously.
4. Discussed its Next Steps

Ms. Brown noted that it is encouraging that the items the Task Force just adopted touch on many of the concerns identified earlier in the year. However, there are still several other areas that can be worked on and the areas of highest importance for the Task Force, interested state insurance regulators and interested parties can be decided.

Skip Myers (NRRA) stated that within the coming months, the impact of these three documents and whether they are working as intended should be seen. If not, they may need to be tweaked. He also noted the importance of the role of the state of domicile to resolve any issues, if necessary. He stated that he was sure that these forms would be referred to frequently by the industry, and he mentioned taking steps in the future to include the issues in an NAIC model or as part of the Handbook, which is something that is referred to by the industry frequently.

Chrys D. Lemon (VCIA) noted that the adoption of these items are important to the industry and regulation, noting that he looks forward to ongoing discussions.

Ms. Brown stated that one of the main goals is to quantify and monitor how helpful these documents are to facilitate discussions between the states and alleviate the questions and concerns that non-domiciliary states have. One item that is not mentioned in the summary, but is important, is monitoring and training on the information developed this year, such as conducting a webinar, working with some of the states’ captive insurance associations, and getting feedback from the NRRA. When the Task Force reconvenes in 2020, she suggested it may consider ways to further spread information and the concepts included in the FAQ document and the Best Practices document. When talking about next steps, the Task Force should keep with the spirit of the federal Liability Risk Retention Act (LRRA). As Mr. Myers mentioned, she said the Task Force should also try to incorporate some of the best practices into the Handbook

Mr. Hill noted that it is difficult to put the next steps in a priority order, and he asked that NRRA and others that have raised the issues that led to these discussions review the list of concerns and be prepared to provide input to the Task Force once more information is gathered on the impact of the items adopted.

Mr. O’Donnell noted that the Task Force will need to consider how to distribute the FAQ document and the Best Practices document, as well as the revised Registration Form, to all the states and RRGs.

Having no further business, the Risk Retention Group (E) Task Force adjourned.
Risk Retention Group (E) Task Force
Conference Call
October 7, 2019

The Risk Retention Group (E) Task Force met via conference call Oct. 7, 2019. The following Task Force members participated: Michael S. Pieciak, Chair, represented by Sandra Bigglestone (VT); Stephen C. Taylor, Vice Chair, represented by Sean O’Donnell (DC); Nancy G. Atkins represented by Sandy Batt (KY); James J. Donelon represented by Stewart Guerin (LA); Matthew Rosendale represented by Steve Matthews (MT); Barbara D. Richardson represented by Kathy Kelley (NV); Glen Mulready represented by Joel Sander (OK); and Raymond G. Farmer represented by Michael Shull (SC). Also participating was: John Talley (MO).

1. Adopted its May 8 and Summer National Meeting Minutes

Mr. Shull made a motion, seconded by Mr. O’Donnell, to adopt the Task Force’s May 8 (Attachment One-A) and Aug. 3 (see NAIC Proceedings – Summer 2019, Risk Retention Group (E) Task Force) minutes. The motion passed unanimously.

2. Adopted its 2020 Proposed Charges

Ms. Bigglestone stated that a new charge is proposed for 2020 to better align with the ongoing work the Task Force is doing to address questions raised related to the registration of risk retention groups (RRGs) in non-domestic states. Overall, the focus for the next year will be to monitor the progress of the work the Task Force has done so far on this issue. The Task Force will then consider how effective the guidance and information is, provide training on the guidance and information, and ultimately determine if there is more work that needs to be done based on feedback received.

Mr. Matthews made a motion, seconded by Ms. Batts, to adopt the Task Force’s 2020 proposed charges (Attachment One-B). The motion passed unanimously.


Ms. Bigglestone stated that the three documents that were exposed—“Risk Retention Groups: Frequently Asked Questions” (FAQ document) (Attachment One-C), “Best Practices: Risk Retention Groups” (Best Practices document) (Attachment One-D) and the NAIC Uniform Risk Retention Group Registration Form (Registration Form) (Attachment One-E)—were developed as a result of concerns raised by both industry and non-domestic states about the registration process for RRGs in non-domestic states.

A total of seven comment letters were received from: District of Columbia; Nevada; Pennsylvania; the National Risk Retention Association (NRRA); the Nonprofits Insurance Alliance; the Vermont Captive Insurance Association (VCIA); and Premier Insurance Management Services (Attachment One-F).

All comments as shown on the three documents were agreed to by the Task Force with the exception of the following: 1) discussion on the FAQ document of what constitutes a “complete” registration form; 2) inclusion of biographical affidavits for all board members on the best practices listing of items provided to the domestic state; and 3) comments on the registration form related to items 7, 17 and 19. These items require more discussion and have been sent back to the drafting group to recommend a solution to the Task Force. This recommendation will then be exposed for a public comment period prior to the Fall National Meeting.

In addition to the comments discussed, Mr. Talley raised a question about handling the registration for an RRG in a hazardous financial condition or that is otherwise non-compliant.

Robert H. Myers Jr. (NRRA) referenced the remedies put forth in Section 3902(a)1 of the Liability Risk Retention Act (LRRRA). He also mentioned the importance of communication with the domestic state.

Having no further business, the Risk Retention Group (E) Task Force adjourned.
The Risk Retention Group (E) Task Force met via conference call May 8, 2019. The following Task Force members participated: Michael S. Pieciak, Chair, represented by Sandra Bigglestone (VT); Stephen C. Taylor, Vice Chair, represented by Sean O’Donnell and Dana Sheppard (DC); Colin M. Hayashida represented by Andrew Kurata (HI); Nancy G. Atkins represented by Sandy Batts (KY); James J. Donelon represented by Bill Werner (LA); Matthew Rosendale represented by Steve Matthews (MT); John G. Franchini represented by Anna Krylova (NM); Barbara D. Richardson represented by Peter Rao (NV); Glen Mulready represented by Joel Sander (OK); and Raymond G. Farmer represented by Michael Shull (SC). Also participating were: Janet Grace (CT); Kathleen Orth (MN); and Barbara Kluger (NY).

1. Discussed Summary of Concerns Regarding Registration of RRGs in Non-Domiciliary States

Ms. Bigglestone stated that a list of concerns/issues regarding non-domiciliary state registration actions, along with potential action items, has been developed to guide the work of the Task Force. She said the list includes concerns raised by the National Risk Retention Association (NRRA) and non-domiciliary states responsible for registering risk retention groups (RRGs). Becky Meyer (NAIC) summarized the list of concerns (Attachment One-A1).

Ms. Bigglestone noted that the list includes concerns of fees and delayed registration time frames presented by the NRRA. It also includes concerns voiced by non-domiciliary states such as incomplete, inaccurate or even non-compliant registrations. The possible action items include short-term solutions such as a frequently asked questions (FAQ) document or updates to the registration form, as well as long-term solutions such as updates to Part D—Organization, Licensing and Change of Control of a Domestic Insurer (Part D) of the Financial Regulation Standards and Accreditation Program or updates to the Model Risk Retention Act (#705).

Ms. Bigglestone stated that it could be beneficial to start work on items that can make the most impact in a short amount of time such as an FAQ document or updating the registration form, then the Task Force could move to more in-depth solutions as needed. She noted that some solutions could be developed by the Task Force while others, such as opening Model #705 for revisions, would require referrals to other NAIC groups.

Robert H. Myers Jr. (NRRA) said there appears to be some confusion about the federal Liability Risk Retention Act (LRRA). The LRRA was designed to give authority to the domestic state; therefore, it does not preempt the domestic state’s ability to regulate an RRG. Consequently, when a non-domestic state has a question or issue, it should be able to contact the domestic state. Because this communication may be a key to mitigating many of the issues summarized, the Task Force may consider starting its work by developing best practices for communication between the domestic and non-domestic state insurance regulators.

Ms. Bigglestone stated that she has seen questionnaires sent from a non-domestic state to a domestic state that appear helpful in gathering information, and they may be a starting point for the Task Force to develop best practices. She also stated that the Task Force could consider drafting guidance for filling out the registration form to further help ensure that information is appropriately shared and received.

Mr. O’Donnell agreed with taking a look at the registration form, and he suggested that the registration form may need to be updated to provide contact information for the domestic state insurance regulator overseeing the RRG. He noted that there is sometimes confusion about what information should be provided to the non-domiciliary state in accordance with the LRRA, and he suggested that updates to the registration form could provide clarity.

Ms. Kluger agreed that updates to the registration form could facilitate speeding up the registration process. She provided the example that sometimes there is confusion about the type of coverage being offered by the RRG and its compliance with the LRRA; if this is clear upfront, she believes delays in registrations may be reduced.
Ms. Bigglestone noted that there are differences between a new RRG registering in other states and an existing RRG that decides to expand to other states. For those RRGs expanding, it is possible that the original feasibility study that must be provided to the non-domiciliary state under the LRRA may not be useful if the business plan has changed. Therefore, the Task Force should consider what information the domiciliary state should be responsible for providing, as the domiciliary state should be aware of any changes in business plan and any expansion activity (which is, in itself, a change in business plan).

Mr. Matthews agreed that communication with the domiciliary state is important, and he suggested that the Task Force consider whether including contact information for the domiciliary state insurance regulator is sufficient or if it should go a step further and request that a statement from the domiciliary state insurance regulator be included with the registration form.

Ms. Orth stated that one concern is when a registration form is received from an RRG that is in a weak financial state and there are concerns of ongoing solvency. She questioned if a statement from the domestic state would remedy the issue or if other steps would be needed. Ms. Bigglestone agreed that situations would vary, and the concept of best practices for a system of communication could contemplate a variety of scenarios.

Mr. Sheppard stated that the ability to trust and rely on other states is a core element of the regulatory system. To help support this system of trust, he recommended reviewing Model #705 and updating it, if needed, including elements from Model #705 in Part B—Regulatory Practices and Procedures (Part B) of the Financial Regulation Standards and Accreditation Program, as well as subjecting RRGs to Part D of the accreditation program.

Ms. Grace stated that the domestic state must take responsibility for sound regulation of the licensing process for RRGs. One challenge with this system is that the RRG may write little to no business in the domestic state, lowering the priority for the domestic state as it focuses on companies with policyholders in its state.

Ms. Meyer stated that subjecting RRGs to Part D of the accreditation program could encourage domestic states to take more responsibility for the licensing process and enhance the states’ reliance on each other. Ms. Bigglestone asked if state insurance regulators believe that subjecting RRGs to Part D would help alleviate concerns. Mr. Matthews stated that there are still challenges with traditional companies that are already subject to Part D. Ms. Bigglestone noted that, per her review of the Part D standards, the process for domestic RRGs is similar, and including RRGs in the Part D standards should not add a burden to the RRG process.

Mr. Sheppard stated that it is important to hold both the domestic and non-domestic states accountable for their roles in regulating RRGs. Mr. Myers agreed, noting that this is the key to addressing the NRRA’s request for the Task Force to review concerns about treatment of non-domiciliary registrations. The NRRA wants to take steps that support a healthy RRG industry, and it believes this includes putting more emphasis on the role of the the domestic states and encouraging non-domestic states to rely on the domestic state as intended by the LRRA. One element to ensure that the process is successful is enhancing communication between the domestic and non-domestic state. If a non-domestic state has questions, concerns or lacks information, it should be able to go to the domestic state for assistance. Developing best practices for communication would support this goal.

Ms. Bigglestone suggested establishing a volunteer drafting group to start developing initial solutions such as best practices in communication, updates to the registration form, instructions/supporting guidance for the registration form, or answers for the FAQ document. The drafting group will report back to the Task Force during its next meeting.

Having no further business, the Risk Retention Group (E) Task Force adjourned.
<table>
<thead>
<tr>
<th>Concern/Issue</th>
<th>Possible Action</th>
<th>Status and Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fees charged by non-domiciliary states (initial and renewal registration fees)</td>
<td>• Develop FAQ &lt;br&gt;• Updates to RRPG Handbook &lt;br&gt;• Updates to the Model Risk Retention Act (#705)</td>
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<tr>
<td>Delays by non-domiciliary states in processing registration forms</td>
<td>• Develop FAQ &lt;br&gt;• Updates to RRPG &lt;br&gt;• Enhance domiciliary state expectations &lt;br&gt;• Consider subjecting RRGs to Part D of accreditation requirements</td>
<td></td>
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<tr>
<td>Time and resources needed to review and process registrations</td>
<td>• Enhance domiciliary state expectations</td>
<td></td>
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<tr>
<td>Lack of instructions/clarity in registration process (includes questions about immediacy of writing once registration submitted)</td>
<td>• Updates to RRPG Handbook &lt;br&gt;• Updates to Company Licensing Best Practices Handbook</td>
<td></td>
</tr>
<tr>
<td>Registration forms received that are not complete or accurate (includes business plans that do not reflect current operations)</td>
<td>• Registration Form review Instructions &lt;br&gt;o Updates to RRPG Handbook &lt;br&gt;o Updates to Company Licensing Best Practices Handbook</td>
<td></td>
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<tr>
<td>Registration forms received that contain violations</td>
<td>• Registration Form review Instructions &lt;br&gt;o Updates to RRPG Handbook &lt;br&gt;o Updates to Company Licensing Best Practices Handbook &lt;br&gt;• Develop FAQ</td>
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<tr>
<td>Registration forms received for RRG that is insolvent or nearly insolvent</td>
<td>• Enhance domiciliary state expectations</td>
<td></td>
</tr>
<tr>
<td>Options for recourse by non-domiciliary state if concerns with RRG</td>
<td>• Develop FAQ – References to LRRA</td>
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<tr>
<td>Notification to non-domiciliary state if serious issues are noted with RRG</td>
<td>• Enhance domiciliary state expectations (communication)</td>
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<tr>
<td>Non-domiciliary state requesting access to same information/detail domiciliary state has upon registration (bios, etc.)</td>
<td>• Enhance domiciliary state expectations (communication) &lt;br&gt;• Updates to online NAIC databases</td>
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</tbody>
</table>
The mission of the Risk Retention Group (E) Task Force is to stay apprised of the work of other NAIC groups as it relates to financial solvency regulation and the NAIC Financial Regulation Standards and Accreditation Program. The Task Force may make referrals to the Financial Regulation Standards and Accreditation (F) Committee and/or other NAIC groups, as deemed appropriate.

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

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

NAIC Support Staff: Becky Meyer
1. What publications are available to help understand RRGs and state’s authority?
      The following key documents can be found as Appendices in the Handbook:
      - Appendix A: Federal Liability Risk Retention Act
      - Appendix B: NAIC Model Risk Retention Act (#705)
      - Appendix D: NAIC Uniform Risk Retention Group Registration Form
   b. Accreditation Program Manual
      - Part A: Laws and Regulations – 18 accreditation standards that outline the laws required specifically for states that charter RRGs
      - Part B: Regulatory Practices and Procedures - RRG specific procedures for financial analysis and procedures when a disclaimer of affiliation is filed

2. How does the LRRA address regulation of RRGs?
   a. Under §3002 of the LRRA, with the exception of the domiciliary state, RRGs are exempt from all state laws, rules, regulations, or orders that would make unlawful, or would regulate, directly or indirectly, the formation and operation of an RRG, except as provided in the LRRA. Only the domiciliary state may regulate the formation and operation of an RRG.
   b. The implementation of the LRRA was intended to allow organizations to come together in the creation of a risk-bearing, risk-sharing entity (the RRG) to offer its members, who are the beneficiaries of the insurance provided, liability coverage in an expedient and economical manner.

3. How does RRG registration in a non-domiciliary state differ from the licensing process for a traditional insurer?
   a. There are no solvency requirements imposed by the non-domiciliary state upon an RRG seeking to register in the State. Regulation as to formation and operation, including the imposition of solvency requirements, are imposed by the domestic state.
   b. RRGs are subject to a substantially similar application and licensing process imposed by the domestic state, or state of domicile. For registration to conduct business in non-domiciliary states, RRGs are not subject to the standard application and licensing process (NAIC UCAA Instructions or NAIC Company Licensing Handbook).
   c. The registration process is intended to be simpler than the licensing process for other types of insurers. Registration is focused on information gathering rather than decision making. Registration is not the same as admission or company licensing; it is not intended to provide non-domiciliary states with any regulatory powers over RRGs other than that provided in the LRRA. It is not within a state’s authority to use the processing of a registration to bar RRGs seeking to lawfully operate in a state, nor can a state declare a “moratorium” on the filing of RRG registrations. Once an RRG provides a complete NAIC Uniform Risk Retention Group Registration Form, they may begin operating in the state and approval from the non-domiciliary state is not required. However, best practice is for the non-domiciliary state to notify the RRG following their initial review of the NAIC Uniform Risk Retention Group Registration Form that either the form received was complete, or that the form was missing
information. The non-domiciliary state may also reach out to the domiciliary state for more information and is encouraged to do so. (see the Best Practices—Risk Retention Groups document)

d. The LRRA references two documents that must be provided to the non-domestic state—a plan of operation OR a feasibility study. There is also additional information such as contact information of the RRG, chartering state information, and the lines of liability insurance business that are written by the RRG seeking to register. All this information is provided in the completed NAIC Uniform Risk Retention Group Registration Form.

e. For an RRG that is compliant with the LRRA and the regulation of their domestic state (including authorization to register to do business in another state), the non-domestic state cannot deny the RRG’s registration. If there is uncertainty, the domestic state should be contacted.

4. What are the steps for the non-domiciliary insurance regulator to take in the registration process for an RRG?

a. Review the NAIC Uniform Risk Retention Group Registration Form and verify the RRG has provided a complete form.

b. Once a complete form is received, the RRG is authorized to write in the state where it registers. The following best practices may also be considered during the registration process; however, they do not impact the registration status of the RRG:
   a. Review the information provided with the registration form for reasonableness.
   b. Reach out to the domiciliary state insurance regulator for additional information or concerns. The best practices Inquiry Template can be used and modified as appropriate.
   c. Notify the RRG once the registration form is deemed complete. They are now registered in the state.

5. What should a non-domiciliary state do if they have concerns about a complete RRG registration form received?

a. If the RRG provided a complete form, but there are concerns about the lines of business or financial solvency, or some other matter, the non-domiciliary state should first communicate with the domiciliary state. If necessary, the non-domiciliary state should consider pursuing the remedies in LRRA §3902(a)(1) also discussed in FAQ #12.

6. When can a non-domiciliary state reject an RRG registration?

a. A non-domiciliary state cannot reject the registration of an RRG that submits a complete registration form. Instead the non-domiciliary state should communicate concerns to the domiciliary state or refer to the remedies in LRRA §3902(a)(1) also discussed in FAQ #12.

7. Can an RRG registration be delayed if a financial statement filing and/or audit is not yet available at the time of application or registration?

a. No, an RRG can register prior to filing of an annual financial statement audit and a statement of opinion on loss and loss adjustment expense reserves with its domiciliary state.

b. Once these initial filings are made, they are available on i-Site for review.

c. If questions arise due to lack of this information, the non-domiciliary state should reach out to the domiciliary state to address its concerns.
8. What items does the LRRA require an RRG provide to the non-domiciliary state in conjunction with the registration?
   a. It is recommended that states adopt the NAIC Uniform Risk Retention Group Registration Form, which has been developed by the NAIC in order to facilitate uniformity. Such forms are included in the Risk Retention and Purchasing Group Handbook.
   b. Consistent with LRRA, each RRG shall submit a copy of the plan of operation OR a feasibility study before it may offer insurance in the state. Note: If the RRG is newly formed, the feasibility study provides relevant information on rates and expected losses. If the RRG is expanding the states in which it operates and has been writing business for an extended period, the feasibility study becomes less relevant and a current business plan, along with documents a non-domiciliary state can easily obtain from the NAIC’s site (Annual Statement(s), RBC Report(s), MD&A(s), Audited Financial Statement(s), Actuarial Certification(s)) provide pertinent information.
   c. If the plan of operation or feasibility study does not appear to be updated, a non-domiciliary state should contact the domiciliary state regulator to obtain more information, including the IPS, and may request revised documents from the RRG if original submission is found to be inaccurate or unclear.

9. What should be included in a plan of operation?
   a. The LRRA states that an RRG’s plan of operation or feasibility study includes information on liability insurance coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer.
   b. In addition, the Best Practices – Risk Retention Groups document offers a list of other suggested items for inclusion in a plan of operations or feasibility study.

10. What does the LRRA say about renewals for RRGs in non-domiciliary states?
    a. The LRRA is silent; therefore, initial registration is sufficient unless the operation of an RRG is affected by runoff, rehabilitation or liquidation processes. RRGs file changes in business plans, financial filings, etc. on an ongoing basis with non-domiciliary states; therefore, non-domiciliary states should consider developing a process for communicating with the domiciliary state (such as the example in the Best Practices—Risk Retention Groups document) and consider an annual request for Certificate of Good Standing/Compliance from the domiciliary state.
    b. Section 3902(4)(3) of the LRRA requires that an RRG submit to the insurance commissioner of each state in which it is doing business a copy of the annual financial statement that it files with the RRG’s domiciliary state. Non-domiciliary states should be aware that in many states where RRGs are licensed/chartered as captive insurers in conformity with NAIC accreditation standards, RRGs are permitted to use Generally Accepted Accounting Principles rather than Statutory Accounting Principles to report on their financial conditions, with required disclosure and reconciliation in footnote one. (see also Section II, page 3 of the Risk Retention and Purchasing Group Handbook)
    c. The filing is an ongoing requirement that must be complied with on an annual basis and is generally due to non-domiciliary states upon filing with the domiciliary state. The annual financial statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by an actuary or loss reserve specialist who is qualified in accordance with the criteria established by the NAIC in the annual statement Instructions.
11. What does the LRRA say about taxes and fees charged by a non-domiciliary RRG?
   a. LRRA §3902(a)(1)(B) says any state may require an RRG to:
      a. Pay on a nondiscriminatory basis, applicable premium and other taxes, which are levied on admitted insurers and surplus lines insurers, brokers, or policyholders under the laws of the state.
   b. Fees are not directly addressed in the LRRA and as such, there has been disagreement about the legality of both initial and renewal registration fees and compliance with LRRA. The authority on this topic is therefore federal case law. Thus far, there is one case, Nat’l Risk Retention Assoc. v. Brown, 927 F. Supp. 195 (M.D. La. 1996) in which the court ruled that certain state requirements, including the payment of an annual renewal registration fee, were preempted by the LRRA. See the Risk Retention and Purchasing Group Handbook for additional detail on the case and other fee considerations.

12. What remedies are available to a non-domiciliary state if violations of applicable State laws occur?
   a. Secure clarification from the RRG’s state of domicile;
   b. Call for an examination of the RRG by the state of domicile [15 U.S.C. §3902(a)(1)(E)];

13. Is there a list of domestic and non-domestic state contact persons in state insurance regulator offices who are knowledgeable about RRGs?
   a. Yes. Appendix C of the NAIC Risk Retention and Purchasing Group Handbook includes a list of state insurance department contact persons. The most recent list is maintained as a separate document on the NAIC’s publication webpage alongside a complete copy of the Risk Retention and Purchasing Group Handbook.


Best Practices – Risk Retention Groups

The domiciliary state maintains authority and has responsibility to regulate the formation and operation of a Risk Retention Group (RRG). Therefore, when concerns arise in a non-domiciliary state about a RRG, the best resource is the domiciliary state. This includes concerns about solvency and capital levels, financial condition, or other non-compliance of an RRG as well as operational questions and concerns that should be directed to the domiciliary state.

States are encouraged to examine their RRG laws to make certain that they are consistent with (1) the LRRA and (2) the NAIC Model Risk Retention Act.

Questions/Concerns from Non-domiciliary State

Upon initial registration of an RRG in a non-domiciliary state, it is not uncommon for questions to arise that are best directed to the domiciliary state. Attachment A outlines a sample Inquiry Template that can be used to request this information. The template may be customized as deemed appropriate by the non-domiciliary state. Domiciliary states should respond in a timely manner to such requests.

Questions about operations and financial solvency that arise following initial registration should also be addressed to the domiciliary state.

If significant concerns still exist after communication with the domiciliary state and the non-domiciliary state concludes that the RRG is not compliant with any of the specific procedures set forth in the LRRA, the following steps may be undertaken:
   a. Refer to your own state RRG statute to ensure compliance of your prospective action;
   b. Provide written notice of any non-compliance directly to the RRG;
   c. Submit a demand for examination of the RRG to the domiciliary regulator, as provided by the LRRA [15 U.S.C. 53902(a)(1)(E)];
   d. Institute suit in a court of competent jurisdiction.

A non-domiciliary state may request the following from the domiciliary state and similarly, the domiciliary state should be prepared to provide the following to the non-domiciliary state:
   e. Insurer Profile Summary (IPS)
   f. Inquire about the extent of biographical affidavit review and results of background checks
   g. Most recent examination report (may be obtained from I-Site)
   h. Amendments to the RRG’s business plan or feasibility study
   i. Verification of domiciliary state approval to expand into non-domiciliary state

Alternatively, Attachment A – Inquiry Template may be used for this request with modifications as necessary.
Registration Timeline

The registration process for RRGs should be shorter than the licensing process for other types of insurers as the RRG is responsible only for a complete registration form and the related attachments. The non-domestic state cannot reject a complete registration that complies with state and federal laws. However, it is still necessary for the non-domiciliary state to review the registration form to ensure it is complete and demonstrates that the RRG complies with the LRRA. In addition, concerns can be raised with the domiciliary state, who has the authority to regulate the formation and operation of an RRG. The following guidelines take into consideration similar guidelines for ordinary insurance companies, and adherence is at the discretion of each state.

- A non-domiciliary state should review the registration form for completeness within 10 business days of its receipt of the form and notify the Risk Retention Group of the need to submit any missing elements.
- Following receipt of a complete application, a non-domiciliary state should notify the RRG within 30 days that its registration is confirmed.
- The domiciliary state should respond to inquiries from a non-domiciliary state in a prompt manner, typically no later than 10 business days after receiving the inquiry.

Domiciliary State Responsibilities

When a domiciliary state identifies an RRG as troubled or potentially troubled, the State insurance regulator should make efforts to communicate proactively with other state insurance regulators in which the RRG is registered (consistent with the Troubled Insurance Company Handbook). Although the domiciliary regulator is responsible for taking actions involving their domiciliary RRGs, awareness by a non-domiciliary state may help them to proactively do what they can to protect their residents and respond to policyholder complaints or concerns directed to them.

Plan of Operation/Feasibility Study

Domiciliary states should ensure the RRG’s plan of operation or feasibility study includes the following, at a minimum:

- information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;
- information sufficient to verify that the liability insurance coverage to be provided by the Risk Retention Group will only cover the members of the Risk Retention Group;
- for each state in which it intends to operate, information regarding the liability insurance coverages, deductibles, coverage limits, rates and/or rating/underwriting methodology for each line of commercial liability insurance the group intends to offer;
- historical and expected loss experience of proposed members and national experience of similar exposures to the extent that this experience is reasonably available;
- appropriate opinions/feasibility work by a qualified independent casualty actuary, including a determination of minimum premium participation levels required to commence operation and to prevent a hazardous financial condition;
- pro forma financial statements and projections, including assumptions, on an expected and adverse basis;
- identification of Board of Directors, including independence determination;
- biographical affidavits for all BOD members;
- evidence of compliance with corporate governance standards, including draft policies;
- underwriting and claim procedures;
- marketing methods and materials if available;
- draft insurance policies;
- names of reinsurers and reinsurance agreements, if available;
- investment policies;
- identification of each state in which the RRG intends to write business/registry;
- identification of service providers, including fee structure and relationships to members; and
- subsequent material revisions to the plan of operation or feasibility study.

Commented [MB1]: Pamela Davis: Can you provide examples of state laws that might be used to deny the Registration of an RRG?

Commented [MB2]: VCI: Recommend revising to: "The non-domestic state cannot reject a complete registration that complies with those laws of the non-domestic state that are not pre-empted under the LRRA. In the event a non-domestic state has concerns with an RRG registration, such concerns should be raised with the domiciliary state regulator, who has the authority to regulate the formation and operation of an RRG."

Commented [MB3]: Pennsylvania: Depending on how "complete" is defined, a 10-day turnaround may not be reasonable.

Commented [MB4]: District of Columbia: Suggests adding "or application for licensing". With this change, also add "//Application" to the heading.

Commented [MB5]: Premier: Will listing this here prompt a non-domiciliary state to also ask for it when this is something handled by the domiciliary state? Limiting the distribution of confidential information (such as SSN#) can help ensure this information is not subject to a security breach and remains confidential.
Attachment A – Inquiry Template

The above-subject company has applied for Registration as a Risk Retention Group ("RRG") in the State of ______ to write __________ liability coverage to its members who are in the business of _______. As you can appreciate, due to the provisions of the Liability Risk Retention Act of 1986 the (state) has limited authority to regulate RRGs and therefore to a large extent, the (state) relies on the RRGs’ domiciliary state to exercise general oversight and responsibility in the areas of licensing, solvency, rates and marketing. As part of our due diligence, we would appreciate any information your office can share with us regarding the company with respect to the following items, some of which may be satisfied by providing the Insurer Profile Summary:

1. Any significant concerns the State of [domicile] has regarding the company.
2. Any issues that may have a significant impact on the company going forward.
3. Any issues regarding the number of consumer complaints the company has in [state of domicile] or other states that may have been brought to your attention.
4. Comments and/or concerns about the financial condition of the company.
5. Comments or concerns about the management or performance of the company.
6. Results of any financial analysis or market conduct findings.
7. The company’s priority level within the Financial Analysis Division.
8. Any conditions imposed by your Department upon the company’s license.
9. Any significant non-compliance issues with the State of [domicile] regulatory authority including filing requirements and corrective action, if any.
10. Comments regarding the company’s application for registration in the State of [state registering].
11. Approval from State of [domicile] for the RRG to register in the State of [state registering].
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

Appendix D

The following is the uniform registration form adopted in 1991 by the NAIC. This registration form is being filed by a Risk Retention Group (RRG) operating in accordance with the Federal Liability Risk Retention Act of 1986 (LLRA), 15 USC 3901-3906, chartered or licensed to write only liability insurance by the state of domicile listed in #1c. The registration form and supplemental documents are provided in accordance with §3902(d)(2) of the LLRA. Under §3902 of the LLRA, with the exception of the domiciliary state, RRGs are exempt from all state laws, rules, regulations, or orders that would make unlawful, or would regulate, directly or indirectly, the operation of an RRG, except that any state may require an RRG to comply with those laws specified in the LLRA. The domiciliary state regulates the formation and operation of the RRG.

Part A

STATE OF [Insert State in which the Risk Retention Group intends to do business]
DEPARTMENT OF INSURANCE
RISK RETENTION GROUP - NOTICE AND REGISTRATION
(All Information Should Be Typed)

1a. Name of the Risk Retention Group as it appears on its Certificate of Authority:

1b. FEIN:

1c. State of domicile and date licensed/chartered:

1d. Primary contact person for state of domicile to whom questions regarding the Risk Retention Group should be addressed (include name, phone number and email address):

2. List any other name(s) by which the Risk Retention Group is known or may be doing business in this State or any other state:

Commented [MB1]: VCIA: Replace with "not exempted by §3902 of "

Commented [MB2]: VCIA: Suggests requesting the address and NAIC cociode of the RRG.

Commented [MB3]: Request feedback from the full Task Force on how this is used and if it is necessary.

Commented [MB4R3]: District of Columbia: DC does not routinely require or use this information from domestic RRGs as suggests deleting the requirement for the FEIN.

Commented [MB5R3]: VCIA: It may be more appropriate to request the organization’s FEIN here in Item 1 rather than requiring in Item 9 the FEIN of the manager.

Commented [MB6]: Pennsylvania: generally speaking, isn’t it likely that the date chartered and the date licensed are different dates.
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

3. The Risk Retention Group is chartered and licensed as a liability insurance company under the laws of the State of ______________________, and is authorized to engage in the following lines and/or classifications of liability insurance under the laws of its chartering State:

4. Give a general description of the liability insurance coverages the Risk Retention Group plans to write in the state it is registering to do business in:

5. Has the Risk Retention Group’s domiciliary state approved the Risk Retention Group to register and expand its writings in the state it is seeking to become registered in?

6. Ownership of the Risk Retention Group consists of one or the other of the following (check one):
   a) the owners of the Group are the only persons who comprise the membership of the Group and the only ones who are provided insurance by the Group.
   b) the sole owner of the Group is: ________________________________
      (Name and Address of Organization)

   an organization which has as its members only persons who comprise the membership of the Group and which has as its owners only persons who comprise the membership of the Group and who are provided insurance by the Group.

7. The Risk Retention Group members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business (whether profit or nonprofit), trade, product, services (including professional services), premises or operations. Give a general description of businesses or activities engaged in by the Group’s members:

Commented [MB7]: Pamela Davis: How is “persons” defined for the purposes of this form. Since RRGs may only insure commercial insurance, does this word encompass both individual professionals and business entities?

Commented [MB8]: NRRA: Recommends revising as follows for consistency with LRRA:
   “the owners of the Group are only persons who comprise the membership of the Group and who are provided insurance by the Group.”

Commented [MB9]: VCIA: makes a similar comment as NRRA - with respect to members and insureds, we recommend that the language in the form be the same as in the LRRA because the language in the proposed form appears to be more restrictive than that in the LRRA.

Commented [MB10]: VCIA: We recommend Item 7 be deleted and a new Item 15 created as follows: “In accordance with the LRRA, and as evidenced by the domiciliary state’s action in approving licensure of the Risk Retention Group, the RRG affirms its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business (whether profit or nonprofit), trade, product, services (including professional services), premises or operations.” *See explanation in comment letter.*
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

8. (a) List the name, **position with the Risk Retention Group, SSR**, and address of each officer and director of the Risk Retention Group: (Attach additional pages, if necessary.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone Number</th>
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(b) Identify and give the telephone number of the officer or director of the Risk Retention Group who can be contacted for any information regarding the management of the insurance activities of the Group:

Name: __________________________ Telephone Number: __________________________

9. List the name, address (postal and email), telephone number and Federal Employer Identification Number (FEIN) of the company responsible for managing the insurance operations of the Risk Retention Group and the company contact person’s name and telephone number at the company. (If none, answer none.)

<table>
<thead>
<tr>
<th>Contact Person</th>
<th>Telephone #</th>
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10. List the name(s), **NPR#, SSR(s), and address(es)** of the licensed insurance agent(s) or broker(s) who will be responsible for marketing the Risk Retention Group’s insurance policies **in the State of [Insert State in which the Risk Retention Group intends to do business]** and the current licensing status in the State of [Insert State in which the Risk Retention Group intends to do business] in which they are licensed. (If none, answer none. Attach additional pages, if necessary.)

<table>
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<tr>
<th>Name</th>
<th>SSR#NPR#</th>
<th>Address</th>
<th>License Status in State Registering</th>
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</tbody>
</table>

11. **In accordance with the Liability Risk Retention Act, we verify the following:**

Commented [MB11]: District of Columbia: DC does not request the FEIN of the manager.

Commented [MB12]: VCIA: It may be more appropriate to request the organization’s FEIN above in Item 1 rather than here in Item 9 the FEIN of the manager.

Commented [MB13]: Pennsylvania: consider requesting an email address for the company contact person.

Commented [MB14]: Items a-d are not new, but were previously items 3,4,6 and 9 on the original form.
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

A. The Risk Retention Group is a corporation or other limited liability association whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its members.

B. The Risk Retention Group is organized for the primary purpose of conducting the activity described under Item “A” above.

C. The Risk Retention Group does not exclude any person from membership in the Group solely to provide for members of the Group a competitive advantage over such a person.

D. The activities of the Risk Retention Group do not include the provision of insurance other than:
   i. liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its Group members; and
   ii. reinsurance with respect to the similar or related liability exposure of another Risk Retention Group (or a member of such other Risk Retention Group) engaged in business or activities so that such Risk Retention Group or member meets the requirement under Item #7 above for membership in the Risk Retention Group which provides such reinsurance.

12. In accordance with the LRRA, if the State in which the Risk Retention Group is registering requires compliance with the following laws and requirements, the RRG agrees to the following:

   A. The Risk Retention Group will comply with the unfair claim settlement practices laws of this State.

   B. The Risk Retention Group will pay, on a non-discriminatory basis, applicable premium and other taxes which are levied on admitted insurers, surplus line insurers, brokers or policyholders, such Group under the laws of this State.

   B.C. The Risk Retention Group will participate, on a nondiscriminatory basis, in any mechanism established or authorized under the law of the State for the equitable apportionment among insurers of liability insurance losses and expenses incurred on policies written through such mechanism.

   C.D. The Risk Retention Group will be designated the Insurance Commissioner [Director, Superintendent] of this State as its agent solely for the purpose of receiving service of legal documents or process by executing Part B of this form, attached hereto.

   D.E. The Risk Retention Group will submit to examination by the Insurance Commissioner [Director, Superintendent] of this State to determine the Group’s financial condition, if:

      i. the Insurance Commissioner [Director, Superintendent] of the Group’s chartering State has not begun or has refused to initiate an examination of the Group; and
      ii. any such examination by the Insurance Commissioner [Director, Superintendent] shall be coordinated to avoid unjustified duplication and unjustified repetition.

   E.F. The Risk Retention Group will comply with a lawful order issued in a delinquency proceeding commenced by the Insurance Commissioner [Director, Superintendent] of this
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

State upon a finding of financial impairment, or in a voluntary dissolution proceeding.

The Risk Retention Group will comply with the laws of this State concerning regarding deceptive, false or fraudulent acts or practices, including any injunctions regarding such conduct obtained from a court of competent jurisdiction.

The Risk Retention Group will comply with an injunction issued by a court of competent jurisdiction upon petition by the Insurance Commissioner [Director, Superintendent] of this State alleging that the Group is in hazardous financial condition or is financially impaired.

The Risk Retention Group will provide the following notice, in at least 10-point type, in any insurance policy issued by the Group:

NOTICE
This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your risk retention group.

In accordance with the LRRA, the Risk Retention Group affirms that it has submitted to the Insurance Commissioner [Director, Superintendent] as part of this filing and before it has offered any insurance in this State, a copy of the plan of operation or feasibility study which it has filed with the Insurance Commissioner [Director, Superintendent] of its abating State of domicile. This plan or study includes the name of the State in which the Group is chartered, as well as the Group’s principal place of business, and such plan of operation or feasibility study further includes the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of liability insurance the Group intends to offer. The Group has also promptly submitted to the Insurance Commissioner [Director, Superintendent] of this State any revisions of such plan of operation or feasibility study to reflect any changes to the plan if the Group intends to offer any additional lines of liability insurance or including any change in the designation of the State in which it is chartered.

The Risk Retention Group will submit a copy of its annual financial statement submitted to its chartering state, to the Insurance Commissioner [Director, Superintendent] of this State by March 1 of each year. The annual financial statement will be certified by an independent public accountant and include a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist. The annual financial statement, certification and statement of opinion on loss and loss adjustment expense reserves will be submitted to the Insurance Commissioner [Director, Superintendent] of this State by the date it is required to be submitted to its chartering state.

The Risk Retention Group will not solicit or sell insurance to any person in this State who is not eligible for membership in the Group.

The Risk Retention Group will not solicit or sell insurance in this State, or otherwise operate in this State, if the Group is in hazardous financial condition or is financially impaired.

The Risk Retention Group will not issue any insurance policy in this State which provides coverage prohibited generally by statute of this State or declared unlawful by the highest court of this State whose law applies to such policy.

The Risk Retention Group has submitted a registration fee of $________________, if applicable, payable to the Insurance Commissioner [Director, Superintendent] of this State.

To the extent required by the LRRA, the Risk Retention Group will comply with all other
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM
applicable state laws.

19. The Risk Retention Group will notify the Insurance Commissioner [Director, Superintendent] as to any subsequent changes in any of the items included in this form.

The undersigned hereby swear and affirm that the foregoing statements and information regarding their principal, the___________________________(Name of Risk Retention Group) are true and correct.

___________________________
President of the Risk Retention Group

___________________________
Secretary of the Risk Retention Group
State of______________
County of______________

Sworn before me this ___ day of ________________, 20___.
___________________________, Notary Public. My Commission Expires: ________________

Commented [MB16]: Pamela Davis: Is the Insurance Commissioner in Item 19 the domicile or non-domicile Commissioner? If non-domicile, does that mean that an RRG must report every change in the board of directors to every non-domicile regulator? If so, how soon after the change?
PART B

APPOINTMENT OF ATTORNEY TO ACCEPT SERVICE AND DESIGNATION

The _______________ ("the Group"), a risk retention group which is chartered and licensed as a liability insurance company under the laws of the State of _______________, having notified the Insurance Commissioner [Director, Superintendent] of the State of _______________ of its intention to do business in this State as a risk retention group pursuant to the federal Liability Risk Retention Act of 1986, hereby appoints the Insurance Commissioner [Director, Superintendent] of the State of _______________, any successor in office, and any authorized deputy its true and lawful attorney, in and for the State of _______________, upon whom all legal documents or process in any proceeding against it may be served. Such service of legal documents or process shall be of the same legal force and validity as if served personally upon the Group.

The Group designates:

________________________________________
(Name)

________________________________________
(Address)

________________________________________
(City, Town or Village)

________________________________________
(State and ZIP Code)

as its officer, agent or other person to whom shall be forwarded all legal documents or process served upon the Insurance Commissioner [Director, Superintendent] of the State of _______________, any successors in office, or any authorized deputy, for the Group. This designation shall continue in full force and effect until superseded by a new written designation filed with the Insurance Commissioner [Director, Superintendent].
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

This appointment and designation is made pursuant to a resolution by the Group’s governing body authorizing it, and a certified copy of the resolution is attached hereto. This appointment shall be binding upon any person or corporation which as successor acquires the Group’s assets or assumes its liabilities, by merger or consolidation or otherwise.

This appointment may be withdrawn only upon a written notice of termination and, in any event, shall not be terminated by the Group or its successor so long as any contracts or liabilities or duties arising out of contracts entered into by the Group while it was doing business in this State are in effect.

IN WITNESS OF THIS APPOINTMENT AND DESIGNATION, the Group, in accordance with the resolution of its Board of Directors duly passed on _________________, 20__, has affixed its corporate seal, and caused the same to be subscribed and attested in its name by its President and Secretary, at the City of _________________ in the State of _________________ on _________________, 20__.

________________________________________
(Name of Risk Retention Group)

By: ____________________________ President

________________________________________
Secretary

State of _________________

) ss:

County of _________________

Sworn before me this ___________ day of _________________, 20__.

__________________________, Notary Public. My Commission Expires: ___________
Risk Retention Groups: Frequently Asked Questions

1. What publications are available to help understand RRGs and state’s authority?
      The following key documents can be found as Appendices in the Handbook:
      • Appendix A: Federal Liability Risk Retention Act
      • Appendix B: NAIC Model Risk Retention Act (#705)
      • Appendix D: NAIC Uniform Risk Retention Group Registration Form
   b. Accreditation Program Manual
      • Part A: Laws and Regulations – 18 accreditation standards that outline the laws required specifically for states that charter RRGs
      • Part B: Regulatory Practices and Procedures - RRG specific procedures for financial analysis, credit for reinsurance for RRGs, and procedures when a disclaimer of affiliation is filed.

2. How does the LRRA address regulation of RRGs?
   a. Under §3902 of the LRRA, with the exception of the domiciliary state, RRGs are exempt from all state laws, rules, regulations, or orders that would make unlawful, or would regulate, directly or indirectly, the formation and operation of an RRG, except as provided in the LRRA. Only the domiciliary state may regulate the formation and operation of an RRG.
   b. The implementation of the LRRA was intended to allow organizations to come together in the creation of a risk-bearing, risk-sharing entity (the RRG) to offer its members, who are the beneficiaries of the insurance provided, liability coverage in an expedient and economical manner.

3. How does RRG registration in a non-domiciliary state differ from the licensing process for a traditional insurer?
   a. There are no solvency requirements imposed by the non-domiciliary state upon an RRG seeking to register in the State. Regulation as to formation and operation, including the imposition of solvency requirements, are imposed by the domestic state.
   b. RRGs are subject to a substantially similar application and licensing process imposed by the domestic state, or state of domicile. For registration to conduct business in non-domestic states, RRGs are not subject to the standard application and licensing process (NAIC UCAA Instructions or NAIC Company Licensing Handbook).
   c. The registration process is intended to be simpler than the licensing process for other types of insurers. Registration is focused on information gathering rather than decision making. Registration is not the same as admission or company licensing; it is not intended to provide non-domiciliary states with any regulatory powers over RRGs other than that provided in the LRRA. It is not within a state’s authority to use the processing of a registration to bar RRGs seeking to lawfully operate in a state, nor can a state declare a “moratorium” on the filing of RRG registrations. Once an RRG provides a complete NAIC Uniform Risk Retention Group Registration Form, it is considered licensed in the non-domiciliary state.
Registration Form they may begin operating in the state and approval from the non-domestic state is not required. However, best practice is for the non-domiciliary state to notify the RRG following their initial review of the NAIC Uniform Risk Retention Group Registration Form that either the form received was complete, or that the form was missing information. The non-domiciliary state may also reach out to the domiciliary state for more information and is encouraged to do so. (see the Best Practices—Risk Retention Groups document)

d. The LRRA references two documents that must be provided to the non-domestic state – a plan of operation OR a feasibility study. There is also additional information such as contact information of the RRG, chartering state information, and the lines of liability insurance business that are written by the RRG seeking to register. All this information is provided in the completed NAIC Uniform Risk Retention Group Registration Form.

e. For an RRG that is compliant with the LRRA and the regulation of their domestic state (including authorization to register to do business in another state), the non-domestic state cannot deny the RRG’s registration. If there is uncertainty, the domestic state should be contacted.

4. What are the steps for the non-domiciliary insurance regulator to take in the registration process for an RRG?

a. Review the NAIC Uniform Risk Retention Group Registration Form and verify the RRG has provided a complete form.

b. Once a complete form is received, the RRG is authorized to write in the state where it registers. The following best practices may also be considered during the registration process; however, they do not impact the registration status of the RRG:

   a. Review the information provided with the registration form for reasonableness.

   b. Reach out to the domestic state insurance regulator for additional information or concerns. The best practices Inquiry Template can be used and modified as appropriate.

   c. Notify the RRG once the registration form is deemed complete. They are now registered in the state.

5. What should a non-domiciliary state do if they have concerns about a complete RRG registration form received?

a. If the RRG provided a complete form, but there are concerns about the lines of business or financial solvency, or some other matter, the non-domiciliary state should first communicate with the domestic state. If necessary, the non-domiciliary state should consider pursuing the remedies in LRRA §3902(a)(1) also discussed in FAQ #12.

6. When can a non-domiciliary state reject an RRG registration?

a. A non-domestic state cannot reject the registration of an RRG that submits a complete registration form. Instead the non-domestic state should communicate concerns to the domestic state or refer to the remedies in LRRA §3902(a)(1) also discussed in FAQ #12.
7. Can an RRG registration be delayed if a financial statement filing and/or audit is not yet available at the time of application or registration?
   a. No, an RRG can register prior to filing of an annual financial statement audit and a statement of opinion on loss and loss adjustment expense reserves with its domiciliary state.
   b. Once these initial filings are made, they are available on I-Site for review.
   c. If questions arise due to lack of this information, the non-domiciliary state should reach out to the domestic state to address its concerns.

8. What items does the LRRA require an RRG provide to the non-domiciliary state in conjunction with the registration?
   a. It is recommended that states adopt the NAIC Uniform Risk Retention Group Registration Form, which has been developed by the NAIC in order to facilitate uniformity. Such forms are included in the Risk Retention and Purchasing Group Handbook.
   b. Consistent with LRRA, each RRG shall submit a copy of the plan of operation OR a feasibility study before it may offer insurance in the state.
      Note: If the RRG is newly formed, the feasibility study provides relevant information on rates and expected losses. If the RRG is expanding the states in which it operates and has been writing business for an extended period, the feasibility study becomes less relevant and a current business plan, along with documents a non-domiciliary state can easily obtain from the NAIC’s I-Site (Annual Statement(s), RBC Report(s), MD&A(s), Audited Financial Statement(s), Actuarial Certification(s)) provide pertinent information.
   c. If the plan of operation or feasibility study does not appear to be updated, a non-domiciliary state should contact the domiciliary state regulator to obtain more information, including the IPS, and may request revised documents from the RRG if original submission is found to be inaccurate or unclear.

9. What should be included in a plan of operation?
   a. The LRRA states that an RRG’s plan of operation or feasibility study includes information on liability insurance coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer.
   b. In addition, the Best Practices – Risk Retention Groups document offers a list of other suggested items for inclusion in a plan of operations or feasibility study.

10. What does the LRRA say about renewals for RRGs in non-domiciliary states?
   a. The LRRA is silent; therefore, initial registration is sufficient unless the operation of an RRG is affected by runoff, rehabilitation or liquidation processes. RRGs file changes in business plans, financial filings, etc. on an ongoing basis with non-domiciliary states; therefore, non-domiciliary states should consider developing a process for communicating with the domiciliary state (such as the example in the Best Practices—Risk Retention Groups document) and consider an annual request for Certificate of Good Standing/Compliance from the domiciliary state.
   b. Section 3902(d)(3) of the LRRA requires that an RRG submit to the insurance commissioner of each state in which it is doing business a copy of the annual financial statement that it files with
the RRG’s domiciliary state. Non-domiciliary states should be aware that in many states where RRGs are licensed/chartered as captive insurers in conformity with NAIC accreditation standards, RRGs are permitted to use Generally Accepted Accounting Principles rather than Statutory Accounting Principles to report on their financial conditions, with required disclosure and reconciliation in footnote one. (see also Section II, page 3 of the Risk Retention and Purchasing Group Handbook)

c. The filing is an ongoing requirement that must be complied with on an annual basis and is generally due to non-domiciliary states upon filing with the domiciliary state. The annual filing requirements for RRGs include an unaudited filing using the Official NAIC Annual Statement Blank (Property/Casualty), an audited financial statement shall be certified by an independent public accountant, and contain a statement of opinion on loss and loss adjustment expense reserves made by an actuary or loss reserve specialist who is qualified in accordance with the criteria established by the NAIC in the annual statement instructions. See the above-mentioned NAIC Accreditation Program Manual, Part A: Laws and Regulations for RRGs, for annual filing requirements for RRGs.

11. What does the LRRA say about taxes and fees charged by a non-domiciliary RRG?
   a. LRRA §3902(a)(1)(B) says any state may require an RRG to:
      a. Pay on a nondiscriminatory basis, applicable premium and other taxes, which are levied on admitted insurers and surplus lines insurers, brokers, or policyholders under the laws of the state.
      b. Fees are not directly addressed in the LRRA and as such, there has been disagreement about the legality of both initial and renewal registration fees and compliance with LRRA. The authority on this topic is therefore federal case law. Thus far, there is one case (Nat’l Risk Retention Assoc. v. Brown, 927 F. Supp. 195 (M.D. La. 1996)) in which the court ruled that certain state requirements, including the payment of an annual renewal registration fee, were preempted by the LRRA. See the Risk Retention and Purchasing Group Handbook for additional detail on the case and other fee considerations.

12. What remedies are available to a non-domiciliary state if violations of applicable State laws occur?
   a. Secure clarification from the RRG’s state of domicile;
   b. Call for an examination of the RRG by the state of domicile [15 U.S.C. §3902(a)(1)(E)];

13. Is there a list of domestic and non-domestic state contact persons in state insurance regulator offices who are knowledgeable about RRGs?
   a. Yes. Appendix C of the NAIC Risk Retention and Purchasing Group Handbook includes a list of state insurance department contact persons. The most recent list is maintained as a separate document on the NAIC’s publication webpage alongside a complete copy of the Risk Retention and Purchasing Group Handbook:
      https://www.naic.org/prod_serv_alpha_listing.htm#risk_retention
Best Practices – Risk Retention Groups

The domiciliary state maintains authority and has responsibility to regulate the formation and operation of a Risk Retention Group (RRG). Therefore, when concerns arise in a non-domiciliary state about a RRG, the best resource is the domiciliary state. This includes concerns about solvency and capital levels, financial condition, or other non-compliance of an RRG as well as operational questions and concerns that should be directed to the domiciliary state.

States are encouraged to examine their RRG laws to make certain that they are consistent with (1) the LRRA and (2) the NAIC Model Risk Retention Act.

Questions/Concerns from Non-domiciliary State

Upon initial registration of an RRG in a non-domiciliary state, it is not uncommon for questions to arise that are best directed to the domiciliary state. Attachment A outlines a sample Inquiry Template that can be used to request this information. The template may be customized as deemed appropriate by the non-domiciliary state. Domiciliary states should respond in a timely manner to such requests.

Questions about operations and financial solvency that arise following initial registration should also be addressed to the domiciliary state.

If significant concerns still exist after communication with the domiciliary state and the non-domiciliary state concludes that the RRG is not compliant with any of the specific procedures set forth in the LRRA, the following steps may be undertaken:

a. Refer to your own state RRG statute to ensure compliance of your prospective action;
b. Provide written notice of any non-compliance directly to the RRG;
c. Submit a demand for examination of the RRG to the domiciliary regulator, as provided by the LRRA [15 U.S.C. S3902(a)(1)(E)];
d. Institute suit in a court of competent jurisdiction.

A non-domiciliary state may request the following from the domiciliary state and similarly, the domiciliary state should be prepared to provide the following to the non-domiciliary state:

e. Insurer Profile Summary (IPS)
f. Inquire about the extent of biographical affidavit review and results of background checks
g. Most recent examination report (may be obtained from I-Site)
h. Amendments to the RRG’s business plan or feasibility study
i. Verification of domiciliary state approval to expand into non-domiciliary state

Alternatively, Attachment A – Inquiry Template may be used for this request with modifications as necessary.
Registration Timeline
The registration process for RRGs should be shorter than the licensing process for other types of insurers as the RRG is responsible only for a complete registration form and the related attachments. The non-domestic state cannot reject a complete registration that complies with state and federal laws. However, it is still necessary for the non-domiciliary state to review the registration form to ensure it is complete and demonstrates that the RRG complies with the LRRA. In addition, concerns can be raised with the domiciliary state, who has the authority to regulate the formation and operation of an RRG. The following guidelines take into consideration similar guidelines for ordinary insurance companies, and adherence is at the discretion of each state:

- A non-domiciliary state should review the registration form for completeness within 10 business days of its receipt of the form notify the Risk Retention Group of the need to submit any missing elements.
- Following receipt of a complete application, a non-domiciliary state should notify the RRG within 30 days that its registration is confirmed.
- The domiciliary state should respond to inquiries from a non-domiciliary state in a prompt manner, typically no later than 10 business days after receiving the inquiry.

Domiciliary State Responsibilities
When a domiciliary state identifies an RRG as troubled or potentially troubled, the State insurance regulator should make efforts to communicate proactively with other state insurance regulators in which the RRG is registered (consistent with the Troubled Insurance Company Handbook). Although the domiciliary regulator is responsible taking actions involving their domiciliary RRGs, awareness by a non-domiciliary state may help them to proactively do what they can to protect their residents and respond to policyholder complaints or concerns directed to the them.

Plan of Operation/Feasibility Study/Application
Domiciliary states should ensure the RRG’s plan of operation, feasibility study, or application for licensing includes the following, at a minimum:
- information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;
- information sufficient to verify that the liability insurance coverage to be provided by the Risk Retention Group will only cover the members of the Risk Retention Group;
- for each state in which it intends to operate, information regarding the liability insurance coverages, deductibles, coverage limits, rates and/or rating/underwriting methodology for each line of commercial liability insurance the group intends to offer;
- historical and expected loss experience of proposed members and national experience of similar exposures to the extent that this experience is reasonably available;
- appropriate opinions/feasibility work by a qualified independent casualty actuary, including a determination of minimum premium participation levels required to commence operation and to prevent a hazardous financial condition;
- pro forma financial statements and projections, including assumptions, on an expected and adverse basis;
- identification of Board of Directors, including independence determination;
- biographical affidavits for all BOD members;
- evidence of compliance with corporate governance standards, including draft policies;
- underwriting and claim procedures;
- marketing methods and materials if available;
- draft insurance policies;
- names of reinsurers and reinsurance agreements, if available;
- investment policies;
- identification of each state in which the RRG intends to write business/register;
- identification of service providers, including fee structure and relationships to members/ and
- subsequent material revisions to the plan of operation or feasibility study.
Attachment A – Inquiry Template

The above-subject company has applied for Registration as a Risk Retention Group ("RRG") in the State of ________, to write __________ liability coverage to its members who are in the business of_______________________________. As you can appreciate, due to the provisions of the Liability Risk Retention Act of 1986 the (state) has limited authority to regulate RRGs and therefore to a large extent, the (state) relies on the RRGs’ domiciliary state to exercise general oversight and responsibility in the areas of licensing, solvency, rates and marketing. As part of our due diligence, we would appreciate any information your office can share with us regarding the company with respect to the following items, some of which may be satisfied by providing the Insurer Profile Summary:

1. Any significant concerns the State of [domicile] has regarding the company.

2. Any issues that may have a significant impact on the company going forward.

3. Any issues regarding the number of consumer complaints the company has in [state of domicile] or other states that may have been brought to your attention.

4. Comments and/or concerns about the financial condition of the company.

5. Comments or concerns about the management or performance of the company.

6. Results of any financial analysis or market conduct findings.

7. The company’s priority level within the Financial Analysis Division.

8. Any conditions imposed by your Department upon the company’s license.

9. Any significant non-compliance issues with the State of [domicile] regulatory authority including filing requirements and corrective action, if any.

10. Comments regarding company’s application for registration in the State of [state registering].

11. Approval from State of [domicile] for the RRG to register in the State of [state registering].
Appendix D

NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

The following is the uniform registration form adopted by the NAIC. This registration form is being filed by a Risk Retention Group (RRG) operating in accordance with the Federal Liability Risk Retention Act of 1986 (LRRA), 15 USC 3901-3906, chartered or licensed to write only liability insurance by the state of domicile listed in #1c. The registration form and supplemental documents are provided in accordance with §3902(d)(2) of the LRRA. Under §3902 of the LRRA, with the exception of the domiciliary state, RRGs are exempt from all state laws, rules, regulations, or orders that would make unlawful, or would regulate, directly or indirectly, the operation of an RRG, except that any state may require an RRG to comply with those laws specified in the LRRA. The domiciliary state regulates the formation and operation of the RRG.

Part A

STATE OF [Insert State in which the Risk Retention Group intends to do business]

DEPARTMENT OF INSURANCE

RISK RETENTION GROUP - NOTICE AND REGISTRATION

(All Information Should Be Typed)

1a. Name of the Risk Retention Group as it appears on its Certificate of Authority:

1b. FEIN:

1c. State of domicile and date licensed/chartered:

1d. Primary contact person for state of domicile to whom questions regarding the Risk Retention Group should be addressed (include name, phone number and email address):

2. List any other name(s) by which the Risk Retention Group is known or may be doing business in this State or any other state:

3. The Risk Retention Group is authorized to engage in the following lines and/or classifications of liability insurance under the laws of its chartering State:
4. Give a general description of the liability insurance coverages the Risk Retention Group plans to write in the state it is registering to do business in.

5. Has the Risk Retention Group’s domiciliary state approved the Risk Retention Group to register and expand its writings in the state it is seeking to become registered in?

6. Ownership of the Risk Retention Group consists of one or the other of the following (check one):
   a) ___ the owners of the Group are the only persons who comprise the membership of the Group and the only ones who are provided insurance by the Group.
   b) ___ the sole owner of the Group is: ________________________________
      (Name and Address of Organization)
      an organization which has as its members only persons who comprise the membership of the Group and which has as its owners only persons who comprise the membership of the Group and who are provided insurance by the Group.

7. The Risk Retention Group members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business (whether profit or nonprofit), trade, product, services (including professional services), premises or operations. Give a general description of businesses or activities engaged in by the Group’s members:

8. (a) List the name, position with the Risk Retention Group, and address of each officer and director of the Risk Retention Group: (Attach additional pages, if necessary.)

   (b) Identify and give the telephone number of the officer or director of the Risk Retention Group who can be contacted for any information regarding the management of the insurance activities of the Group:
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

Name: __________________________ Telephone Number: __________________________

9. List the name, addresses (postal and email), telephone number and Federal Employer Identification Number (FEIN) of the company responsible for managing the insurance operations of the Risk Retention Group and the company contact person’s name and telephone number. (If none, answer none.)

Contact Person: _______________________ Telephone #: __________________________

10. List the name(s) NPR#, and address(es) of the licensed insurance agent(s) or broker(s) who will be responsible for marketing the Risk Retention Group’s insurance policies in the State of [Insert State in which the Risk Retention Group intends to do business] and the current licensing status in the State of [Insert State in which the Risk Retention Group intends to do business]: (If none, answer none. Attach additional pages, if necessary.)

<table>
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<tr>
<th>Name</th>
<th>NPR#</th>
<th>Address</th>
<th>License Status in State Registering</th>
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11. In accordance with the Liability Risk Retention Act, we verify the following:

A. The Risk Retention Group is a corporation or other limited liability association whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its members.

B. The Risk Retention Group is organized for the primary purpose of conducting the activity described under item “A” above.

C. The Risk Retention Group does not exclude any person from membership in the Group solely to provide for members of the Group a competitive advantage over such a person.

D. The activities of the Risk Retention Group do not include the provision of insurance other than:
   
i. liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its Group members; and
   
ii. reinsurance with respect to the similar or related liability exposure of another Risk Retention Group (or a member of such other Risk Retention Group) engaged in
12. In accordance with the LRRA, if the State in which the Risk Retention Group is registering requires compliance with the following laws and requirements, the RRG agrees to the following:

A. The Risk Retention Group will comply with the unfair claim settlement practices laws of this State.

B. The Risk Retention Group will pay, on a non-discriminatory basis, applicable premium and other taxes which are levied on admitted insurers, surplus line insurers, brokers or policyholders under the laws of this State.

C. The Risk Retention Group will participate, on a nondiscriminatory basis, in any mechanism established or authorized under the law of the State for the equitable apportionment among insurers of liability insurance losses and expenses incurred on policies written through such mechanism.

D. The Risk Retention Group will designate the Insurance Commissioner [Director, Superintendent] of this State as its agent solely for the purpose of receiving service of legal documents or process by executing Part B of this form, attached hereto.

E. The Risk Retention Group will submit to examination by the Insurance Commissioner [Director, Superintendent] of this State to determine the Group’s financial condition, if:

   i. the Insurance Commissioner [Director, Superintendent] of the Group’s chartering State has not begun or has refused to initiate an examination of the Group; and

   ii. any such examination by the Insurance Commissioner [Director, Superintendent] shall be coordinated to avoid unjustified duplication and unjustified repetition.

F. The Risk Retention Group will comply with a lawful order issued in a delinquency proceeding commenced by the Insurance Commissioner [Director, Superintendent] of this State upon a finding of financial impairment, or in a voluntary dissolution proceeding.

G. The Risk Retention Group will comply with the laws of this State regarding deceptive, false or fraudulent acts or practices, including any injunctions regarding such conduct obtained from a court of competent jurisdiction.

H. The Risk Retention Group will comply with an injunction issued by a court of competent jurisdiction upon petition by the Insurance Commissioner [Director, Superintendent] of this State alleging that the Group is in hazardous financial condition or is financially impaired.

I. The Risk Retention Group will provide the following notice, in at least 10-point type, in any insurance policy issued by the Group:

   NOTICE

   This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your risk retention group.
13. In accordance with the LRRA, the Risk Retention Group affirms that it has submitted to the Insurance Commissioner [Director, Superintendent] as part of this filing and before it has offered any insurance in this State, a copy of the plan of operation or feasibility study which it has filed with the Insurance Commissioner [Director, Superintendent] of its state of domicile. This plan or study includes the name of the State in which the Group is chartered, as well as the Group’s principal place of business, and such plan of operation or feasibility study further includes the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of liability insurance the Group intends to offer. The Group has also submitted to the Insurance Commissioner [Director, Superintendent] of this State any revisions of such plan of operation or feasibility study to reflect any changes if the Group intends to offer any additional lines of liability insurance or change in the designation of the State in which it is chartered.

14. The Risk Retention Group will submit a copy of its annual financial statement submitted to its chartering state, to the Insurance Commissioner [Director, Superintendent] of this State. The annual financial statement shall be certified by an independent public accountant and include a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist. The annual financial statement, certification and statement of opinion on loss and loss adjustment expense reserves will be submitted to the Insurance Commissioner [Director, Superintendent] of this State by the date it is required to be submitted to its chartering state.

15. The Risk Retention Group will not solicit or sell insurance to any person in this State who is not eligible for membership in the Group.

16. The Risk Retention Group will not solicit or sell insurance in this State, or otherwise operate in this State, if the Group is in a hazardous financial condition or is financially impaired.

17. The Risk Retention Group will not issue any insurance policy in this State which provides coverage prohibited generally by statute of this State or declared unlawful by the highest court of this State whose law applies to such policy.

18. To the extent required by the LRRA, the Risk Retention Group will comply with all other applicable state laws.

19. The Risk Retention Group will notify the Insurance Commissioner [Director, Superintendent] as to any subsequent changes in any of the items included in this form.

The undersigned hereby swear and affirm that the foregoing statements and information regarding their principal, the __________________________ (Name of Risk Retention Group) are true and correct.

President of the Risk Retention Group

Secretary of the Risk Retention Group

State of )

County of )

Sworn before me this day of , 20__.

_____________________, Notary Public. My Commission Expires: __________
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

Part B

APPOINTMENT OF ATTORNEY TO ACCEPT SERVICE AND DESIGNATION

The ___________________________ ("the Group"), a risk retention group which is chartered and licensed as a liability insurance company under the laws of the State of ________________, having notified the Insurance Commissioner [Director, Superintendent] of the State of ________________ of its intention to do business in this State as a risk retention group pursuant to the federal Liability Risk Retention Act of 1986, hereby appoints the Insurance Commissioner [Director, Superintendent] of the State of ________________, any successor in office, and any authorized deputy its true and lawful attorney, in and for the State of ________________, upon whom all legal documents or process in any proceeding against it may be served. Such service of legal documents or process shall be of the same legal force and validity as if served personally upon the Group.

The Group designates:

______________________________
(Name)

______________________________
(Address)

______________________________
(City, Town or Village)

______________________________
(State and ZIP Code)

as its officer, agent or other person to whom shall be forwarded all legal documents or process served upon the Insurance Commissioner [Director, Superintendent] of the State of ________________, any successors in office, or any authorized deputy, for the Group. This designation shall continue in full force and effect until superseded by a new written designation filed with the Insurance Commissioner [Director, Superintendent].
This appointment and designation is made pursuant to a resolution by the Group’s governing body authorizing it, and a certified copy of the resolution is attached hereto. This appointment shall be binding upon any person or corporation which as successor acquires the Group’s assets or assumes its liabilities, by merger or consolidation or otherwise.

This appointment may be withdrawn only upon a written notice of termination and, in any event, shall not be terminated by the Group or its successor so long as any contracts or liabilities or duties arising out of contracts entered into by the Group while it was doing business in this State are in effect.

IN WITNESS OF THIS APPOINTMENT AND DESIGNATION, the Group, in accordance with the resolution of its Board of Directors duly passed on ____________, 20__, has affixed its corporate seal, and caused the same to be subscribed and attested in its name by its President and Secretary, at the City of ____________ in the State of ____________on ______________, 20__. 

____________________
(Name of Risk Retention Group)

By: ________________________ President

_____________________________ Secretary

State of ____________) 

) ss:

County of _________________

Sworn before me this ______ day of _________________, 20__. 

__________________________, Notary Public. My Commission Expires: __________
Nevada has no objections to the changes/updates regarding RRGs.

Thank you for the opportunity to assist you in this matter.

Kathy Kelley (Lamb), AA 4 with the APIR designation
PLEASE NOTE MY NEW EMAIL: kkelley@doi.nv.gov
State of Nevada, Division of Insurance
Corporate & Financial Affairs
1818 E. College Parkway, Ste. 103
Carson City, NV 89706-7986
T: (775) 687-0753
F: (775) 687-0787
E-Mail: kkelley@doi.nv.gov
Facebook: https://www.facebook.com/NevadaDivisionofInsurance
Twitter: https://twitter.com/nevadadoi
Visit Nevada Division of Insurance web pages: Address Changes, Annual Renewals of Company License, Annual Statement Filings, Biographical Affidavits, Electronic Payments, Holding Company Forms, Primary, Expansion & Corporate Amendment Applications, Statutory Deposits, Withdrawal of Company License.
NAIC Uniform Risk Retention Group – Notice and Registration form

Item 1c. – generally speaking, isn’t it likely that the date chartered and date licensed are different dates.

Item 8. – typo “Rroup”

Item 9. – consider requesting an email address for the company contact person

Risk Retention Groups: Frequently Asked Questions

General observation - “Complete” is used but not defined throughout the document. Several examples follow:

3.c. Once an RRG provides a complete NAIC Uniform Risk Retention Group Registration Form they may begin operating in the state and approval from the non-domestic state is not required.

4.a. Review the NAIC Uniform Risk Retention Group Registration Form and verify the RRG has provided a complete form.

6.a. A non-domestic state cannot reject the registration of an RRG that submits a complete registration form.

There is a difference between (1) a registration form in which all questions are answered and attachments are provided; and, (2) a registration form in which all questions are answered and attachments are provided with responses/documents demonstrating compliance with state and federal laws.

Considering the interpretation of the LRRA that an RRG can commence business in the state once a “complete” registration is filed, consider adding some definition or discussion around what a “complete” registration form is.

FAQ 4.b.a. – consider changing “for reasonableness” to “to verify that the RRG is qualified under the definition of Risk Retention Group.”

Best Practices – Risk Retention Groups

Registration Timeline – depending upon how “complete” is defined, a 10-day turnaround may not be reasonable.

Domiciliary State Responsibilities – Second sentence clean-up to read as:

Although the domiciliary regulator is responsible for taking actions involving their domiciliary RRGs, awareness by a non-domiciliary state may help them to proactively do what they can to protect their residents and respond to policyholder complaints or concerns directed to the them.
Attachment A – Inquiry Template – revisions to 5, 6 and 10 as follows:

Item 5 – Comments and/or concerns about the management or performance of the company.

Item 6 – Results of any financial analysis and/or market conduct findings.

Item 10 – Comments regarding the company’s application for registration in the State of [state registering].
September 5, 2019

VIA EMAIL - BMeyer@naic.org

Becky Meyer, CPA
Senior Accreditation Manager
National Association of Insurance Commissioners
1100 Walnut, Suite 1500
Kansas City, MO 64106

Re: Risk Retention Group (E) Task Force
Ongoing Support of NAIC Programs, Products or Services

Dear Ms. Meyer:

Attached are the comments of the National Risk Retention Association (NRRA) in redline format.

Our only comment on the Best Practices document is grammatical so that the sentence would read properly.

For the FAQ document, we only added the *ALAS v. Fitzgerald* case and a cite to the NAIC RRG Handbook where both *NRRA v. Brown* and the *ALAS v. Fitzgerald* cases are discussed.

We recommend one change for the Notice and Registration document. The current version of Item 6(a) deviates from the language in the LRRA, 15 USC § 3901 (a)(4)(E)(i). In order to be consistent, 6(a) should be:

_____ the owners of the Group are only persons who comprise the membership of
the Group and who are provided Insurance by the Group.

The drafting committee has done an excellent job of conforming the Notice and Registration document to the LRRA, *e.g.*, in Items 11 and 12, which is important to avoid a conflict between state and federal law. To avoid any confusion, we believe Item 6(a) should be conformed as noted above.
Becky Meyer, CPA
September 5, 2019
Page 2

The NRRA very much appreciates the opportunity to comment on the work of the Risk Retention Group Task Force.

Very truly yours,

[Signature]
Joseph E. Deems
Executive Director
National Risk Retention Association

rjm
Risk Retention Groups: Frequently Asked Questions

1. What publications are available to help understand RRGs and state’s authority?
   a. NAIC Risk Retention and Purchasing Group Handbook is available from the NAIC publications webpage at https://www.naic.org/documents/prod_serv_legal_ris_bb.pdf. The following key documents can be found as Appendices in the Handbook:
      • Appendix A: Federal Liability Risk Retention Act
      • Appendix B: NAIC Model Risk Retention Act (#705)
      • Appendix D: NAIC Uniform Risk Retention Group Registration Form
   b. Accreditation Program Manual
      • Part A: Laws and Regulations – 18 accreditation standards that outline the laws required specifically for states that charter RRGs
      • Part B: Regulatory Practices and Procedures - RRG specific procedures for financial analysis and procedures when a disclaimer of affiliation is filed

2. How does the LRRA address regulation of RRGs?
   a. Under §3902 of the LRRA, with the exception of the domiciliary state, RRGs are exempt from all state laws, rules, regulations, or orders that would make unlawful, or would regulate, directly or indirectly, the formation and operation of an RRG, except as provided in the LRRA. Only the domiciliary state may regulate the formation and operation of an RRG.
   b. The implementation of the LRRA was intended to allow organizations to come together in the creation of a risk-bearing, risk-sharing entity (the RRG) to offer its members, who are the beneficiaries of the insurance provided, liability coverage in an expedient and economical manner.

3. How does RRG registration in a non-domiciliary state differ from the licensing process for a traditional insurer?
   a. There are no solvency requirements imposed by the non-domiciliary state upon an RRG seeking to register in the State. Regulation as to formation and operation, including the imposition of solvency requirements, are imposed by the domestic state.
   b. RRGs are subject to a substantially similar application and licensing process imposed by the domestic state, or state of domicile. For registration to conduct business in non-domestic states, RRGs are not subject to the standard application and licensing process (NAIC UCAA Instructions or NAIC Company Licensing Handbook).
   c. The registration process is intended to be simpler than the licensing process for other types of insurers. Registration is focused on information gathering rather than decision making. Registration is not the same as admission or company licensing; it is not intended to provide non-domiciliary states with any regulatory powers over RRGs other than that provided in the LRRA. It is not within a state’s authority to use the processing of a registration to bar RRGs seeking to lawfully operate in a state, nor can a state declare a “moratorium” on the filing of RRG registrations. Once an RRG provides a complete NAIC Uniform Risk Retention Group
Registration Form they may begin operating in the state and approval from the non-domestic state is not required. However, best practice is for the non-domiciliary state to notify the RRG following their initial review of the NAIC Uniform Risk Retention Group Registration Form that either the form received was complete, or that the form was missing information. The non-domiciliary state may also reach out to the domiciliary state for more information and is encouraged to do so. (see the Best Practices—Risk Retention Groups document)

d. The LRRA references two documents that must be provided to the non-domestic state – a plan of operation OR a feasibility study. There is also additional information such as contact information of the RRG, chartering state information, and the lines of liability insurance business that are written by the RRG seeking to register. All this information is provided in the completed NAIC Uniform Risk Retention Group Registration Form.
e. For an RRG that is compliant with the LRRA and the regulation of their domestic state (including authorization to register to do business in another state), the non-domestic state cannot deny the RRG’s registration. If there is uncertainty, the domestic state should be contacted.

4. What are the steps for the non-domiciliary insurance regulator to take in the registration process for an RRG?
   a. Review the NAIC Uniform Risk Retention Group Registration Form and verify the RRG has provided a complete form.
   b. Once a complete form is received, the RRG is authorized to write in the state where it registers. The following best practices may also be considered during the registration process; however, they do not impact the registration status of the RRG:
      a. Review the information provided with the registration form for reasonableness.
      b. Reach out to the domestic state insurance regulator for additional information or concerns. The best practices Inquiry Template can be used and modified as appropriate.
      c. Notify the RRG once the registration form is deemed complete. They are now registered in the state.

5. What should a non-domiciliary state do if they have concerns about a complete RRG registration form received?
   a. If the RRG provided a complete form, but there are concerns about the lines of business or financial solvency, or some other matter, the non-domiciliary state should first communicate with the domestic state. If necessary, the non-domiciliary state should consider pursuing the remedies in LRRA §3902(a)(1) also discussed in FAQ #12.

6. When can a non-domiciliary state reject an RRG registration?
   a. A non-domestic state cannot reject the registration of an RRG that submits a complete registration form. Instead the non-domestic state should communicate concerns to the domestic state or refer to the remedies in LRRA §3902(a)(1) also discussed in FAQ #12.
7. Can an RRG registration be delayed if a financial statement filing and/or audit is not yet available at the time of application or registration?
   a. No, an RRG can register prior to filing of an annual financial statement audit and a statement of opinion on loss and loss adjustment expense reserves with its domiciliary state.
   b. Once these initial filings are made, they are available on I-Site for review.
   c. If questions arise due to lack of this information, the non-domiciliary state should reach out to the domestic state to address its concerns.

8. What items does the LRRA require an RRG provide to the non-domiciliary state in conjunction with the registration?
   a. It is recommended that states adopt the NAIC Uniform Risk Retention Group Registration Form, which has been developed by the NAIC in order to facilitate uniformity. Such forms are included in the Risk Retention and Purchasing Group Handbook.
   b. Consistent with LRRA, each RRG shall submit a copy of the plan of operation or a feasibility study before it may offer insurance in the state.
      Note: If the RRG is newly formed, the feasibility study provides relevant information on rates and expected losses. If the RRG is expanding the states in which it operates and has been writing business for an extended period, the feasibility study becomes less relevant and a current business plan, along with documents a non-domiciliary state can easily obtain from the NAIC’s I-Site (Annual Statement(s), RBC Report(s), MD&A(s), Audited Financial Statement(s), Actuarial Certification(s)) provide pertinent information.
   c. If the plan of operation or feasibility study does not appear to be updated, a non-domiciliary state should contact the domiciliary state regulator to obtain more information, including the IPS, and may request revised documents from the RRG if original submission is found to be inaccurate or unclear.

9. What should be included in a plan of operation?
   a. The LRRA states that an RRG’s plan of operation or feasibility study includes information on liability insurance coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer.
   b. In addition, the Best Practices – Risk Retention Groups document offers a list of other suggested items for inclusion in a plan of operations or feasibility study.

10. What does the LRRA say about renewals for RRGs in non-domiciliary states?
    a. The LRRA is silent; therefore, initial registration is sufficient unless the operation of an RRG is affected by runoff, rehabilitation or liquidation processes. RRGs file changes in business plans, financial filings, etc. on an ongoing basis with non-domiciliary states; therefore, non-domiciliary states should consider developing a process for communicating with the domiciliary state (such as the example in the Best Practices—Risk Retention Groups document) and consider an annual request for Certificate of Good Standing/Compliance from the domiciliary state.
b. Section 3902(d)(3) of the LRRA requires that an RRG submit to the insurance commissioner of each state in which it is doing business a copy of the annual financial statement that it files with the RRG’s domiciliary state. Non-domiciliary states should be aware that in many states where RRGs are licensed/chartered as captive insurers in conformity with NAIC accreditation standards, RRGs are permitted to use Generally Accepted Accounting Principles rather than Statutory Accounting Principles to report on their financial conditions, with required disclosure and reconciliation in footnote one. (see also Section II, page 3 of the Risk Retention and Purchasing Group Handbook)

c. The filing is an ongoing requirement that must be complied with on an annual basis and is generally due to non-domiciliary states upon filing with the domiciliary state. The annual financial statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by an actuary or loss reserve specialist who is qualified in accordance with the criteria established by the NAIC in the annual statement instructions.

11. What does the LRRA say about taxes and fees charged by a non-domiciliary RRG?
   a. LRRA S3902(a)(1)(B) says any state may require an RRG to:
      a. Pay on a nondiscriminatory basis, applicable premium and other taxes, which are levied on admitted insurers and surplus lines insurers, brokers, or policyholders under the laws of the state.
   b. Fees are not directly addressed in the LRRA and as such, there has been disagreement about the legality of both initial and renewal registration fees and compliance with LRRA. The authority on this topic is therefore federal case law. Thus far, there is one case are two cases (Nat’l Risk Retention Assoc. v. Brown, 927 F. Supp. 195 (M.D. La. 1996) and Attorney’s Liab. Assurance Society, Inc. v. Fitzgerald, 174 F. Supp. 2d 619 (W.D. Mich. 2001) in which the court ruled that certain state requirements, including the payment of an annual renewal registration fee, were preempted by the LRRA. See the Risk Retention and Purchasing Group Handbook [II-5, 6, 7] for additional detail on the case and other fee considerations.

12. What remedies are available to a non-domiciliary state if violations of applicable State laws occur?
   a. Secure clarification from the RRG’s state of domicile;
   b. Call for an examination of the RRG by the state of domicile [15 U.S.C. §3902(a)(1)(E)];

13. Is there a list of domestic and non-domestic state contact persons in state insurance regulator offices who are knowledgeable about RRGs?
   a. Yes. Appendix C of the NAIC Risk Retention and Purchasing Group Handbook includes a list of state insurance department contact persons. The most recent list is maintained as a separate document on the NAIC’s publication webpage alongside a complete copy of the Risk Retention and Purchasing Group Handbook.
The domiciliary state maintains authority and has responsibility to regulate the formation and operation of a Risk Retention Group (RRG). Therefore, when concerns arise in a non-domiciliary state about a RRG, the best resource is the domiciliary state. This includes concerns about solvency and capital levels, financial condition, or other non-compliance of an RRG as well as operational questions and concerns that should be directed to the domiciliary state.

States are encouraged to examine their RRG laws to make certain that they are consistent with (1) the LRRA and (2) the NAIC Model Risk Retention Act.

**Questions/Concerns from Non-domiciliary State**

Upon initial registration of an RRG in a non-domiciliary state, it is not uncommon for questions to arise that are best directed to the domiciliary state. *Attachment A* outlines a sample Inquiry Template that can be used to request this information. The template may be customized as deemed appropriate by the non-domiciliary state. Domiciliary states should respond in a timely manner to such requests.

Questions about operations and financial solvency that arise following initial registration should also be addressed to the domiciliary state.

If significant concerns still exist after communication with the domiciliary state and the non-domiciliary state concludes that the RRG is not compliant with any of the specific procedures set forth in the LRRA, the following steps may be undertaken:

a. Refer to your own state RRG statute to ensure compliance of your prospective action;
b. Provide written notice of any non-compliance directly to the RRG;
c. Submit a demand for examination of the RRG to the domiciliary regulator, as provided by the LRRA [15 U.S.C. S3902(a)(1)(E)];
d. Institute suit in a court of competent jurisdiction.

A non-domiciliary state may request the following from the domiciliary state and similarly, the domiciliary state should be prepared to provide the following to the non-domiciliary state:

e. Insurer Profile Summary (IPS)
f. Inquire about the extent of biographical affidavit review and results of background checks
g. Most recent examination report (may be obtained from I-Site)
h. Amendments to the RRG’s business plan or feasibility study
i. Verification of domiciliary state approval to expand into non-domiciliary state

Alternatively, *Attachment A – Inquiry Template* may be used for this request with modifications as necessary.
Registration Timeline
The registration process for RRGs should be shorter than the licensing process for other types of insurers as the RRG is responsible only for a complete registration form and the related attachments. The non-domiciliary state cannot reject a complete registration that complies with state and federal laws. However, it is still necessary for the non-domiciliary state to review the registration form to ensure it is complete and demonstrates that the RRG complies with the LRRA. In addition, concerns can be raised with the domiciliary state, who has the authority to regulate the formation and operation of an RRG. The following guidelines take into consideration similar guidelines for ordinary insurance companies, and adherence is at the discretion of each state.

- A non-domiciliary state should review the registration form for completeness within 10 business days of its receipt of the form and notify the Risk Retention Group of the need to submit any missing elements.
- Following receipt of a complete application, a non-domiciliary state should notify the RRG within 30 days that its registration is confirmed.
- The domiciliary state should respond to inquiries from a non-domiciliary state in a prompt manner, typically no later than 10 business days after receiving the inquiry.

Domiciliary State Responsibilities
When a domiciliary state identifies an RRG as troubled or potentially troubled, the State insurance regulator should make efforts to communicate proactively with other state insurance regulators in which the RRG is registered (consistent with the Troubled Insurance Company Handbook). Although the domiciliary regulator is responsible taking actions involving their domiciliary RRGs, awareness by a non-domiciliary state may help them to proactively do what they can to protect their residents and respond to policyholder complaints or concerns directed to them.

Plan of Operation/Feasibility Study
Domiciliary states should ensure the RRG’s plan of operation or feasibility study includes the following, at a minimum:
- information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;
- information sufficient to verify that the liability insurance coverage to be provided by the Risk Retention Group will only cover the members of the Risk Retention Group;
- for each state in which it intends to operate, information regarding the liability insurance coverages, deductibles, coverage limits, rates and/or rating/underwriting methodology for each line of commercial liability insurance the group intends to offer;
- historical and expected loss experience of proposed members and national experience of similar exposures to the extent that this experience is reasonably available;
- appropriate opinions/feasibility work by a qualified independent casualty actuary, including a determination of minimum premium participation levels required to commence operation and to prevent a hazardous financial condition;
- pro forma financial statements and projections, including assumptions, on an expected and adverse basis;
- identification of Board of Directors, including independence determination;
- biographical affidavits for all BOD members;
- evidence of compliance with corporate governance standards, including draft policies;
- underwriting and claim procedures;
- marketing methods and materials if available;
- draft insurance policies;
- names of reinsurers and reinsurance agreements, if available;
- investment policies;
- identification of each state in which the RRG intends to write business/register;
- identification of service providers, including fee structure and relationships to members; and
- subsequent material revisions to the plan of operation or feasibility study.
Attachment A – Inquiry Template

The above-subject company has applied for Registration as a Risk Retention Group ("RRG") in the State of _______ to write _________ liability coverage to its members who are in the business of_____________________________. As you can appreciate, due to the provisions of the Liability Risk Retention Act of 1986 the (state) has limited authority to regulate RRGs and therefore to a large extent, the (state) relies on the RRGs’ domiciliary state to exercise general oversight and responsibility in the areas of licensing, solvency, rates and marketing. As part of our due diligence, we would appreciate any information your office can share with us regarding the company with respect to the following items, some of which may be satisfied by providing the Insurer Profile Summary:

1. Any significant concerns the State of [domicile] has regarding the company.
2. Any issues that may have a significant impact on the company going forward.
3. Any issues regarding the number of consumer complaints the company has in [state of domicile] or other states that may have been brought to your attention.
4. Comments and/or concerns about the financial condition of the company.
5. Comments or concerns about the management or performance of the company.
6. Results of any financial analysis or market conduct findings.
7. The company’s priority level within the Financial Analysis Division.
8. Any conditions imposed by your Department upon the company’s license.
9. Any significant non-compliance issues with the State of [domicile] regulatory authority including filing requirements and corrective action, if any.
10. Comments regarding company’s application for registration in the State of [state registering].
11. Approval from State of [domicile] for the RRG to register in the State of [state registering].
RISK RETENTION GROUP FORM

Appendix D

The following is the uniform registration form adopted in 1991 by the NAIC. This registration form is being filed by a Risk Retention Group (RRG) operating in accordance with the Federal Liability Risk Retention Act of 1986 (LRRA), 15 USC 3901-3906, chartered of licensed to write only liability insurance by the state of domicile listed in #1c. The registration form and supplemental documents are provided in accordance with §3902(d)(2) of the LRRA. Under §3902 of the LRRA, with the exception of the domiciliary state, RRGs are exempt from all state laws, rules, regulations, or orders that would make unlawful, or would regulate, directly or indirectly, the operation of an RRG, except that any state may require an RRG to comply with those laws specified in the LRRA. The domiciliary state regulates the formation and operation of the RRG.

Part A

STATE OF [Insert State in which the Risk Retention Group intends to do business]

DEPARTMENT OF INSURANCE

RISK RETENTION GROUP - NOTICE AND REGISTRATION

(All Information Should Be Typed)

1a. Name of the Risk Retention Group as it appears on its Certificate of Authority:

1b. FEIN:

1c. State of domicile and date license/chartered:

1d. Primary contact person for state of domicile to whom questions regarding the Risk Retention Group should be addressed (include name, phone number and email address):

2. List any other name(s) by which the Risk Retention Group is known or may be doing business in this State or any other state:

3. The Risk Retention Group is chartered and licensed as a liability insurance company under the laws of the State of ____________ and is authorized to engage in the following lines and/or classifications of liability insurance under the laws of its chartering State:

Commented (Meyer, Becky): Request feedback from the full Task Force on how this is used and if it is necessary.
RISK RETENTION GROUP FORM

4. Give a general description of the liability insurance coverages the Risk Retention Group plans to write in the state it is registering to do business in.

5. Has the Risk Retention Group’s domiciliary state approved the Risk Retention Group to register and expand its writings in the state it is seeking to become registered in?

6. Ownership of the Risk Retention Group consists of one or the other of the following (check one):
   a) ______ the owners of the Group are the only persons who comprise the membership of the Group and the only ones who are provided insurance by the Group.
   b) ______ the sole owner of the Group is: ________________________________

   (Name and Address of Organization)

   an organization which has as its members only persons who comprise the membership of the Group and which has as its owners only persons who comprise the membership of the Group and who are provided insurance by the Group.

7. The Risk Retention Group members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business (whether profit or nonprofit), trade, product, services (including professional services), premises or operations. Give a general description of businesses or activities engaged in by the Group’s members.

8. (a) List the name, position with the Risk Retention Group, SSI, and address of each officer and director of the Risk Retention Group: (Attach additional pages, if necessary.)
RISK RETENTION GROUP FORM

(b) Identify and give the telephone number of the officer or director of the Risk Retention Group who can be contacted for any information regarding the management of the insurance activities of the Group:

Name: __________________________ Telephone Number: __________________________

9. List the name, address(es), postal and email, telephone number and Federal Employer Identification Number (FEIN) of the company responsible for managing the insurance operations of the Risk Retention Group and the contact person’s name and telephone number at the company: (If none, answer none.)

Contact Person: __________________________ Telephone #: __________________________

10. List the name(s), NPR#, SS# and address(es) of the licensed insurance agent(s) or broker(s) who will be responsible for marketing the Risk Retention Group’s insurance policies in the State of [Insert State in which the Risk Retention Group intends to do business] and the current licensing status in the State of [Insert State in which the Risk Retention Group intends to do business] in which they are licensed: (If none, answer none. Attach additional pages, if necessary.)

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11. In accordance with the Liability Risk Retention Act, we verify the following:

A. The Risk Retention Group is a corporation or other limited liability association whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its members.

B. The Risk Retention Group is organized for the primary purpose of conducting the activity described under Item “A” above.

C. The Risk Retention Group does not exclude any person from membership in the Group solely to provide for members of the Group a competitive advantage over such a person.

D. The activities of the Risk Retention Group do not include the provision of insurance other than:
RISK RETENTION GROUP FORM

i. Liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its Group members; and

ii. Reinsurance with respect to the similar or related liability exposure of another Risk Retention Group (or a member of such other Risk Retention Group) engaged in business or activities so that such Risk Retention Group or member meets the requirement under Item #7 above for membership in the Risk Retention Group which provides such reinsurance.

12. In accordance with the LRRA, if the State in which the Risk Retention Group is registering requires compliance with the following laws and requirements, the RRG agrees to the following:

A. The Risk Retention Group will comply with the unfair claim settlement practices laws of this State.

B. The Risk Retention Group will pay, on a non-discriminatory basis, applicable premium and other taxes which are levied on admitted insurers, surplus line insurers, brokers or policyholders, each Group under the laws of this State.

H-C. The Risk Retention Group will participate, on a nondiscriminatory basis, in any mechanism established or authorized under the law of the State for the equitable apportionment among insurers of liability insurance losses and expenses incurred on policies written through such mechanism.

G-D. The Risk Retention Group will designate the Insurance Commissioner [Director, Superintendent] of this State as its agent solely for the purpose of receiving service of legal documents or process by executing Part B of this form, attached hereto.

D-E. The Risk Retention Group will submit to examination by the Insurance Commissioner [Director, Superintendent] of this State to determine the Group’s financial condition, if:

i. the Insurance Commissioner [Director, Superintendent] of the Group’s chartering State has not begun or has refused to initiate an examination of the Group; and

ii. any such examination by the Insurance Commissioner [Director, Superintendent] shall be coordinated to avoid unjustified duplication and unjustified repetition.

E-F. The Risk Retention Group will comply with a lawful order issued in a delinquency proceeding commenced by the Insurance Commissioner [Director, Superintendent] of this State upon a finding of financial impairment, or in a voluntary dissolution proceeding.

E-G. The Risk Retention Group will comply with the laws of this State concerning deceptive, false or fraudulent acts or practices, including any injunctions regarding such conduct obtained from a court of competent jurisdiction.

G-H. The Risk Retention Group will comply with an injunction issued by a court of competent jurisdiction upon petition by the Insurance Commissioner [Director, Superintendent] of this State alleging that the Group is in hazardous financial condition or is financially impaired.

H-I. The Risk Retention Group will provide the following notice, in at least 10-point type, in any insurance policy issued by the Group:
RISK RETENTION GROUP FORM

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your risk retention group.

12.13. In accordance with the LRRA, the Risk Retention Group affirms that it has submitted to the Insurance Commissioner [Director, Superintendent] as part of this filing and before it has offered any insurance in this State, a copy of the plan of operation or feasibility study which it has filed with the Insurance Commissioner [Director, Superintendent] of its chartered State of domicile. This plan or study includes the name of the State in which the Group is chartered, as well as the Group's principal place of business, and such plan of operation or feasibility study further includes the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of liability insurance the Group intends to offer. The Group has also submitted to the Insurance Commissioner [Director, Superintendent] of this State any revisions of such plan of operation or feasibility study to reflect any changes to the plan if the Group intends to offer any additional lines of liability insurance or including any change in the designation of the State in which it is chartered.

12.14. The Risk Retention Group will submit a copy of its annual financial statement submitted to its chartering state, to the Insurance Commissioner [Director, Superintendent] of this State by March 1 of each year. The annual financial statement will be certified by an independent public accountant and include a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist. The annual financial statement certification and statement of opinion on loss and loss adjustment expense reserves will be submitted to the Insurance Commissioner [Director, Superintendent] of this State by the date it is required to be submitted to its chartering state.

14.15. The Risk Retention Group will not solicit or sell insurance to any person in this State who is not eligible for membership in the Group.

14.16. The Risk Retention Group will not solicit or sell insurance in this State, or otherwise operate in this State, if the Group is in hazardous financial condition or is financially impaired.

14.17. The Risk Retention Group will not issue any insurance policy in this State which provides coverage prohibited generally by statute of this State or declared unlawful by the highest court of this State whose law applies to such policy.

17. The Risk Retention Group has submitted a registration fee of $__________ if applicable, payable to the Insurance Commissioner [Director, Superintendent] of this State.

18. To the extent required by the LRRA, the Risk Retention Group will comply with all other applicable state laws.

19. The Risk Retention Group will notify the Insurance Commissioner [Director, Superintendent] as to any subsequent changes in any of the items included in this form.

The undersigned hereby swear and affirm that the foregoing statements and information regarding their principal, ________________ (Name of Risk Retention Group) are true and correct.

President of the Risk Retention Group
RISK RETENTION GROUP FORM

Secretary of the Risk Retention Group

State of ___________

County of ___________

Sworn before me this _____ day of _________________, 20__.

_________________, Notary Public. My Commission Expires: ____________
RISK RETENTION GROUP FORM

Part B

APPOINTMENT OF ATTORNEY TO ACCEPT SERVICE AND DESIGNATION

The ________________ (“the Group”), a risk retention group which is chartered and licensed as a liability insurance company under the laws of the State of ________________, having notified the Insurance Commissioner [Director, Superintendent] of the State of ________________ of its intention to do business in this State as a risk retention group pursuant to the federal Liability Risk Retention Act of 1986, hereby appoints the Insurance Commissioner [Director, Superintendent] of the State of ________________, any successor in office, and any authorized deputy its true and lawful attorney, in and for the State of ________________, upon whom all legal documents or process in any proceeding against it may be served. Such service of legal documents or process shall be of the same legal force and validity as if served personally upon the Group.

The Group designates:

________________________________________
(Name)

________________________________________
(Address)

________________________________________
(City, Town or Village)

________________________________________
(State and ZIP Code)

as its officer, agent or other person to whom shall be forwarded all legal documents or process served upon the Insurance Commissioner [Director, Superintendent] of the State of ________________, any successors in office, or any authorized deputy, for the Group. This designation shall continue in full force and effect until superseded by a new written designation filed with the Insurance Commissioner [Director, Superintendent].
RISK RETENTION GROUP FORM

This appointment and designation is made pursuant to a resolution by the Group’s governing body authorizing it, and a certified copy of the resolution is attached hereto. This appointment shall be binding upon any person or corporation which as successor acquires the Group’s assets or assumes its liabilities, by merger or consolidation or otherwise.

This appointment may be withdrawn only upon a written notice of termination and, in any event, shall not be terminated by the Group or its successor so long as any contracts or liabilities or duties arising out of contracts entered into by the Group while it was doing business in this State are in effect.

IN WITNESS OF THIS APPOINTMENT AND DESIGNATION, the Group, in accordance with the resolution of its Board of Directors duly passed on ________________, 20__, has affixed its corporate seal, and caused the same to be subscribed and attested in its name by its President and Secretary, at the City of ________________ in the State of ________________ on ________________, 20__.  

________________________ (Name of Risk Retention Group)

By: ________________________ President

________________________ Secretary

State of ________________

) ss:

County of ________________

Sworn before me this ___ day of ________________, 20__.

________________________, Notary Public. My Commission Expires: __________
Comments on the Uniform Registration Form for RRGs

Item 6 (a) and (b): How is “persons” defined for the purposes of this form. Since RRGs may only insure commercial insurance, does this word encompass both individual professionals and business entities?

Item 19: Is the Insurance Commissioner in Item 19 the domicile or non-domicile Commissioner? If non-domicile, does that mean that an RRG must report every change in the board of directors to every non-domicile regulator? If so, how soon after the change?

Comments on the Q&A

In the paragraph entitled Registration Timeline it states that, “The non-domestic state cannot reject a complete registration that complies with state and federal laws.” Can you provide examples of state laws that might be used to deny the Registration of an RRG?

Please let me know if you have any questions.

Cordially,

Pamela

Pamela E. Davis
Founder, President and CEO
831-621-6018 | Direct
800-359-6422 | Office

Nonprofits Insurance Alliance
A head for insurance. A heart for nonprofits.
insurancefornonprofits.org
September 6, 2019

Via email: bmeyer@naic.org

Ms. Becky Meyer, CPA
Senior Accreditation Manager
National Association of Insurance Commissioners
1100 Walnut, Suite 1500
Kansas City, MO 64106

Re: Comments on Risk Retention Group (E) Task Force on RRG Notice and Registration Form; Frequently Asked Questions and Best Practices

Dear Ms. Meyer:

The Vermont Captive Insurance Association (VCIA) and its 450 member organizations appreciate the opportunity to provide comments on these three documents relating to risk retention groups (RRGs). The State of Vermont is the domicile of approximately 40% of the roughly 220 active RRGs operating in the United States, and most of these are members of VCIA.

We greatly appreciate the hard work of the RRG (E) Task Force to tackle some of the issues raised by impermissible requirements imposed by non-domiciliary states on RRGs. We believe that many of the problems encountered by RRGs in non-domiciliary states result from efforts to impose requirements, particularly registration requirements and fees, not permitted by the Liability Risk Retention Act (LRRA).

VCIA commends the Task Force for its efforts to clarify application of the LRRA and educate state regulators and the RRG community on authority given by the LRRA to domiciliary states and to non-domiciliary states. The Task Force has done an excellent job addressing and clarifying these issues. The revised NAIC Uniform RRG Notice and Registration Form, Frequently Asked Questions, and Best Practices are comprehensive and straightforward, and provide clarity to the most serious registration issues raised by RRGs.
VCIA comment letter re: NAIC RRG TF Exposure Drafts – September 6, 2019

VCIA has four comments on the draft registration form:

(1) We recommend the second to last sentence of the introductory paragraph on page 1 be rephrased as follows: “Under §3902 of the LRRA, with the exception of the domiciliary state, RRGs are exempt from all state laws, rules, regulations, or orders that would make unlawful, or would regulate, directly or indirectly, the operation of an RRG, except that any state may require an RRG to comply with those specific state laws not exempted by §3902 of the LRRA.” We believe this revision is important to clarify that the right of non-domiciliary states to regulate RRGs is limited to specific state laws.

(2) The Task Force may want to consider in Item 1 requesting the address and NAIC Company Code of the organization. It may also be more appropriate to request the organization’s FEIN in Item 1 rather than requiring in Item 9 the FEIN of the manager.

(3) In Item 6(a), with respect to members and insureds, we recommend that the language in the form be the same as in the LRRA because the language in the proposed form appears to be more restrictive than that in the LRRA. [See Section 3901 (a)(4)(E)(i)].

(4) We recommend Item 7 be deleted and a new Item 15 created as follows: “In accordance with the LRRA, and as evidenced by the domiciliary state’s action in approving licensure of the Risk Retention Group, the RRG affirms its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business (whether profit or nonprofit), trade, product, services (including professional services), premises or operations.” Presently, Item 7 of the registration form requires RRG registrants to affirmatively prove to non-domiciliary states that the RRG is compliant with this LRRA requirement by requiring the RRG to include a description of the businesses or activities engaged in by the RRG’s members. Including this affirmative requirement in the registration form is inconsistent with the LRRA. The LRRA is very clear that the domicile state is solely empowered to regulate the formation and operation of RRGs. To form and license an RRG, the domicile state must review the RRG application to determine whether the applicant meets the federal law requirements for forming an RRG. One of the key requirements is a showing that the applicant’s members are sufficiently similar or related with respect to their liability exposures by virtue of any related, similar or common business, etc. Without satisfying this LRRA requirement, the RRG cannot be licensed in its domicile state. The revision recommended above will help clarify that the membership’s compliance with the LRRA is confirmed by the domicile state as part of formation and licensure and that this is not a determination subject to non-domiciliary state regulation.

(5) Item 17 appears to expand Section 3905(c) of the LRRA, which provides: “Prohibited insurance policy coverage. The terms of any insurance policy provided by a risk retention group . . . shall not provide or be construed to provide insurance policy coverage prohibited generally by the state statute or declared unlawful by the highest court of the state whose law applies to such policy.”
VCIA comment letter re: NAIC RRG TF Exposure Drafts – September 6, 2019

As drafted, Item 17 states that the law of the state in which the RRG is registering applies to the policy and that RRGs are barred from writing coverages that have been declared unlawful by such state’s highest court. This prohibition is much broader than what is contained in the LRRA. VCIA recommends that the language of Item 17 track Section 3905(c) more closely; i.e., “[t]he risk retention group will not issue any policy in the state which provides coverage prohibited generally by statute or declared unlawful by the highest court of the state whose law applies to the policy.”

In addition, VCIA has one comment on the draft Best Practices document:

(1) We recommend the second and third sentences of the section titled “Registration Timeline” be revised as the current language could be interpreted as implying that non-domiciliary states have broader authority over the registration process than that granted under the LRRA. Our suggested revision is as follows: “The non-domestic state cannot reject a complete registration that complies with those laws of the non-domestic state that are not pre-empted under the LRRA. In the event a non-domestic state has concerns with an RRG registration, such concerns should be raised with the domiciliary state regulator, who has the authority to regulate the formation and operation of an RRG.”

Thank you again for the opportunity to submit these comments.

Sincerely,

[Signature]

Richard Smith
President

cc: Sandra Bigglestone
    Vermont Dept. of Financial Regulation
I think the three exposed RRG documents are well drafted and I support them. I have been managing RRGs since 1990 and have struggled in dealing with non-domiciliary states over the years. I think these documents would help clarify roles and responsibilities.

I did notice a couple of typos in the Best Practice document:

On page 2 in the Registration Timeline section

- A non-domiciliary state should review the registration form for completeness within 10 business days of its receipt of the form and notify the Risk Retention Group of the need to submit any missing elements.

On page 2 in the Domiciliary State Responsibilities section

When a domiciliary state identifies an RRG as troubled or potentially troubled, the State insurance regulator should make efforts to communicate proactively with other state insurance regulators in which the RRG is registered (consistent with the Troubled Insurance Company Handbook). Although the domiciliary regulator is responsible for taking actions involving their domiciliary RRGs, awareness by a non-domiciliary state may help them to proactively do what they can to protect their residents and respond to policyholder complaints or concerns directed to the them.

Also in the plan of operations/feasibility section I do question the need to provide copies of biographical affidavits to the non-domiciliary states. There are a couple of states that take this to heart and request that we send them updated bios whenever a new director is elected. In this day and age of identity theft and state level data theft/data ransom events (even though the bio form in VT no longer asks for SSN), directors expect us to keep their information confidential. What I typically do is tell the non-domiciliary state that the bio has been filed with Vermont DFR and they can contact Vermont for access to the bio if need be. So far that has been successful.

Sincerely,

Kate Boucher

---

**Kathryn M. Boucher, CPA, ARM-E, ACI, FCI**  
**Director of Captive Management**  
Premier Insurance Management Services - a Premier, Inc. company  
American Excess Insurance Exchange, Risk Retention Group  
150 Dorset St., PMB #238  
S. Burlington, VT 05403  
802-863-4400 (T) | 802-343-2015 (M) | 704-733-2229 (F)  
Kate_boucher@premierinc.com  
For information on AEIX: www.aeixrrg.com
1. What publications are available to help understand RRGs and state’s authority?
   
   The following key documents can be found as Appendices in the Handbook:
   
   - Appendix A: Federal Liability Risk Retention Act
   - Appendix B: NAIC Model Risk Retention Act (#705)
   - Appendix D: NAIC Uniform Risk Retention Group Registration Form

2. How does the LRRA address regulation of RRGs?
   a. Under §3902 of the LRRA, with the exception of the domiciliary state, RRGs are exempt from all state laws, rules, regulations, or orders that would make unlawful, or would regulate, directly or indirectly, the formation and operation of an RRG, except as provided in the LRRA. Only the domiciliary state may regulate the formation and operation of an RRG.
   b. The implementation of the LRRA was intended to allow organizations to come together in the creation of a risk-bearing, risk-sharing entity (the RRG) to offer its members, who are the beneficiaries of the insurance provided, liability coverage in an expedient and economical manner.

3. How does RRG registration in a non-domiciliary state differ from the licensing process for a traditional insurer?
   a. There are no solvency requirements imposed by the non-domiciliary state upon an RRG seeking to register in the State. Regulation as to formation and operation, including the imposition of solvency requirements, are imposed by the domiciliary state.
   b. RRGs are subject to a substantially similar application and licensing process imposed by the domestic state, or state of domicile. For registration to conduct business in non-domestic states, RRGs are not subject to the standard application and licensing process (NAIC UCAA Instructions or NAIC Company Licensing Handbook).
   c. The registration process is intended to be simpler than the licensing process for other types of insurers. Registration is focused on information gathering rather than decision making. Registration is not the same as admission or company licensing; it is not intended to provide non- domiciliary states with any regulatory powers over RRGs other than that provided in the LRRA. It is not within a state’s authority to use the processing of a registration to bar RRGs seeking to lawfully operate in a state, nor can a state declare a “moratorium” on the filing of RRG registrations. Once an RRG provides a complete NAIC Uniform Risk Retention Group Registration Form they may begin operating in the state and approval from the non-domiciliary state is not required. However, best practice is for the non-domiciliary state to notify the RRG following their initial review of the NAIC Uniform Risk Retention Group Registration Form that either the form received was complete, or that the form was missing information. The non-domiciliary state may also reach out to the domiciliary state for more information and is encouraged to do so. (see the Best Practices—Risk Retention Groups document)

Commented [MB1]: Pennsylvania: Consider defining what constitutes a “complete” registration form as reference throughout this document.

Commented [MB2R1]: Drafting group recommends replacing this sentence with:
"Once an RRG (that it is in compliance with the definition of an RRG as stated in the LRRA) provides the NAIC Uniform Risk Retention Group Registration Form with all required information entered and attached, they may begin operating in the state. Approval from the non-domestic regulator is not required."

Commented [OS3]: DC agrees with the proposed change with the following highlighted modification:
"Once an RRG (that it is in compliance with the definition of an RRG as stated in the LRRA) provides the NAIC Uniform Risk Retention Group Registration Form with all required information entered and attached (i.e., a "complete form"), they may begin operating in the state. Approval from the non-domestic regulator is not required."
d. The LRRA references two documents that must be provided to the non-domestic state – a plan of operation OR a feasibility study. There is also additional information such as contact information of the RRG, chartering state information, and the lines of liability insurance business that are written by the RRG seeking to register. All this information is provided in the completed NAIC Uniform Risk Retention Group Registration Form.

e. For an RRG that is compliant with the LRRA and the regulation of their domestic state (including authorization to register to do business in another state), the non-domestic state cannot deny the RRG’s registration. If there is uncertainty, the domestic state should be contacted.

4. What are the steps for the non-domiciliary insurance regulator to take in the registration process for an RRG?
   a. Review the NAIC Uniform Risk Retention Group Registration Form and verify the RRG has provided a complete form.
   b. Once a complete form is received, the RRG is authorized to write in the state where it registers. The following best practices may also be considered during the registration process; however, they do not impact the registration status of the RRG:
      a. Review the information provided with the registration form for reasonableness.
      b. Reach out to the domestic state insurance regulator for additional information or concerns. The best practices Inquiry Template can be used and modified as appropriate.
      c. Notify the RRG once the registration form is deemed complete. They are now registered in the state.

5. What should a non-domiciliary state do if they have concerns about a complete RRG registration form received?
   a. If the RRG provided a complete form, but there are concerns about the lines of business or financial solvency, or some other matter, the non-domiciliary state should first communicate with the domestic state. If necessary, the non-domiciliary state should consider pursuing the remedies in LRRA §3902(a)(1) also discussed in FAQ #12.

6. When can a non-domiciliary state reject an RRG registration?
   a. A non-domestic state cannot reject the registration of an RRG that submits a complete registration form. Instead the non-domestic state should communicate concerns to the domestic state or refer to the remedies in LRRA §3902(a)(1) also discussed in FAQ #12.

7. Can an RRG registration be delayed if a financial statement filing and/or audit is not yet available at the time of application or registration?
   a. No, an RRG can register prior to filing of an annual financial statement audit and a statement of opinion on loss and loss adjustment expense reserves with its domiciliary state.
   b. Once these initial filings are made, they are available on I-Site for review.
   c. If questions arise due to lack of this information, the non-domiciliary state should reach out to the domestic state to address its concerns.

8. What items does the LRRA require an RRG provide to the non-domiciliary state in conjunction with the registration?
   a. It is recommended that states adopt the NAIC Uniform Risk Retention Group Registration Form, which has been developed by the NAIC in order to facilitate uniformity. Such forms are included in the Risk Retention and Purchasing Group Handbook.
   b. Consistent with LRRA, each RRG shall submit a copy of the plan of operation OR a feasibility study before it may offer insurance in the state.
Note: If the RRG is newly formed, the feasibility study provides relevant information on rates and expected losses. If the RRG is expanding the states in which it operates and has been writing business for an extended period, the feasibility study becomes less relevant and a current business plan, along with documents a non-domiciliary state can easily obtain from the NAIC's I-Site (Annual Statement(s), RBC Report(s), MD&A(s), Audited Financial Statement(s), Actuarial Certification(s)) provide pertinent information.

c. If the plan of operation or feasibility study does not appear to be updated, a non-domiciliary state should contact the domiciliary state regulator to obtain more information, including the IPS, and may request revised documents from the RRG if original submission is found to be inaccurate or unclear.

9. What should be included in a plan of operation?
   a. The LRRA states that an RRG’s plan of operation or feasibility study includes information on liability insurance coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer.
   b. In addition, the Best Practices – Risk Retention Groups document offers a list of other suggested items for inclusion in a plan of operations or feasibility study.

10. Where can the non-domiciliary state get information about an RRG's directors and officers?
    a. Directors and officers are listed in the annual and quarterly financial statements available from the NAIC’s I-Site. All changes in Directors and Officers, with accompanying biographical affidavit(s), are submitted to and reviewed by the domiciliary state. In order to eliminate the need for redundant regulatory functions and unnecessary transfer of sensitive personal identifiable information, a non-domiciliary state should rely on the domiciliary state’s review, which includes background checks on directors, officers and key management personnel of an RRG to ensure the competency, character and integrity of the insurer’s management.

10.11. What does the LRRA say about renewals for RRGs in non-domiciliary states?
    a. The LRRA is silent; therefore, initial registration is sufficient unless the operation of an RRG is affected by runoff, rehabilitation or liquidation processes. RRGs file changes in business plans, financial filings, etc. on an ongoing basis with non-domiciliary states; therefore, non-domiciliary states should consider developing a process for communicating with the domiciliary state (such as the example in the Best Practices—Risk Retention Groups document) and consider an annual request for Certificate of Good Standing/Compliance from the domiciliary state.
    b. Section 3902(d)(3) of the LRRA requires that an RRG submit to the insurance commissioner of each state in which it is doing business a copy of the annual financial statement that it files with the RRG’s domiciliary state. Non-domiciliary states should be aware that in many states where RRGs are licensed/chartered as captive insurers in conformity with NAIC accreditation standards, RRGs are permitted to use Generally Accepted Accounting Principles rather than Statutory Accounting Principles to report on their financial conditions, with required disclosure and reconciliation in footnote one. (See also Section II, page 3 of the Risk Retention and Purchasing Group Handbook)
    c. The filing is an ongoing requirement that must be complied with on an annual basis and is generally due to non-domiciliary states upon filing with the domiciliary state. The annual filing requirements for RRGs include an unaudited filing using the official Annual Statement Blank (property/casualty), an audited financial statement certified by an independent public accountant and a statement of opinion on loss and loss adjustment expense reserves made by an actuary or loss reserve specialist who is qualified in accordance with the criteria established by the NAIC in the annual statement instructions. See the
above-mentioned NAIC Accreditation Program Manual, Part A: Laws and Regulations for annual filing requirements for RRGs.

12. What does the LRRA say about taxes and fees charged by a non-domiciliary RRG?
   a. LRRA §3902(a)(1)(B) says any state may require an RRG to:
      a. Pay on a nondiscriminatory basis, applicable premium and other taxes, which are levied on admitted insurers and surplus lines insurers, brokers, or policyholders under the laws of the state.
   b. Fees are not directly addressed in the LRRA and as such, there has been disagreement about the legality of both initial and renewal registration fees and compliance with LRRA. The authority on this topic is therefore federal case law. For example, there is one case (Nat'l Risk Retention Assoc. v. Brown, 927 F. Supp. 195 (M.D. La. 1996)) in which the court ruled that certain state requirements, including the payment of an annual renewal registration fee, were preempted by the LRRA. See the Risk Retention and Purchasing Group Handbook for additional detail on relevant cases and other fee considerations.

13. What remedies are available to a non-domiciliary state if violations of applicable State laws occur?
   a. Secure clarification from the RRG’s state of domicile;
   b. Call for an examination of the RRG by the state of domicile [15 U.S.C. §3902(a)(1)(E)];

14. Is there a list of domestic and non-domestic state contact persons in state insurance regulator offices who are knowledgeable about RRGs?
   a. Yes. Appendix C of the NAIC Risk Retention and Purchasing Group Handbook includes a list of state insurance department contact persons. The most recent list is maintained as a separate document on the NAIC’s publication webpage alongside a complete copy of the Risk Retention and Purchasing Group Handbook. (Link to Handbook: https://www.naic.org/documents/prod_serv_legal_ris_bb.pdf)
Best Practices – Risk Retention Groups

The domiciliary state maintains authority and has responsibility to regulate the formation and operation of a Risk Retention Group (RRG). Therefore, when concerns arise in a non-domiciliary state about a RRG, the best resource is the domiciliary state. This includes concerns about solvency and capital levels, financial condition, or other non-compliance of an RRG as well as operational questions and concerns that should be directed to the domiciliary state.

States are encouraged to examine their RRG laws to make certain that they are consistent with (1) the LRRA and (2) the NAIC Model Risk Retention Act.

Questions/Concerns from Non-domiciliary State

Upon initial registration of an RRG in a non-domiciliary state, it is not uncommon for questions to arise that are best directed to the domiciliary state. Attachment A outlines a sample Inquiry Template that can be used to request this information. The template may be customized as deemed appropriate by the non-domiciliary state. Domiciliary states should respond in a timely manner to such requests.

Questions about operations and financial solvency that arise following initial registration should also be addressed to the domiciliary state.

If significant concerns still exist after communication with the domiciliary state and the non-domiciliary state concludes that the RRG is not compliant with any of the specific procedures set forth in the LRRA, the following steps may be undertaken:

a. Refer to your own state RRG statute to ensure compliance of your prospective action;
b. Provide written notice of any non-compliance directly to the RRG;
c. Submit a demand for examination of the RRG to the domiciliary regulator, as provided by the LRRA [15 U.S.C. 53902(a)(1)(E)];
d. Institute suit in a court of competent jurisdiction.

A non-domiciliary state may request the following from the domiciliary state and similarly, the domiciliary state should be prepared to provide the following to the non-domiciliary state:

ea. Insurer Profile Summary (IPS)
b. Inquire about the extent of biographical affidavit review and results of background checks
c. Most recent examination report (may be obtained from I-Site)
d. Amendments to the RRG’s business plan or feasibility study
e. Verification of domiciliary state approval to expand into non-domiciliary state

Alternatively, Attachment A – Inquiry Template may be used for this request with modifications as necessary.

Registration Timeline

The registration process for RRGs should be shorter than the licensing process for other types of insurers as the RRG is responsible only for a complete registration form and the related attachments. The non-domiciliary
state cannot reject a complete registration* that complies with those laws of the non-domiciliary state that are not preempted under the LRRA. In the event a non-domiciliary state has concerns with an RRG registration, such concerns should be raised with the domiciliary state, who has the authority to regulate the formation and operation of an RRG. The following guidelines take into consideration similar guidelines for ordinary insurance companies, and adherence is at the discretion of each state.

- A non-domiciliary state should review the registration form to ensure all required information is entered on the form within 10 business days of its receipt of the form and notify the Risk Retention Group of the need to submit any missing elements.
- Following receipt of a complete registration* application, a non-domiciliary state should notify the RRG within 30 days that its registration is confirmed.
- The domiciliary state should respond to inquiries from a non-domiciliary state in a prompt manner, typically no later than 10 business days after receiving the inquiry.


Domiciliary State Responsibilities
When a domiciliary state identifies an RRG as troubled or potentially troubled, the State insurance regulator should make efforts to communicate proactively with other state insurance regulators in which the RRG is registered (consistent with the Troubled Insurance Company Handbook). Although the domiciliary regulator is responsible for taking actions involving their domiciliary RRGs, awareness of a non-domiciliary state may help them to proactively do what they can to protect their residents and respond to policyholder complaints or concerns directed to them.

General Licensing Guidance
Domiciliary states should ensure the RRG’s application for licensing, which includes the plan of operation and feasibility study, includes the following, at a minimum:
- information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;
- information sufficient to verify that the liability insurance coverage to be provided by the Risk Retention Group will only cover the members of the Risk Retention Group;
- for each state in which it intends to operate, information regarding the liability insurance coverages, deductibles, coverage limits, rates and/or rating/underwriting methodology for each line of commercial liability insurance the group intends to offer;
- historical and expected loss experience of proposed members and national experience of similar exposures to the extent that this experience is reasonably available;
- appropriate opinions/feasibility work by a qualified independent casualty actuary, including a determination of minimum premium participation levels required to commence operation and to prevent a hazardous financial condition;
- pro forma financial statements and projections, including assumptions, on an expected and adverse basis;
- identification of Board of Directors, including independence determination;
- biographical affidavits for all BOD members;
- evidence of compliance with corporate governance standards, including draft policies;
- underwriting and claim procedures;
- marketing methods and materials if available;
- draft insurance policies;
- names of reinsurers and reinsurance agreements, if available;
- investment policies;
- identification of each state in which the RRG intends to write business/register;
- identification of service providers, including fee structure and relationships to members; and
- subsequent material revisions to the plan of operation or feasibility study.

Commented [MB1]: Premier: Will listing this here prompt a non-domiciliary state to also ask for it when this is something handled by the domiciliary state? Limiting the distribution of confidential information (such as SSNs) can help ensure this information is not subject to a security breach and remains confidential.

Commented [MB2R1]: Drafting Group recommends adding the following FAQ to the FAQ document.
FAQ: Where can the non-domiciliary state get information about an RRG's directors and officers?
•Directors and officers are listed in the annual and quarterly financial statements available from the NAIC’s L-File. All changes in Directors and Officers, with accompanying biographical affidavits(s), are submitted to and reviewed by the domiciliary state. In order to eliminate the need for redundant regulatory functions and unnecessary transfer of sensitive personal identifiable information, a non-domiciliary state should rely on the domiciliary state’s review, which includes background checks on directors, officers and key management personnel of an RRG to ensure the competency, character and integrity of the insurer’s management.
Attachment A – Inquiry Template

The above-subject company has applied for Registration as a Risk Retention Group ("RRG") in the State of ______ to write ________ liability coverage to its members who are in the business of ________. As you can appreciate, due to the provisions of the Liability Risk Retention Act of 1986 the (state) has limited authority to regulate RRGs and therefore to a large extent, the (state) relies on the RRGs' domiciliary state to exercise general oversight and responsibility in the areas of licensing, solvency, rates and marketing. As part of our due diligence, we would appreciate any information your office can share with us regarding the company with respect to the following items, some of which may be satisfied by providing the Insurer Profile Summary:

1. Any significant concerns the State of [domicile] has regarding the company.
2. Any issues that may have a significant impact on the company going forward.
3. Any issues regarding the number of consumer complaints the company has in [state of domicile] or other states that may have been brought to your attention.
4. Comments and/or concerns about the financial condition of the company.
5. Comments and/or concerns about the management or performance of the company.
6. Results of any financial analysis and/or market conduct findings.
7. The company's priority level within the Financial Analysis Division.
8. Any conditions imposed by your Department upon the company's license.
9. Any significant non-compliance issues with the State of [domicile] regulatory authority including filing requirements and corrective action, if any.
10. Comments regarding the company's application for registration in the State of [state registering].
11. Approval from State of [domicile] for the RRG to register in the State of [state registering].
November 8, 2019

VIA EMAIL - BMeyer@naic.org

Becky Meyer, CPA
Senior Accreditation Manager
National Association of Insurance Commissioners
1100 Walnut, Suite 1500
Kansas City, MO  64106

Re: Comments on Risk Retention Group (E) Task Force on RRG Notice and Registration Form, Frequently Asked Questions, and Best Practices

Dear Ms. Meyer:

The National Risk Retention Association (“NRRA”) appreciates the opportunity to comment on the three documents issued by the Risk Retention (E) Task Force (“RRG Task Force”) on October 18, 2019:

1. NAIC Uniform Risk Retention Group – Notice and Registration Form
2. Risk Retention Groups: Frequently Asked Questions

NRRA has no specific changes to suggest to these documents. We appreciate the hard work of the Task Force, particularly the Drafting Group, in producing these documents. We believe that when the documents are adopted by the states and put into use on a daily basis, they will provide guidance to both the industry and to the regulators and will help to make the RRG registration process more fair and efficient.

We would particularly like to commend the Task Force on their adherence to the language of the Liability Risk Retention Act, 15 U.S.C. 3901, et seq. The intent of Congress was to enact a type of regulation which provides to the chartering, or “lead state,” the vast preponderance of authority over its RRGs, while specifying those limited authorities permitted under federal law to the non-domiciliary states. Where there is a conflict regarding the interpretation of the law, the federal law, under the Supremacy Clause of the U.S. Constitution, will prevail.

16133 Ventura Blvd., Suite 1055
Encino, CA  91436
(818) 995-3274
Fax: (818) 995-6496
www.riskretention.org
Becky Meyer, CPA
November 8, 2019
Page 2

We appreciate your allowing us the opportunity to comment on these documents and will be available at the meeting of the Task Force at the NAIC meeting in Austin, Texas to respond to any inquiries.

Very truly yours,

Joseph E. Deems
Executive Director
National Risk Retention Association

rjm
November 8, 2019

*Via email: bmeyer@naic.org*

Ms. Becky Meyer, CPA  
Senior Accreditation Manager  
National Association of Insurance Commissioners  
1100 Walnut, Suite 1500  
Kansas City, MO 64106

Re: Comments on Risk Retention Group (E) Task Force on RRG Notice and Registration Form; Frequently Asked Questions and Best Practices

Dear Ms. Meyer:

The Vermont Captive Insurance Association (VCIA) and its 450 member organizations appreciate the opportunity to provide comments on the three updated RRG (E) Task Force documents relating to risk retention groups (RRGs).

We greatly appreciate the hard work of the Task Force to tackle many of the issues raised by impermissible requirements imposed by non-domiciliary states on RRGs. VCIA commends the Task Force for its efforts to clarify application of the LRRA and educate state regulators and the RRG community on authority given by the LRRA to domiciliary states and to non-domiciliary states.

We understand the position of the Task Force regarding one of VCIA’s recommendations in the registration form that sought to clarify compliance with the Liability Risk Retention Act (LRRA). We believe that many of the problems encountered by RRGs in non-domiciliary states result from efforts to impose requirements, particularly registration requirements and fees, not permitted by the LRRA. Therefore we suggested adherence to the language in the statute as much as possible.

Overall, the Task Force has done an excellent job addressing and clarifying these issues. The updated NAIC Uniform RRG Notice and Registration Form, Frequently Asked Questions, and Best Practices are comprehensive and straightforward, and provide clarity to the most serious registration issues raised by RRGs.
VCIA comment letter re: NAIC RRG TF Exposure Drafts – November 8, 2019

Thank you again for your work.

Sincerely,

[Signature]

Richard Smith
President

cc: Sandra Bigglestone
Vermont Dept. of Financial Regulation
MEMORANDUM

TO: Property and Casualty Insurance (C) Committee

FROM: Risk Retention Group (E) Task Force

DATE: December 7, 2019

RE: Revisions to the NAIC Uniform Risk Retention Group Registration Form

The Risk Retention Group (E) Task Force has worked to address concerns from non-domiciliary states and industry regarding the registration process of risk retention groups (RRGs) in non-domiciliary states.

Concerns were initially raised by the National Risk Retention Association (NRRA) in a letter to the Task Force dated Nov. 19, 2018. The letter specifically cited extensive registration processing time and fees imposed. In discussions that followed, non-domiciliary states also raised concerns, including RRGs attempting to register that were in a hazardous financial condition or were not compliant with the federal Liability Risk Retention Act (LRRA).

To help address some of the concerns, the Task Force proposed updates to the NAIC Uniform Risk Retention Group Registration Form (Registration Form). The revisions were exposed for two public comment periods before finalizing the attached recommendation to the Property and Casualty Insurance (C) Committee.

The Task Force requests that the Committee consider adopting the proposed revisions to the Registration Form for inclusion in the Risk Retention and Purchasing Group Handbook.

If you have any questions regarding this referral, please contact NAIC staff (Becky Meyer, bmeyer@naic.org).

G:\ACCREDITATION\Data\RRGTF\Emails\Drafting Group\RRGTF Referral to C Cmte - Registration Form.docx
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

Appendix D

The following is the uniform registration form adopted in 1991 by the NAIC. This registration form is being filed by a Risk Retention Group (RRG) operating in accordance with the Federal Liability Risk Retention Act of 1986 (LRRA), 15 USC 3901-3906, chartered or licensed to write only liability insurance by the state of domicile listed in #1e. The registration form and supplemental documents are provided in accordance with §3902(d)(2) of the LRRA. Under §3902 of the LRRA, with the exception of the domiciliary state, RRGs are exempt from any state laws, rules, regulations, or orders that would make unlawful, or would regulate, directly or indirectly, the operation of an RRG, except that any state may require an RRG to comply with those laws specified in §3902(a)(1)(A),(B),(C) and (G) of the LRRA. The domiciliary state regulates the formation and operation of the RRG.

Part A

STATE OF [Insert State in which the Risk Retention Group intends to do business]

DEPARTMENT OF INSURANCE

RISK RETENTION GROUP - NOTICE AND REGISTRATION
(All Information Should Be Typed)

1a. Name of the Risk Retention Group as it appears on its Certificate of Authority:

__________________________________________________________________________

1b. Address of the Risk Retention Group:

__________________________________________________________________________

1c. NAIC Company Code:

__________________________________________________________________________

1d. FEIN:

__________________________________________________________________________

1e. State of domicile, date licensed and date chartered:

__________________________________________________________________________

1f. Primary contact person for state of domicile to whom questions regarding the Risk Retention Group should be addressed (include name, phone number and email address):

__________________________________________________________________________
2. List any other name(s) by which the Risk Retention Group is known or may be doing business in this State or any other state:

__________________________________________________________________________

3. The Risk Retention Group is chartered and licensed as a liability insurance company under the laws of the State of ____________ and is authorized to engage in the following lines and/or classifications of liability insurance under the laws of its chartering State:

__________________________________________________________________________

4. Give a general description of the liability insurance coverages the Risk Retention Group plans to write in the state it is registering to do business in:

__________________________________________________________________________

5. Has the Risk Retention Group’s domiciliary state approved the Risk Retention Group to register and expand its writings in the state it is seeking to become registered in?

__________________________________________________________________________

6. Ownership of the Risk Retention Group consists of one or the other of the following (check one):
   a) _____ the owners of the Group are only persons who comprise the membership of the Group and who are provided insurance by the Group.

   b) _____ the sole owner of the Group is: ________________________________

   (Name and Address of Organization)

   an organization which has as its members only persons who comprise the membership of the Group and which has as its owners only persons who comprise the membership of the Group and who are provided insurance by the Group.

7. The Risk Retention Group members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business (whether profit or nonprofit), trade, product, services (including professional services), premises or operations. Give a general description of businesses or activities engaged in by the Group’s members:

__________________________________________________________________________

Commented [MB1]: VCIA: We recommend Item 7 be deleted and a new Item 15 created as follows: “In accordance with the LRRA, and as evidenced by the domiciliary state’s action in approving licensure of the Risk Retention Group, the RRG affirms its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business (whether profit or nonprofit), trade, product, services (including professional services), premises or operations.” *See explanation in comment letter.*

Commented [MB2R1]: Drafting group recommendation is to leave #7 here.
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

8. (a) List the name, position with the Risk Retention Group, SSB, and address of each officer and director of the Risk Retention Group. (Attach additional pages, if necessary.)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(b) Identify and give the telephone number of the officer or director of the Risk Retention Group who can be contacted for any information regarding the management of the insurance activities of the Group:

Name: ____________________________ Telephone Number: __________________

9. List the name, address, and telephone number and Federal Employer Identification Number (FEIN) of the company responsible for managing the insurance operations of the Risk Retention Group and the company contact person’s name, telephone number and email, at the company. (If none, answer none.)

________________________________________________________________________
________________________________________________________________________

Contact Person: ____________________ Telephone #: _______________________

Email: ______________________________

10. List the name(s), NPR#, SSB#, and address(es) of the licensed insurance agent(s) or broker(s) who will be responsible for marketing the Risk Retention Group’s insurance policies in the State of [Insert State in which the Risk Retention Group intends to do business] and the current licensing status in the State of [Insert State in which the Risk Retention Group intends to do business] in which they are licensed. (If none, answer none. Attach additional pages, if necessary.)

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<th>Name</th>
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<th>License Status in State Registering(s)</th>
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NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

11. In accordance with the Liability Risk Retention Act, we verify the following:

A. The Risk Retention Group is a corporation or other limited liability association whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its members.

B. The Risk Retention Group is organized for the primary purpose of conducting the activity described under Item “A” above.

C. The Risk Retention Group does not exclude any person from membership in the Group solely to provide for members of the Group a competitive advantage over such a person.

D. The activities of the Risk Retention Group do not include the provision of insurance other than:
   i. liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its Group members; and
   ii. reinsurance with respect to the similar or related liability exposure of another Risk Retention Group (or a member of such other Risk Retention Group) engaged in business or activities so that such Risk Retention Group or member meets the requirement under Item #7 above for membership in the Risk Retention Group which provides such reinsurance.

12. In accordance with the LRRA, if the State in which the Risk Retention Group is registering requires compliance with the following laws and requirements, the BRG agrees to the following:

A. The Risk Retention Group will comply with the unfair claim settlement practices laws of this State.

B. The Risk Retention Group will pay, on a non-discriminatory basis, applicable premium and other taxes which are levied on admitted insurers, surplus line insurers, brokers or policyholders, such Group under the laws of this State.

B.C. The Risk Retention Group will participate, on a nondiscriminatory basis, in any mechanism established or authorized under the law of the State for the equitable apportionment among insurers of liability insurance losses and expenses incurred on policies written through such mechanism.

C.D. The Risk Retention Group will be designated the Insurance Commissioner [Director, Superintendent] of this State as its agent solely for the purpose of receiving service of legal documents or process by executing Part B of this form, attached hereto.

D.E. The Risk Retention Group will submit to examination by the Insurance Commissioner [Director, Superintendent] of this State to determine the Group’s financial condition, if:
   i. the Insurance Commissioner [Director, Superintendent] of the Group’s charting State has not begun or has refused to initiate an examination of the Group; and
   ii. any such examination by the Insurance Commissioner [Director, Superintendent] shall be coordinated to avoid unjustified duplication and unjustified repetition.

E.F. The Risk Retention Group will comply with a lawful order issued in a delinquency
**NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM**

proceeding commenced by the Insurance Commissioner [Director, Superintendent] of this State upon a finding of financial impairment, or in a voluntary dissolution proceeding.

E-G. The Risk Retention Group will comply with the laws of this State concerning regarding deceptive, false or fraudulent acts or practices, including any injunctions regarding such conduct obtained from a court of competent jurisdiction.

G4. The Risk Retention Group will comply with an injunction issued by a court of competent jurisdiction upon petition by the Insurance Commissioner [Director, Superintendent] of this State alleging that the Group is in hazardous financial condition or is financially impaired.

H4. The Risk Retention Group will provide the following notice, in at least 10-point type, in any insurance policy issued by the Group:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your risk retention group.

14.13. In accordance with the LRRA, the Risk Retention Group **affirms that it has** submitted to the Insurance Commissioner [Director, Superintendent] as part of this filing and before it has offered any insurance in this State, a copy of the plan of operation or feasibility study which it has filed with the Insurance Commissioner [Director, Superintendent] of its chartering State/state of domicile. This plan or study includes the name of the State in which the Group is chartered, as well as the Group’s principal place of business, and such plan of operation or feasibility study further includes the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of liability insurance the Group intends to offer. The Group **has also** submitted to the Insurance Commissioner [Director, Superintendent] of this State any revisions of such plan of operation or feasibility study to reflect any changes in the plan if the Group intends to offer any additional lines of liability insurance or including any change in the designation of the State in which it is chartered.

14.14. The Risk Retention Group will submit a copy of its annual financial statement submitted to its chartering state, to the Insurance Commissioner [Director, Superintendent] of this State, by March 31 of each year. The annual financial statement shall be certified by an independent public accountant and include a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist. The annual financial statement, certification and statement of opinion on loss and loss adjustment expense reserves will be submitted to the Insurance Commissioner [Director, Superintendent] of this State by the date it is required to be submitted to its chartering state.

14.15. The Risk Retention Group will not solicit or sell insurance to any person in this State who is not eligible for membership in the Group.

14.16. The Risk Retention Group will not solicit or sell insurance in this State, or otherwise operate in this State, if the Group is in hazardous financial condition or is financially impaired.

16.17. The Risk Retention Group will not issue any insurance policy in this State which provides coverage prohibited generally by statute of this State or declared unlawful by the highest court of this State whose law applies to such policy. In accordance with the LRRA, the terms of any insurance policy provided by the Risk Retention Group shall not provide or be construed to provide insurance policy coverage prohibited generally by State statute or declared unlawful by the highest court of the State whose law applies to such policy.
**NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM**

17. The Risk Retention Group has submitted a registration fee of $__________, if applicable, payable to the Insurance Commissioner (Director, Superintendent) of the State.

18. To the extent required by the LRRA, the Risk Retention Group will comply with all other applicable state laws.

19. The Risk Retention Group will notify the Insurance Commissioner (Director, Superintendent) as to any subsequent changes in any of the items included in this form (except for items #11, #8 and #10).

The undersigned hereby swear and affirm that the foregoing statements and information regarding their principal, the________________________(Name of Risk Retention Group) are true and correct.

_____________________________
President of the Risk Retention Group

_____________________________
Secretary of the Risk Retention Group

State of________________________
County of_______________________

___________ day of ____________, 20__.

______________________________ Notary Public. My Commission Expires: ____________________

---

Commented [MB6]: Pamela Davis: Is the Insurance Commissioner in Item 19 the domicile or non-domicile Commissioner? If non-domicile, does that mean that an RRG must report every change in the board of directors to every non-domicile regulator? If so, how soon after the change?

Commented [MB7R6]: Drafting Group notes the reporting is to the non-domiciliary regulatory and recommends including a list of items that would not require notification (11, #8 and #10 on this form).

Further, the drafting group recommends adding an item to the Task Force’s Issues Summary to consider if further guidance should be considered in the future.
**NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM**

**Part B**

**APPOINTMENT OF ATTORNEY TO ACCEPT SERVICE AND DESIGNATION**

The [name of the group] ("the Group"), a risk retention group which is chartered and licensed as a liability insurance company under the laws of the State of [name of state], having notified the Insurance Commissioner [Director, Superintendent] of the State of [name of state] of its intention to do business in this State as a risk retention group pursuant to the federal Liability Risk Retention Act of 1986, hereby appoints the Insurance Commissioner [Director, Superintendent] of the State of [name of state], any successor in office, and any authorized deputy its true and lawful attorney, in and for the State of [name of state], upon whom all legal documents or process in any proceeding against it may be served. Such service of legal documents or process shall be of the same legal force and validity as if served personally upon the Group.

The Group designates:

__________________________
(Name)

__________________________
(Address)

__________________________
(City, Town or Village)

__________________________
(State and ZIP Code)

as its officer, agent or other person to whom shall be forwarded all legal documents or process served upon the Insurance Commissioner [Director, Superintendent] of the State of [name of state], any successors in office, or any authorized deputy, for the Group. This designation shall continue in full force and effect until superseded by a new written designation filed with the Insurance Commissioner [Director, Superintendent].
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

This appointment and designation is made pursuant to a resolution by the Group’s governing body authorizing it, and a certified copy of the resolution is attached hereto. This appointment shall be binding upon any person or corporation which as successor acquires the Group’s assets or assumes its liabilities, by merger or consolidation or otherwise.

This appointment may be withdrawn only upon a written notice of termination and, in any event, shall not be terminated by the Group or its successor so long as any contracts or liabilities or duties arising out of contracts entered into by the Group while it was doing business in this State are in effect.

IN WITNESS OF THIS APPOINTMENT AND DESIGNATION, the Group, in accordance with the resolution of its Board of Directors duly passed on ________________, 20__, has affixed its corporate seal, and caused the same to be subscribed and attested in its name by its President and Secretary, at the City of ______________ in the State of ______________ on ________________, 20__.

(Name of Risk Retention Group)

By: _________________________________ President

_______________________________ Secretary

State of ________________ )

( ) ss:

County of ________________

Sworn before me this ______ day of ________________, 20__

_______________________________, Notary Public. My Commission Expires: ________________
VALUATION OF SECURITIES (E) TASK FORCE

Valuation of Securities (E) Task Force Dec. 8, 2019, Minutes ........................................................................................................ 10-1104

Valuation of Securities (E) Task Force Oct. 31, 2019, Minutes (Attachment One) ................................................................. 10-1111

Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to Update the Interim Instructions for Mortgage-Referenced Securities (Attachment One-A) .................................................................................................. 10-1118

Valuation of Securities (E) Task Force Sept. 5, 2019, Minutes (Attachment Two) ................................................................. 10-1119

Amendment to Add Text to the P&P Manual Referencing Administrative Codes Used to Report Regulatory Transactions (Attachment Two-A) ........................................................................................................... 10-1121

Amendment to the P&P Manual to Add Ground Lease Financing Transactions as New Asset Class (Attachment Three) ................................................................................................................................. 10-1133
Draft: 12/16/19

Valuation of Securities (E) Task Force
Austin, Texas
December 8, 2019

The Valuation of Securities (E) Task Force met in Austin, TX, Dec. 8, 2019. The following Task Force members participated: Robert H. Muriel, Chair, represented by Kevin Fry (IL); James J. Donelon, Vice Chair, represented by Stewart Guerin (LA); Lori K. Wing-Heier represented David Phifer and Wally Thomas (AK); Andrew N. Mais represented by Kathy Belfi and William Arfanis (CT); Trinidad Navarro represented by Rylynn Brown (DE); David Altmaier represented by Ray Spudeck and Carolyn Morgan (FL); Doug Ommen represented by Carrie Mears (IA); Vicki Schmidt represented by Tish Becker and Joe McGarry (KS); Gary Anderson represented by John Turchi (MA); Al Redmer Jr. represented by Matt Kozak (MD); Chlora Lindley-Myers represented by Debbie Doggett (MO); Bruce R. Ramge represented by Lindsay Crawford and Justin Schrader (NE); Marlene Caride represented by John Sirovetz (NJ); John G. Franchini represented by Lea Geckler (NM); Glen Mulready represented by Eli Snowbarger (OK); Jessica Altman represented by Kimberly Rankin (PA); Kent Sullivan represented by Jamie Walker and Amy Garcia (TX); Todd E. Kiser represented by Jake Garn and Reed Stringham (UT); Scott A. White represented by Doug Stolte (VA); Mike Kreidler represented by Patrick McNaughton (WA); and Mark Afable represented by Randy Milquett (WI).

1. Adopted its Oct. 31, Sept. 5 and Summer National Meeting Minutes

Ms. Belfi made a motion, seconded by Mr. Phifer, to adopt the Task Force’s Oct. 31 (Attachment One), Sept. 5 (Attachment Two) and Aug. 4 (see NAIC Proceedings – Summer 2019, Valuation of Securities (E) Task Force) minutes. The motion passed unanimously.

2. Heard a Staff Report on Projects Before the Statutory Accounting Principles (E) Working Group

Mr. Fry said the next item on the agenda is to hear a report on projects before the Statutory Accounting Principles Working Group from Julie Gann (NAIC).

Ms. Gann said the purpose of the update aligns with the coordination efforts between the Working Group and the Task Force. She highlighted a few items to the Task Force, beginning with the adopted items:

- **Other Derivatives** – The Working Group adopted revisions to clarify that other derivatives—which are derivatives that are not used in hedging, income generation or replication transactions—shall be reported at fair value and nonadmitted.

- **Goodwill** – For subsidiary, controlled and affiliated investments (SCAs), the Working Group adopted minor revisions to clarify that goodwill from an insurance entity acquisition of an SCA is subject to the 10% adjusted capital and surplus limit, regardless if the goodwill had been “pushed down.” The Working Group re-exposed the agenda item considering pushdown to provide more time for the industry to provide examples on the application of pushdown.

- **Wash Sales** – The Working Group adopted revisions to clarify that the wash sale disclosure shall only include wash sale transactions that cross reporting periods. Insurers are currently reporting wash sales that occur inter-quarter (for example, sell in January, purchase back in February). There is no need to report that transaction in the wash sale disclosure.

**Items Exposed by Working Group:**

- **Preferred Stock** – The Working Group exposed a revised issue paper and proposed substantively revised Statement of Statutory Accounting Principles (SSAP) No. 32R—Preferred Stock as part of the investment classification project. The overall project proposes to revise definitions, measurement and impairment guidance for these investments. The issue paper was revised to consider a number of the industry comments received from the past exposure.

- **Related Party Transactions** – The Working Group exposed two separate agenda items focusing on related party transactions. The first agenda item proposes to data-capture existing disclosures in accordance with SSAP No. 25—Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties. Affiliate transactions already captured in Schedule Y would not need to be duplicated in these disclosures, but the data-capture would collect...
information on related party (non-affiliate) transactions. These disclosures already exist in narrative form but are not currently data-captured. The second exposure clarifies the types of entities that are included as related parties, clarification that non-controlling ownership interest greater than 10% is a related party subject to related party disclosures, and guidance for disclaimers of affiliation and control for statutory accounting. Although an entity may have a disclaimer of control, the edits clarify that the entity is still a related party. These two items are being addressed separately to ensure that the data-capturing of disclosures is available for year-end 2020.

- **Working Capital Finance Investments** – The Working Group exposed substantive revisions to SSAP No. 105—Working Capital Finance Investments as directed by the Working Group at the Summer National Meeting. These revisions reflect six of the recommendations provided by the industry and referred from the Task Force.

- **Qualifying Cash Pools** – The Working Group exposed revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments to incorporate concepts to allow cash pools to be reported as cash equivalents. The proposed revisions will only allow cash pools that meet certain criteria for this reporting.

- **Rolling Short-Term Investments** – The Working Group exposed revisions to SSAP No. 2R to incorporate principle concepts in classifying investments as cash equivalents or short-term investments. This exposure intends to limit the amount of time an investment can be reported as a short-term investment. For investments that are expected to terminate after 364 days and are renewed for another 364 days, this proposal would no longer allow that to be reported as a short-term investment. There are specific exclusions to this guidance to avoid unintended consequences for short-term investments like cash pools that are expected to be regularly renewed and rolled. As such, the proposed revisions would not include any nonaffiliated SSAP No. 26R—Bonds investments. It would include affiliated SSAP No. 26R investments, all SSAP No. 43R—Loan-Backed and Structured Securities investments and anything that would be reported as a Schedule BA investment if not reported as short-term.

- **Financial Modeling** – SSAP No. 43R – The Working Group exposed revisions to eliminate the financial modeling guidance from SSAP No. 43R, noting that this exposure was contingent on the Task Force taking a similar action. The Working Group will not consider adoption action on this guidance until after the Task Force takes final action.

- **Financing Derivatives** – The Working Group exposed revisions for the reporting of derivatives with financing premiums. With the exposed revisions, the gross value of the derivative—without reflection of financing components—would be reported for the derivative on Schedule DB. The financing provisions (e.g., liability for derivative) would be reported separately.

- **Equity Instruments in SSAP No. 43R** – The Working Group did not discuss the agenda item for equity instruments in SSAP No. 43R. A conference call is scheduled for Jan. 8, 2020, for this discussion. The comment deadline is Jan. 31, 2020.

3. **Received and Exposed a Nonsubstantive Proposed P&P Manual Amendment to Reflect the SEC’s Adoption of a New Rule to Modernize Regulation of Exchange-Traded Funds**

Mr. Fry said that on Sept. 26, the U.S. Securities and Exchange Commission (SEC) adopted Rule 6c-11 under the Investment Company Act of 1940, for exchange-traded funds (ETFs). Mr. Fry asked Marc Perlman (NAIC) to give a brief update on this change and proposed amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual).

Mr. Perlman said Rule 6c-11 will permit ETFs that satisfy certain conditions to operate without first obtaining an exemptive order from the SEC under the Act. The SEC has stated that the intent of the rule is to modernize the regulatory framework for ETFs by reducing expenses and delays in creating new ETFs; promoting greater consistency, transparency and efficiency for ETFs; and facilitating greater competition among ETFs. The rule becomes effective Dec. 23, followed by a one-year transition period for compliance.

Mr. Perlman noted that ETFs contain certain features that distinguish them from the types of investment companies originally contemplated by the Act and its rules and, therefore, have needed to rely on SEC exemptive orders to operate as investment companies under the Act. The new rule will end the need for most exemptive relief. Additionally, the rule permits ETFs to use “custom baskets” that do not reflect a pro rata representation or representative sampling of the ETF’s portfolio holdings, and the SEC is rescinding current ETF marketing restrictions. In order to rely on the new rule, an ETF must satisfy a new definition of ETF and various conditions, including: updated website disclosures (such as historical net asset value (NAV), premium and
discount, and bid-ask spread information), and adoption of policies and procedures that govern the construction and acceptance of baskets.

The new rule will rescind the exemptive orders from existing ETFs, which will be able to rely on the rule going forward. However, certain categories of ETFs will not be covered by the rule, including leveraged ETFs, inverse ETFs, ETFs organized as unit investment trusts (UITs), share class ETFs and non-transparent active ETFs. The SEC expects the “vast majority” of ETFs to be covered by the rule.

Mr. Perlman said the NAIC Securities Valuation Office (SVO) takes the position that because the new rule primarily affects SEC exemptive relief and ETF reporting and disclosure, it will not impact the quantitative and qualitative factors the SVO considers when analyzing ETFs. As such, the SVO recommends nonsubstantive P&P Manual amendments to remove references to SEC exemptive orders from descriptions of ETFs and clarification that Regulatory Treatment Analysis Service (RTAS) application filers only need to provide SEC exemptive orders to the SVO to the extent they are applicable.

Ms. Mears made a motion, seconded by Ms. Belfi, to receive this P&P Manual amendment to remove references to SEC exemptive orders from descriptions of ETFs and clarification that RTAS application filers only need to provide SEC exemptive orders to the SVO, to the extent they are applicable, and to expose this proposed amendment for a 45-day public comment period ending Jan. 23, 2020. The motion passed unanimously.

4. Adopted a Proposed P&P Manual Amendment to Add Instructions for GLF Transactions

Mr. Fry said the next item on the agenda is a substantive proposed amendment to the P&P Manual to add instructions for ground lease financing (GLF) transactions. This is a joint proposed amendment was exposed during the Task Force’s Oct. 31 conference call for a public comment period that ended Nov. 22.

Mr. Fry said the SVO became aware that certain insurance company filers were submitting credit tenant loan (CTL) transactions and transactions—which the SVO is now calling GLF transactions—through the filing exempt (FE) process. The SVO considers GLF transactions distinct from CTL transactions. The SVO studied the GLF transactions, working closely with the industry, several of whom agreed to jointly sponsor this proposed amendment. He asked Mr. Perlman to provide a summary of the proposal.

Mr. Perlman said the amendment recommends a “decision-tree” approach to analyzing GLF transactions. First, the SVO would analyze the ground lease to determine if it meets the P&P Manual CTL criteria (meaning it is “hell or high water” or “triple net”). Second, the SVO would determine if the sub-leases would similarly meet the CTL criteria and, if so, potentially review the transaction as akin to a CTL. Third, if the SVO cannot look at the whole structure as akin to a CTL, the SVO would work with the NAIC Structured Securities Group (SSG) to determine if SSG can model the sub-leases or business operation like it would a commercial mortgage-backed security (CMBS). And, lastly, if the SSG determines that it cannot model the sub-leases or business operation, and if the GLF transaction has been assigned a rating by a rating agency, the SVO can use the rating agency analysis to assist in its analysis. The SVO’s analysis will be entirely at the discretion of the SVO, and the SVO will be under no obligation to accept the rating agency analysis, conclusions or ratings. Most GLF transactions are expected to fall in this final category.

Mr. Fry said this effort is the best of what the Task Force does when it coordinates with the industry, noting that the SVO staff worked closely and had several meetings with the industry to come to an amicable solution. This all started from a spot in the P&P Manual that identifies which securities are not eligible for filing exemptions. CTLs are not eligible for filing exemption and are securities that do not fit the definition of CTLs but are still in the spirit of a CTL. It is this subset of securities for which the Task Force needed to find a solution. The solution that was found covers the ground lease, which covers the more concerning of the securities that lost the regulatory treatment. In 2020, the Task Force will need to do some work on another subset of securities and this framework may serve as a template or at least a starting point to develop that solution. Mr. Fry thanked the industry and the SVO staff for working so productively on this effort.

David Persky (TIAA), representing the American Council of Life Insurers (ACLI) and interested parties, said the industry worked closely since last August to reach this compromise, noting that it works well for everyone and the industry look forward to implementing it. There are several deals in the marketplace right now and the market is eager to see the actual implementation of this change beginning Jan. 1, 2020.

Mr. Guerin made a motion, seconded by Ms. Walker to adopt this this P&P Manual amendment to add instructions for GLF transactions and make a referral to the Statutory Accounting Principles (E) Working Group so it can assess this definition for inclusion in the Accounting Practices and Procedures Manual (Attachment Three). The motion passed unanimously.
5. Received and Exposed a Substantive Proposed P&P Manual Amendment to Remove the Financial Modeling Instruction for RMBS/CMBS Securities and Direct IAO Staff to Produce NAIC Designation and NAIC Designation Categories for These Securities

Mr. Fry said the next agenda item is a substantive proposed amendment to the P&P Manual to add instructions to remove the financial modeling instructions for residential mortgage-backed securities (RMBS)/CMBS and direct NAIC Investment Analysis Office (IAO) staff to produce NAIC designation and NAIC designation categories for these securities.

At the Summer National Meeting, the SVO staff discussed the idea that, at some point, the NAIC should align the RMBS/CMBS modeling to provide a single NAIC designation for modeled RMBS/CMBS. This would be a change from the current practice of providing a series of book/adjusted carrying value price breakpoints to companies to determine the NAIC designation. Staff raised this issue because of the upcoming implementation of NAIC designation categories for year-end 2020; i.e., the addition of 20 levels of credit risks instead of six. This will add a lot of complexity to create 19 breakpoints instead of the five current breakpoints that are being used now, and might add expense and create some inconsistency across insurers reporting on these securities.

Mr. Fry said the IAO staff is recommending that the Task Force move to a single NAIC designation and NAIC designation category for the modeled assessment of credit risk for RMBS/CMBS to simplify NAIC and insurer processes, along with improving uniformity. The Task Force has discussed this a few times and it will be wise to expose this for a public comment period to get formal comments from the industry during a longer comment period. The SSG has offered to do some impact studies during the comment period that will give the Task Force additional insights.

Joshua Bean (Transamerica), representing the ACLI, said the industry appreciates the extended comment period and asked if it is possible to make it 75 days. The financial modeling process has been occurring for almost 10 years and there is a diversity of legitimate interest across this constituency to understand the new mappings. Mr. Fry said NAIC staff are recommending a 60-day public comment period to meet the year-end deadline.

Ms. Belfi made a motion, seconded by Ms. Rankin to receive and expose for a 60-day public comment period this P&P Manual amendment to remove the financial modeling instructions for RMBS/CMBS securities and move to the production of a single NAIC designation and NAIC designation categories for these securities and to make a referral to the Statutory Accounting Principles (E) Working Group, as this would impact SSAP No. 43R. The motion passed unanimously.

6. Heard an NAIC Staff Update on the Definition of “Principal Protected Securities”

Mr. Fry said SVO staff discussed during the Task Force’s meeting at the Summer National Meeting an observation that certain classes of structured securities receive ratings that may not reflect a regulator’s view of risk. The SVO advised the Task Force that it believes the credit rating providers are following their published methodologies for these investments but those methodologies, in staff’s opinion, do not meet the NAIC’s needs. The recommendation of the IAO directors was to exclude these investments from filing exemption and permit the SVO to review them using their methodologies, in this case most likely a look-through approach. On its Oct. 31 call, the Task Force directed the IAO staff to work with the industry on refining the definition that was exposed. This is a matter that may affect some insurers, so the Task Force is trying to accurately reflect the scope of securities. Mr. Fry asked Charles Therriault (NAIC) to provide an update on that work.

Mr. Therriault said the IAO staff met with industry representatives on calls held Dec. 3, Nov. 22, Nov. 15 and Nov. 8. There have been multiple versions of this definition exchanged to address each group’s concerns. A general framework has evolved that identifies principal protected notes (PPNs) as a type of security that repackages one or more underlying investments and for which contractually promised payments according to a fixed schedule are satisfied by proceeds from an underlying bond(s) that, if purchased by an insurance company on a stand-alone basis, would be eligible for filing exemption, but for which the underlying investments could generate potential returns in addition to the contractually promised cash flows paid according to a fixed schedule or the contractual interest rate paid by the PPN is zero or below market and the insurer would obtain a more favorable risk-based capital (RBC) charge or regulatory treatment for the PPN through filing exemption than it would were it to separately file the underlying investments in accordance with the policies in the P&P Manual.

Investments meeting these criteria would need to be filed with the SVO to determine if the security possesses any other non-payment risks that the SVO must assess under its Subscript S authority. There were a few noted exclusions, such as defeased or pre-refunded securities, and broadly syndicated securitizations. IAO staff believe this criteria hits upon the core issue—i.e. restructing an investment to receive a more favorable RBC charge—and provides the SVO with discretion to review the transaction. At the industry’s request, SVO staff is expanding the definition to include transaction examples. The goal of adding
the examples is to provide additional clarity as to the regulatory concern and transactional structure that is a concern to the Task Force. Staff will bring this back to the Task Force for consideration in early 2020.

Mr. Fry said one of the principles is that a security—for example, a bond—usually has fixed cash flows. If a security promises additional returns in excess of those fixed cash flows, then that is a characteristic to identify that security. The second is that a lot of these are rated, and the rating agencies are rating these to achieve a below market return. The third principle—when looking underneath one of these securities—it just carries that same asset on a fixed income schedule, so it produces one set of RBC charges. It is questionable that those same securities can be packaged into a different structure to create a more favorable RBC charge, so on its surface, this causes some pause. Those are the three tenants that staff are looking at right now and are working with the industry to define. My Fry asked if there were any questions from the Task Force members or interested parties.

Ms. Becker said Kansas is supportive of this framework and approach, and that the Task Force is looking at this matter. She expressed appreciation for the effort and cooperation involved in coming to a consensus and helping ensure that this is moving forward appropriately and to making sure all of the regulatory issues are being addressed.

Mr. Spudeck said this is a fairly important issue for a lot of people on both sides of the aisle. He asked whether there is a target timeline for when there will be some physical documentation revised for people to look at and start digesting before the market starts creating the next generation.

Mr. Fry said he is open to suggestions and will continue working on this and finalize it early next year when the Task Force has a call, possibly as early as Feb. 15, 2020. He said he wants people to get a sense of what the Task Force is doing and asked Mr. Therriault when a draft could be ready for exposure.

Mr. Therriault said he would also expect a draft could be ready for the Task Force’s first meeting in 2020. There has been extensive work already and a draft amendment is almost ready, but another iteration is needed. Ideally, he said he would like to have this ready for consideration at the Spring National Meeting.

Mr. Andersen (Andersen Insights) said he knows that a number of people have been working on this issue and commended them. Hopefully, as the discussions are open, some of the things that were mentioned will be considered but, most important, is how these assets meet the regulatory views of risk and meet the NAIC needs. His understanding of credit instruments, in general, is a question of credit because these are debt instrument and maybe are not as complicated as they may seem. There are three things Mr. Fry listed, one as promised returns that could exceed based returns, and it is true that an asset can be structured so that the returns that are reflected on the books and records of an insurer as one thing, and an asset may offer returns that are better than that. In his opinion, as long as the returns that are reported on a financial statement are minimal returns that are governed by the credit rating, he does not see how having excess returns is necessarily a problem. The question of what is the market rate of return can be a difficult and complicated thing for staff of a limited number to look at a broad number of deals and try to determine what a market rate of return is. Even if that is done, he is not sure what the question is. If an insurer elects to invest in an asset with a relatively lower return and reports that on its books and records, then the question of solvency and creditworthiness is addressed. The third point looking “underneath the hood” as to what the asset is, he said he believes everyone should support that, and it is possible with these structures to include assets that are prohibited assets. It is possible to include assets in these structures that will fill or overfill the basket. He said he believes that through structuring, it is possible to reduce risks—and the notion that there are building blocks and the building blocks result in the same risk additively as the structure itself is not necessarily always the case. He appreciates the fact that the Task Force is willing to have a discussion and open this up.

Mr. Bean said he appreciates Mr. Therriault’s summary of the discussion thus far. It has been an excellent collaboration with a lot of different perspectives to cover. Ultimately, this has been successful in working toward truly defining in assessible terms what the actual analytical concern is and how it can be addressed in a manner that actually provides guidance and clear instruction to the filing entities and does not create unintended “scope creep.” As Mr. Therriault has outlined, there is some work that we are continuing to do and hope that some of the examples will help illustrate further exactly what is meant to be targeted by this updated guidance, noting that it legitimately does present a risk profile that should be subjected to additional review at the hands of the SVO and the SSG and that is ultimately the core objective.

Mr. Fry said people should realize that what this would create is that these securities would not be able to use rating agencies ratings through the FE process. These securities will still be able to be filed with the SVO and will likely remain on the bond schedule; they may just get a different NAIC designation because the SVO will be using a different methodology.
7. Received an IAO Staff Report on the Infrastructure Investment Study

Mr. Fry said NAIC staff earlier this year conducted a request for information on the U.S. insurance industry’s infrastructure investments. He asked Nikki Hall (NAIC) to provide an update on this study.

Ms. Hall said the NAIC Center for Insurance Policy and Research (CIPR) and the NAIC Capital Markets Group—specifically, Michele Wong and Eric Kolchinsky—are collaborating on this study. The study will focus on infrastructure investment as an asset class and the insurance industry’s participation in the infrastructure market, including barriers and opportunities.

The study was initiated in late August shortly after the Summer National Meeting with a request for information (RFI) to gather information and input from market participants and interested parties on key topics, such as the definition of infrastructure, the market size for infrastructure assets, the historical credit performance of infrastructure investments, and the treatment of infrastructure investments by state insurance regulators.

The first deadline for the RFI was in late September, where initial comments were requested on the definition of “infrastructure.” Fourteen comment letters were received to this request and, after a thorough review and internal discussion, a proposed definition was drafted of “infrastructure,” which was discussed during an Oct. 18 conference call with interested parties.

For the purposes of the study, it was decided the definition will focus on economic infrastructure, which is defined as “long-lived, capital intensive, large physical assets that provide essential services or facilities to a country, state, municipality, or region and contributes to its economic development or prosperity.”

Some of the comments received suggested that social infrastructure should also be included in the definition; however, it was decided to exclude social infrastructure from the definition for now and do a separate analysis of social infrastructure at a later time.

Ms. Hall said the presentation, which includes the proposed definition, can be found on the CIPR website. The RFI document that was distributed in August is also available on the CIPR website.

The second deadline was Nov. 22, where a request was made for comments on the other components of the request for information, such as market size, credit performance and NAIC treatment of infrastructure. Seven comment letters have been received so far. While the comment deadline has passed, additional comments from interested parties can be submitted.

In regard to next steps for the study, the process of reviewing all the submissions received from the Nov 22 deadline has begun. The team is also following up with some that have submitted comments, and this work will continue over the next few weeks.

An issue brief is being drafted that will explain the rationale behind the proposed definition, which will be shared and posted to the NAIC website when final. Drafting of the full study will begin after that.

There are plans to hold another conference call before the 2020 Spring National Meeting to provide an update on the study drafting process.

8. Heard a Staff Update on Projects

Mr. Therriault provided updates on five projects:

- The integration of securities identifiers into the FE process. These two projects have both been deferred. The first component was the incorporation of the business entity cross-reference service (BECRS), which identifies the relationship between issuers and securities. The second component was the incorporation of the global identifier cross-reference service (GICRS) which would have added additional security identifiers. These two services can be implemented separately, but they are both complex. Given the other projects that are being worked on, coupled with the complexity of this data, the two projects had to be deferred.

- The next project is a status of the application of the Japan Credit Rating Agency, Ltd., to be a vendor of credit ratings to the NAIC. The securities rated by this credit ratings provider (CRP) require NAIC systems to have International Securities Identification Numbers (ISINs). Those identifiers are part of the GICRS data set, which is a project that is being deferred. Because of that dependency, this project is also being deferred.
• Implementation of CRP data feeds for securities subject to the private rating letters component of filing exemption is also deferred for data feeds from Fitch Ratings, Morningstar and HR Ratings de Mexico. Priority was given to the carry-over procedure project and NAIC designation category project.

• Implement of the carry-over procedure in 2019 was released this month. This project implements the administrative symbols and process to extend an NAIC designation into the next filing year with a “YE” suffix and identify initial filing properly filed and self-designated with an “IF” suffix. The project also included the change over from administrative symbol NR (not rated) to ND (not designated) along with some operational improvements related to these processes and downstream reporting through AVS+.

• The effort to add NAIC designation categories into NAIC systems is on schedule for release in early 2020. This project will add the letter modifier to create NAIC designation categories for reporting at year-end 2020. This project was discussed in passing during the discussion on RMBS/CMBS modeling. NAIC designations will continue to be produced and reported, but this additional level of granular assessment of credit risk reporting will be available for insurer reporting for Dec. 31, 2020. There are no RBC factors associated with the NAIC designation categories, so there is no change to the RBC charges; however, this detail reporting of investment credit risk still has significant value when looking at an insurer portfolio.

9. Discussed Other Matters

Mr. Kolchinsky said the Capital Markets Group, working with the SSG, completed the collateralized loan obligation (CLO) stress test, or at least the initial batch of the CLO stress test. A special report was published Dec. 6 on the NAIC website, and an in-depth methodology for CLO stress testing was also published. He said he will be covering some of the results at the Financial Stability (EX) Task Force and will be contacting the states to talk about what was found.

Having no further business, the Valuation of Securities (E) Task Force adjourned.
Valuation of Securities (E) Task Force
Conference Call
October 31, 2019

The Valuation of Securities (E) Task Force met via conference call Oct. 31, 2019. The following Task Force members participated: Robert H. Muriel, Chair, represented by Kevin Fry (IL); James J. Donelon, Vice Chair, represented by Stewart Guerin (LA); Ricardo Lara represented by Kim Hudson (CA); Andrew N. Mais represented by Kathy Belfi (CT); Trinidad Navarro represented by Rylynn Brown (DE); David Altmairer represented by Ray Spudeck (FL); Doug Ommen represented by Carrie Mears (IA); Dean L. Cameron represented by Eric Fletcher (ID); Vicki Schmidt represented by Tish Becker (KS); Gary Anderson represented by John Turchi (MA); Al Redmer Jr. represented by Vincent O’Grady (MD); Chlora Lindley-Myers represented by John Rehagen (MO); Bruce R. Range represented by Lindsay Crawford and Justin Schrader (NE); Marlene Caride represented by John Sirovetz (NJ); Linda A. Lacewell represented by James Matheson and Jim Everett (NY); Kent Sullivan represented by Jamie Walker (TX); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); Mike Kreidler represented by Patrick McNaughton (WA); and Marlene Caride represented by Randy Milquet (WI). Also participating were: Howard Liebers (DC); and Matt Kozak (MD).

1. Received a Nonsubstantive Proposed P&P Manual Amendment to Add Instructions for ETFs that Contain a Combination of Preferred Stocks and Bonds

Mr. Fry said this agenda item is a proposed nonsubstantive amendment to add instructions for exchange-traded funds (ETFs) that contain both preferred stocks and bonds. The current instructions permit the Securities Valuation Office (SVO) to consider for inclusion on the bond or preferred stock list ETFs that predominantly only invest in one or the other security type. This amendment proposes permitting an ETF that invests in both preferred stocks and bonds to be included on the preferred stock ETF list. This leads to issues of classification in a situation in which it holds 75% preferred stock and 25% bonds. Derivatives are also permitted up to certain levels, called speculative risk, and above that level it is ineligible. Mr. Fry suggested combining these issues into an SVO paper.

Charles Therriault (NAIC) said it was a good description of the concerns and the issues. The SVO keeps the list fairly pure, and if there is any excess outside the definition of predominantly bond or preferred stock, the ETF will be rejected.

Mr. Everett said the U.S. Securities and Exchange Commission (SEC) guidance has been as low as 65% in fund guidance of whatever the title might indicate, which is what is tied into the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual); the title of the fund should reflect what is in it. He asked what is being used now to determine what predominately is and what percentage of funds are permitted for derivatives, and how that percentage is calculated.

Mr. Therriault said is not a hard-set limit, but the SVO looks at what the ETF strategy is, how those instruments are being used to achieve bond like performance, and if it is consistent with what the SVO considers a portfolio of bonds. Generally, there is a minor percentage of derivatives overall; the exposure is based on market value. Funds should not have any embedded leverage.

Mr. Everett asked if it is the market value as of the date of the valuation or if the percentage of the fund that is set out in the offering is circular. Mr. Therriault said the typical process looks at multiple quarters of historical holdings, and it is the market value as of those quarter ends.

Mr. Fry said while the SEC may have a limit of 65%, the SVO would be uncomfortable approving a fund with such a low concentration. Mr. Therriault said the SVO expects “predominant” to mean a portfolio with a high percentage invested only in bonds.

Mr. Everett asked, when speaking about derivatives, if it is limited to only the three types that are permitted in the Statements of Statutory Accounting Principles (SSAPs) that are limited to income generation, hedging etc., and what kinds of derivatives are being considered in the universe of these. Mr. Therriault said different types of derivative instruments may be used. The SVO looks at what derivative instruments are used, how they are used to achieve the fund objective, and the strategy that it performs as a portfolio bond.
Mr. Kozak said he has seen confusion with insurers reporting a U.S.-issued ETF with the underlying investments being non-U.S. based. Mr. Fry agreed and said a separate schedule may be needed for fund investments.

Mr. Fry directed SVO staff to prepare a memorandum working with the Statutory Accounting Principles (E) Working Group staff summarizing the issues discussed to classify an ETF.

2. Received a Nonsubstantive Proposed P&P Manual Amendment to Rename the U.S. Direct Obligations/Full Faith and Credit Exempt List to the U.S. Government Fund List and Discontinue the Bond Fund List

Mr. Fry said the SVO maintains the following two fund lists: 1) the U.S. Direct Obligations/Full Faith and Credit Exempt List; and 2) the Bond Fund List. The title of the first list is lengthy and sometimes confusing; this amendment proposes shortening it to the “NAIC U.S. Government Money Market Fund List.”

The second list, called the Bond Fund List, comprises funds that have only U.S. government investments and maintain the “highest market risk rating,” a rating type that is no longer assigned by any rating agency. There are only four funds on this list today, and the proposal is to merge these existing funds that were on the list for 2019 over to the new NAIC Fixed Income-Like SEC Registered Funds List when they come up for renewal in 2020.

Mr. Therriault said the first list is sometimes confusing as to the definition. The idea is to just call it the “NAIC U.S. Government Money Market Fund List” to make it clearer. For the Bond Fund List, the SVO analysts preparing the list report that there is no longer a “highest market risk rating” available from any of the rating agencies, and they are concerned that no fund may qualify. The Bond Fund List would fit into the NAIC Fixed Income-Like SEC Registered Funds List; and if the Task Force agrees, it can be migrated there.

Mr. Everett said the first list was prepared on an explicit backing by the U.S. government of issuances and issuances by Fannie Mae and Freddie Mac if those issuances were backed by the direct power and authority by the U.S. government. He asked if there was some way that the default risks or the weighted average default risks could be looked at for funds of the two different lists. The way the lists were broken down initially when the Task Force adopted this is that they were two fundamentally different types of securities. If the lists are going to be merged, it would seem that they should be merged only if there is a statistical identity between the two types of securities.

Mr. Fry said the U.S. Direct Obligations/Full Faith and Credit Exempt List gets no risk-based capital (RBC). The Bond Fund List would be going away, and it would be included with the other mutual funds.

Mr. Therriault said the U.S. Direct Obligations/Full Faith and Credit Exempt List is reported on the cash schedule; and the second list, the Bond Fund List, is reported on Schedule D. They do get different reporting treatment, but they are both high quality. There is no “market risk rating” being produced any longer, and the funds on the Bond Fund List would satisfy the criteria for the NAIC Fixed Income-Like SEC Registered Funds List.

Mr. Everett said being registered with the SEC does not address the quality or default risk of the funds, only that they have made the correct representations. He asked if there was a statistical identity between the two lists that would justify them being joined.

Mr. Therriault said the intent of the proposal was not to combine the U.S. Direct Obligations/Full Faith and Credit Exempt List and the Bond Fund List. The U.S. Direct Obligations/Full Faith and Credit Exempt List would be renamed, this is a title change and the definition remains the same. The Bond Fund List would be migrated to the NAIC Fixed Income-Like SEC Registered Funds List on the stock schedule with the appropriate NAIC designation based on its underlying investments. Once the Capital Adequacy (E) Task Force decides on the RBC factors for those funds, it would receive that treatment.

Mr. Rehagen made a motion, seconded by Mr. Milquet, to receive and expose a proposed P&P Manual to rename the U.S. Direct Obligations/Full Faith and Credit Exempt List to the U.S. Government Fund List, and discontinue the Bond Fund List and make a referral to Statutory Accounting Principles (E) Working Group for a 45-day public comment period. The motion passed, with New York abstaining.
3. Received a Nonsubstantive Proposed P&P Manual Amendment to Add Instructions to Limit NAIC Designations to the NAIC Assigned Sovereign Rating

Mr. Fry said this agenda item is a nonsubstantive proposed amendment to the P&P Manual to add instructions limiting all NAIC designations to the NAIC foreign sovereign designation equivalent. This change is being proposed because the current limitation could be interpreted to mean that only NAIC designations assigned by the SVO (as opposed those produced through the filing exempt [FE] process) are capped at the NAIC Foreign Sovereign Designation Equivalent List. This amendment addresses the potential interpretation inconsistency by clarifying that all NAIC designations for foreign securities will be capped according to the NAIC Foreign Sovereign Designation Equivalent List published on the SVO’s webpage. This change would ensure consistency and uniformity regardless of how an NAIC designation is assigned and that the NAIC Foreign Sovereign Designation Equivalent List would govern over all NAIC designations.

Mr. Everett made a motion, seconded by Mr. Liebers, to receive and expose a proposed P&P Manual amendment to add instructions to limit NAIC designations to the NAIC Foreign Sovereign Designation Equivalent List for a 45-day public comment period. The motion passed unanimously.

4. Adopted a Nonsubstantive Proposed P&P Manual Amendment to Update the Interim Instructions for Mortgage-Referenced Securities

Mr. Fry said this agenda item is a nonsubstantive proposed amendment to the P&P Manual to update the interim instructions for mortgage-referenced securities. This is a group of securities that are residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS), but the SVO gets involved in designating. The amendment provides guidance to insurers on how to assign an NAIC designation to a newly issued or newly acquired mortgage-referenced security prior to the publication of the annual surveillance data.

Mr. Fry said this change was requested by the industry and discussed at the Summer National Meeting, where it was exposed for a 30-day public comment period ending Sept. 4. One comment letter was received from the American Council of Life Insurers (ACLI) and the North American Securities Valuation Association (NASVA) in support of the proposal. Mr. Fry asked if anyone from the ACLI or NASVA would like to comment on their letter.

Josh Bean (Transamerica), representing the ACLI, said he submitted a comment letter in support of this clarification. It provides appropriate instructions for reporting entities and appreciation for the time and work on this exposure.

Robin Marcotte (NAIC) noted that the Statutory Accounting Principles (E) Working Group is working on a Form A that will include these securities, and she recommended a referral to the Working Group.

Ms. Mears made a motion, seconded by Mr. Fletcher, to adopt the P&P Manual amendment to update the interim instructions for mortgage-referenced securities and send a referral to the Statutory Accounting Principles (E) Working Group (Attachment One-A). The motion passed unanimously.

5. Received a Substantive Proposed P&P Manual Amendment to Add Instructions for Ground Lease Transactions

Mr. Fry said this agenda item is a substantive joint proposed amendment to the P&P Manual to add instructions for ground lease financing (GLF) transactions. This is an item that came up in recent credit tenant loan (CTL) discussions when the Task Force decided that CTLs were outside of FE. Certain transactions are like CTLs, but they do not qualify to be a CTL. The SVO has done some good work with industry on finding a treatment for these securities that have historically performed well. If the Task Force would like to consider this at the Fall National Meeting, it will require a shorter than usual exposure period. Mr. Fry said he would ask Mr. Therriault and Marc Perlman (NAIC) to provide a summary of this proposal.

Mr. Therriault thanked Mr. Perlman, Daniel Favero (Mayer Brown LLP) and David Persky (Nuveen) for the hard work they put into this proposal, along with others from the industry group. Technical methodologies like this require a lot of research, discussion and brainstorming on different possible analytical and structural approaches. Through this interactive and dynamic process, which was also used to develop the power generation projects methodology, a better end-product for the Task Force, industry and SVO staff has been produced. Assuming that the Task Force and industry agree, SVO staff will continue using this approach for the other lease-based transactions.
Mr. Perlman said the SVO considers CTL transactions to be different from ground lease transactions. First, Mr. Perlman explained why the SVO makes this distinction; and second, he outlined the SVO’s proposed approach to analyzing GLF transactions going forward.

Mr. Perlman said in a CTL transaction, the loan is made, primarily in reliance on the credit standing of a highly rated tenant on a long-term lease of the property. Importantly, the SVO can rely on the credit tenant rating because CTLs are generally structured around the terms of the lease which, in its strongest form, require the tenant to perform all or most obligations related to the leased premises and continue to pay rent regardless of what occurs to the premises. These leases are typically called “hell or high water” or “triple net” leases.

Mr. Perlman said GLF transactions, while sharing certain similarities with CTL transactions, differ in several crucial ways. A GLF transaction typically has two components. First, there is a ground lease for up to 99 years, between a ground lessor who owns the land and a ground lessee who leases the land for the purpose of developing it. Second, there is the subleasing of space by the ground lessee or operation of a business in an existing or to-be-constructed building to one or more subtenants under shorter subleases or a business operator under a franchise agreement or other arrangement.

In a GLF transaction, it is often the case that the terms of the ground lease itself (the first leg of the transaction) makes it a “hell or high water” or “triple net” lease. However, because the ground lessee is a special purpose entity, rather than an operating entity, there is no rating agency rating to rely on; there is no credit tenant. To determine whether the ground lessee will have sufficient funds to pay its ground lease obligations, the SVO must look to the rent payments of the subtenants or the operation of the business being conducted on the property.

Mr. Perlman said the SVO, in conjunction with the NAIC Structured Securities Group (SSG), takes the position that the analysis of subleases and subtenants can be more akin to a CMBS analysis than the corporate analysis in a CTL transaction. This is because ultimate payment on the ground lease loan is dependent not on a single credit tenant, but rather on payments by multiple, possibly unrated, subtenants of differing credit profiles pursuant to multiple subleases of differing terms (which are not necessarily “hell or high water” or “triple net”). The SVO also noted that some of the rating agencies which assign ratings to GLF transactions have utilized their CMBS models in their GLF ratings process, but their methodologies and criteria vary widely.

Mr. Perlman said recognizing that there are variances in how GLF transactions are structured, the SVO proposes amending the P&P Manual to institute a multi-pronged, decision-tree approach to analyzing these transactions. The proposed P&P amendments would include adding GLF transactions as a new asset class and outline the GLF analytic process as follows.

- First, the SVO would analyze the ground lease to determine if it meets the P&P Manual CTL criteria (meaning, it is “hell or high water” or “triple net”). The SVO expects most ground leases to meet this test.

- Second, if the ground lease meets the CTL criteria, it would be determined whether three or fewer subtenants combined comprise 90% or more of the total sublease payment obligations, whether those subtenants are rated or can be analyzed by the SVO, and whether their subleases each meet the P&P Manual criteria for CTLs. If so, the SVO could, in its sole discretion, analyze the transaction as akin to a CTL, based on the triple-net nature of both the ground and subleases, the limited number of subleases, and the credit profiles of the subtenants. The SVO expects a small fraction of all GLF transactions to fall into this category.

- Third, if the ground lease meets the P&P Manual CTL criteria and there are four or more subtenants; the SVO has determined that the transaction does not meet the criteria just explained; or there are no subtenants, but a single operator of a business, the SVO may refer the subleases or the business operation to the SSG for possible financial modeling. If the SSG determines that the subleases or business operation can be modeled, it would analyze the subleases or business operation to determine whether they will provide sufficient cash flow to pay the ground lease rent payments and any additional costs which the ground lessee would be obligated to cover pursuant to the ground lease terms.
Fourth, if the SSG determines that it is unable to model the subleases or business operation, and if the GLF transaction has been assigned a public or private rating by a rating agency, the SVO may use the rating agency analysis provided by the filer to assist the SVO in its own analysis. The SVO’s analysis will be entirely at the discretion of the SVO, and the SVO will be under no obligation to accept the rating agency analysis, conclusions or ratings. The SVO expects most GLF transactions to fall into this final category.

Mr. Perlman concluded with a summary of the proposed GLF amendment to the P&P Manual, and he recommended that this criteria should apply to all GLF securities purchased after Jan. 1, 2020.

Resh Reese (Teachers Insurance and Annuity Association of America—TIAA) and Mr. Persky said they would like to thank the Task Force and SVO staff for the continued engagement with industry on this matter. With respect to the ground lease topic, the industry is appreciative of the efforts and thorough analysis that was put forth by staff in creating and crafting a resolution for both industry and state insurance regulators, and they look forward to continuing to partner with the Task Force and the SVO on all future matters.

John Garrison (John Hancock) said the framework that was just outlined is a well thought-out and workable solution.

Mr. Everett said he appreciates the clarity of the materials and summary.

Benjamin Guzman (Catholic Order of Foresters) said they appreciate all the SVO and Task Force’s hard work on this solution, noting that it is an important asset class.

Tom Sargent (Waterway Capital) said Waterway is also appreciative of the work it took to develop a palatable solution.

Michael M. Monahan (ACLI) said the ACLI supports the expedited comment deadline.

Mr. Everett made a motion, seconded by Mr. Kozak, to receive and expose a proposed P&P Manual amendment to add instructions for GLF transactions and make a referral to the Statutory Accounting Principles (E) Working Group for a 22-day public comment period. The motion passed unanimously.

6. Discussed a Substantive Proposed P&P Manual Amendment for Principal Protected Securities

Mr. Fry said this agenda item is to discuss a substantive proposed amendment to the P&P Manual to update the definition and instructions for principal protected securities. The amendment may benefit from some additional work on the definition and the Task Force may direct the SVO staff to work with the industry to refine it and re-expose the amendment at the Fall National Meeting. The idea is to take this class of securities called principal protected notes, sometimes called “collateralized loan obligation (CLO) combo notes,” and make them ineligible for FE. The SVO would apply a look-through methodology to capture the regulatory risk. Mr. Fry asked Mr. Therriault to provide an update on the proposal.

Mr. Therriault said the NAIC Investment Analysis Office (IAO), SVO and SSG staff believe that these securities should not be FE. IAO staff also believe that the rating agencies are following their published methodologies, which focus primarily on the contractual payments, particularly the re-payment of principal, but do not believe the rating assigned using these methodologies reflects how the NAIC views risk from a financial solvency perspective.

Mr. Therriault said the concerns voiced in the comment letters focused primarily on four issues:

- The first issue is one centered on the resources of the SVO. The NAIC has and does assign resources where it is needed to meet the needs of its members. Mr. Therriault advised the Task Force that policy decisions should not be made based on resource concerns. The Executive (EX) Committee is charged with that responsibility, and it makes those decisions based on member needs and industry feedback. As of today, the SVO does not believe that additional resources will be required to analyze this asset class.

- Second, there were concerns about assigning a specific methodology to analyze these securities. Summarizing existing P&P Manual instructions, the SVO has reasonable professional latitude to interpret how the instructions and methodologies contained in the P&P manual apply to specific securities, financial products, or differing analytical situations. Factors that may affect how the SVO interprets instructions and methodologies include, but are not limited
to, the terms of individual securities, unique features or characteristics of securities, legal or regulatory issues associated with structured transactions, the issuer’s industry, the introduction of a new security type or asset class, and NAIC regulatory objectives. The SVO is expressly authorized to employ any analytical technique that is taught in standard undergraduate and graduate business school financial analysis curriculum and any analytical technique otherwise widely or commonly used by lending officers, securities professionals, or credit rating analysts, despite the lack of an express authorization to use the technique in the P&P Manual. Mr. Therriault said these existing instructions are being mentioned because these securities can come in a number of forms, and the SVO needs the flexibility and analytical discretion to apply the methodology that it believes is appropriate to the security being reviewed.

The SVO is also authorized in the P&P manual to analyze securities for other non-payment risk and can express this by assignment of an NAIC Designation with a subscript S. SVO staff believe that these securities fall into such a category. State insurance regulators attach certain economic expectations to certain terms used to describe securities or financial instruments owned by insurers and reported as invested assets. This reflects that the regulatory objective is to assess the financial ability of an insurer to pay claims. Any contractual modification of these regulatory assumptions is deemed to create a rebuttable inference that the security or instrument contains an additional or other non-payment risk—albeit one that is sanctioned by the contract—that may result in the insurer not being paid in accordance with the underlying regulatory assumption. The SVO is granted significant discretion when assigning an NAIC designation to a security that reflects other non-payment risk.

The proposal requests that the Task Force permit the SVO to apply these existing instructions to this class of securities and reflect these other risks that, while sanctioned by the contract, may result in the insurer not being paid in accordance with the underlying regulatory assumption. Rating agencies, while they may be adhering to their methodologies, do not have these same concerns or responsibilities as the Task Force.

Nevertheless, the SVO is likely to apply a variant of the look through weighted average rating factor (WARF) methodology because such a methodology permits the SVO to look at each source of risk. For example, in analyzing a CLO Combo Note, the SVO would look at the underlying securities based on their credit rating provider (CRP) ratings and weight the ratings factor by their balances to generate the overall NAIC designation. However, the SVO would not want to be artificially constrained to only that one methodology.

- A third concern was definitional, that additional assets may be pulled in that do not possess the characteristics that are of concern. The SVO agrees that this may be an issue and would be happy to work with the ACLI to refine the definition of these securities in the amendment. There was also concern expressed about the performance assets not being eligible for Schedule D reporting. Any guidance on the admissibility of an asset falls under the NAIC’s accounting standards of the Statutory Accounting Principles (E) Working Group; and as mentioned in the memorandum, the SVO recommends a referral to the Working Group to consider the issue.

- The fourth concern related to application of this amendment to only newly acquired securities. The SVO is sensitive to disrupting insurer investing; particularly, near year end. Mr. Therriault said the SVO recommends that this amendment become effective on Jan. 1, 2020, to avoid any such disruption and provide insurers an ample transition period; however, the SVO does not recommend exempting any securities from this policy because of the potentially significant inherent risks the SVO sees in these securities. When the SVO sees a situation where it does not believe a security’s rating reflects risk from the NAIC’s perspective, the SVO is obligated to bring it to the Task Force’s attention and propose a recommendation to address that risk; the SVO recommends removing this class of securities from FE eligibility.

Mr. Fry said the Task Force received comments letters from the ACLI, NASVA, Kroll Bond Rating Agency (KBRA), Security Benefit Life Insurance, Delaware Life Insurance Company and Guggenheim Life and Annuity Company. He asked if anyone from those organizations would like to make any brief comments.

Mr. Bean said Mr. Therriault did a nice job of outlining the concerns and has already gone down the road of alleviating or addressing some of them. Certainly Mr. Fry’s comments about directing the SVO and industry to work further on the definition and appropriately refine the scope is really the ultimate focus of the ACLI and NASVA as of this point in time. The ACLI and NASVA look forward in continuing to refine that definition and ensure that the scope is appropriate but truly supports the analytical objectives, and they appreciate the opportunity to be part of the process.
Patrick Welch (KBRA) said principal-protected notes (PPNs), from a credit risk analysis perspective, are not inherently or always problematic. KBRA provides thoughtful, clear, respected credit rating methodology that addresses the terms of the issue or the issuance. The credit rating addresses the downside credit risk, and the performance asset could return zero and the rating will still hold.

Joseph Wittrock (Security Benefit Life Insurance) said not all PPNs are created equal. If one looks at statutory accounting guidance, if it immediately went to zero, not only will the insurer get all their principal back plus the contractual coupon; but because the risk asset immediately goes to zero, statutory accounting guidance requires an immediate write down and impairment—a direct impact to surplus—of the diminution in value of these PPN assets because of the risk asset going to zero. Mr. Wittrock said he believes that the current accounting guidance already provides significant protection to policy holders because of their requirements to address prospective cashflow when assessing current carrying value on a statutory balance sheet. In regards to the definition, Security Benefit Life Insurance has engaged in multiple conversations with industry participants, as well as the ACLI; it was quite clear that there were many industry participants that were not engaged and elected not to get involved because the definition was not clear or they did not have any PPNs. Depending on how the definition of a PPN ultimately falls, there may be a lot more industry feedback because there may be a quite a number of insurance companies who have PPN exposures. Mr. Wittrock urged the Task Force to consider a definition which provides crystal clarity of what a PPN is versus what a PPN is not, with no qualitative assessment or ambiguity in terms of what a PPN is.

Mr. Fry said this is not being considered for adoption today, and the SVO has already offered to work with the ACLI and whomever else would like to provide input into refining the definition of these securities in the amendment. Hopefully an update will be available to review at the Fall National Meeting.

Mr. Fry said the last two agenda items can be deferred, having run out of time. One of those deferred items is moving from price breakpoints on RMBS/CMBS securities to assigning a single NAIC designation independent of the carrying value, a capability that the SSG already has. The idea is to get input on this change, as it would simplify processes. The other item was an update on an SEC adoption. He said both topics can be discussed at the Fall National Meeting.

Having no further business, the Valuation of Securities (E) Task Force adjourned.
MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
    Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group

DATE: July 2, 2019

RE: Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to Update the Interim Instructions for Mortgage-Referenced Securities

1. **Introduction** – The SVO proposes a non-substantive amendment to the P&P Manual to update guidance in Part Four under the The NAIC Structured Securities Group, Mortgage-Referenced Securities. The Structured Securities Group (SSG) is responsible to financially model this group of securities; however, they only review them during their annual surveillance process. Insurers currently do not have instructions to assign an NAIC designation to a newly issued or newly acquired mortgage reference security prior to the publication of the annual surveillance data. This proposal would provide that interim guidance.

2. **Proposed Amendment** – The proposed amendment is shown below in red-underline.

   **Part Four The NAIC Structured Securities Group**

   **MORTGAGE REFERENCED SECURITIES**

   **Definition**

   ...

   **Quarterly Reporting for Mortgage Reference Securities**

   To determine the NAIC Designation to be used for quarterly financial statement reporting for a Mortgage Reference Security purchased subsequent to the annual surveillance described in this Part, the insurer uses the prior year-end modeling data for that CUSIP (which can be obtained from the NAIC) until the annual surveillance data is published for the current year. For a Mortgage Reference Security that is not in the prior year-end modeling data for that CUSIP, the insurer may follow the instructions in Part Two of this manual for the assignment of the SVO Administrative Symbol “Z” provided the insurer owned security meets the criteria for a security that is in transition in reporting or filing status.

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The Valuation of Securities (E) Task Force met via conference call Sept. 5, 2019. The following Task Force members participated: Robert H. Muriel, Chair, represented by Kevin Fry (IL); James J. Donelon, Vice Chair, represented by Stewart Guerin (LA); Lori K. Wing-Heier, represented by Wally Thomas (AK); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kathy Belfi (CT); Trinidad Navarro represented by Rylynn Brown (DE); David Altmaier represented by Ray Spudeck (FL); Doug Ommen represented by Carrie Mears (IA); Dean L. Cameron represented by Eric Fletcher (ID); Vicki Schmidt represented by Tish Becker (KS); Gary Anderson represented by John Turchi (MA); Al Redmer Jr. represented by Vincent O’Grady (MD); Chlora Lindley-Myers represented by Debbie Doggett (MO); Bruce R. Ramge represented by Lindsay Crawford and Justin Schrader (NE); Marlene Caride represented by John Sirovetz (NJ); Linda A. Lacewell represented by James Matheson and Jim Everett (NY); Glen Mulready represented by Eli Snowbarger (OK); Kent Sullivan represented by Jamie Walker (TX); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); Mike Kreidler represented by Patrick McNaughton (WA); and Mark Afable represented by Randy Milquet (WI).

1. Adopted an Updated Amendment to the P&P Manual to Add Instructions for New Administrative Fields “RTS” and “RT”

Mr. Fry said this agenda item is a referral from the Statutory Accounting Principles (E) Working Group requesting the Task Force add new reporting codes for investments that meet the definition of “regulatory transaction” in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual). Given the P&P Manual restrictions in reporting NAIC designations for regulatory transactions, the Working Group noted that there was no reporting mechanism to identify regulatory transactions or a Securities Valuation Office (SVO) analytical value for risk-based capital (RBC) assessment on the investment schedules.

Charles A. Therriault (NAIC) said the Task Force discussed this referral and amendment during its Aug. 4 meeting at the Summer National Meeting. At that time, the industry had requested some language clarifications and inclusion of needed administrative symbols. The Task Force agreed and directed SVO staff to work with industry on these clarifications and administrative updates to the amendment and then re-expose the amendment, after those revisions were made, for a two-week public comment period ending Aug. 30.

Mr. Therriault said given that it is now in September, it is unlikely that Blanks (E) Working Group or insurers can implement these symbol changes by year-end. He said SVO staff recommend that these symbols be optional for year-end 2019 reporting, but required as of Jan. 1, 2020. This would include the application of the carry-over administrative symbols “YE” and “IF” for regulatory transaction that were properly filed with the SVO. The amendment highlights in yellow the changes that were made to the amendment since the Summer National Meeting.

Mr. Fry said the Task Force received one joint comment letter from the American Council of Life Insurers (ACLI) and the North American Securities Valuation Association (NASVA). He said they are supportive of the revised proposal and its adoption. Mr. Fry asked if anyone here from the ACLI or NASVA would like to comment on this letter.

Joshua Bean (Transamerica), representing the ACLI and NASVA, said they appreciate the opportunity to comment on the proposal and support its adoption, as recommended by NAIC staff.

Mr. Everett made a motion, seconded by Ms. Belfi, to adopt the revised amendment adding the new reporting codes for investments that meet the definition of a regulatory transaction within the P&P Manual and make referrals to Blanks (E) Working Group to add these codes to the SVO Administrative Symbol list in the 2020 Annual Statement Instructions. This amendment would be optional for Dec. 31, 2019, annual financial statement reporting, but required effective Jan. 1, 2020 (Attachment Two-A). The motion passed unanimously.
2. **Adopted its 2020 Proposed Charges**

Mr. Fry provided an overview of the Task Force’s 2020 proposed charges. He said there was one deletion from its 2019 charges: the implementation of the NAIC designation category was removed as this project is on track and will be implemented in 2020. He also said there was an addition to: “Identify potential improvements to the filing exempt process (the use of credit rating provider ratings to determine an NAIC designation) to ensure greater consistency, uniformity and appropriateness to achieve the NAIC’s financial solvency objectives.” This charge is consistent with recent discussions by Task Force on the use of credit ratings.

The Financial Condition (E) Committee manages the work of its various task forces by assigning time periods for any activity that is not an ongoing activity. No new deadlines were proposed in these charges.

Mr. Sirovetz made a motion, seconded by Mr. Thomas, to adopt the Task Force’s 2020 proposed charges and direct SVO staff to provide them to the Financial Condition (E) Committee for consideration (see *NAIC Proceedings – Fall 2019, Financial Condition (E) Committee, Attachment One-A*). The motion passed unanimously.

Having no further business, the Valuation of Securities (E) Task Force adjourned.
MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
    Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
       Robert Carcano, NAIC Consultant

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau


DATE: April 20, 2019 (Amended August 15, 2019)

I. Introduction – The Valuation of Securities (E) Task Force has received a referral (Exhibit One) from the Statutory Accounting Principles (E) Working Group to address reporting for regulatory transactions. The P&P Manual defines the term “regulatory transactions” and provides that such transactions: 1) are not eligible for credit assessment by the SVO; 2) are not eligible for filing exemption (FE); 3) cannot be self-assigned the administrative symbol Z under the 120 rule; 4) cannot be self-assigned as 5GI securities; and 5) cannot be entered into NAIC systems maintained for the Task Force. The P&P Manual also provides that a domiciliary state insurance department may request SVO or SSG assistance in the assessment of a regulatory transaction, with the understanding that the state can adopt the SVO or SSG work product as its own, but the determination is a state determination and not an NAIC work product. Despite this specified treatment, there is no specific instruction for reporting regulatory transactions, and reporting entities do not have any available reporting options when investment schedules require an NAIC designation. The Working Group initiated a project (agenda item 2018-06) to address reporting for regulatory transactions in response to a referral from the Reinsurance (E) Task Force.

On April 6, the Working Group adopted a revised staff recommendation to add reporting codes for the investment component of regulatory transactions. Under the adopted procedure, a reporting entity would use the code “RTS” when the domiciliary state has received assistance from the SVO (or SSG) in reviewing a regulatory transaction. In those cases, the code would be reported with the “analytical value” (a new term defined below) assigned by the SVO and given to the state. The code “RT” would be used for all other regulatory transactions; i.e., those in which the domiciliary state did not ask the SVO for assistance or those where the SVO was unable to determine an analytical value for the transaction for the state. This code would be reported with an NAIC 6 designation for measurement and risk-based capital (RBC) assessments. These codes are specific to Schedule D, Part 1 reporting because those schedules require reporting a “designation” for all securities. A reporting entity may identify a regulatory transaction on other investment schedules, but such other schedules do not require that an NAIC designation be reported (e.g., Schedule BA items are not required to be reported with an NAIC designation.)

The Working Group’s referral requests that the new codes be incorporated into the P&P Manual as part of the guidance on regulatory transactions. SVO staff worked with staff in the NAIC Financial Regulatory Services (FRS) Division...
on the outline of the adopted proposal and so supports the recommended change because it aligns the reporting for regulatory transactions structured as bonds with the limitations prescribed by the P&P Manual mentioned above. Accordingly, the SVO proposes an amendment to the P&P Manual, shown below, to implement it. If the Task Force adopts the proposed amendment, the SVO recommends a further referral to the Blanks (E) Working Group to add these codes to the administrative list in the instructions.

2. Proposed Amendments – The proposed amendments are shown in both the 2018 P&P Manual format and in the newly adopted 2019 P&P Manual format. Please note that the Task Force adopted revisions to the text to clarify treatment for an investment security that may be a component of a regulatory transaction. That version of the text, which is on the Task Force’s/SVO page on the NAIC website, is used to show the proposed amendments in both P&P Manual formats.

The updated amendment includes instructions and Administrative Codes for newly acquired regulatory transactions, the continuation of an analytical value over year-end and clarifying updates to the definitions.
Amendments Shown in 2018 P&P Manual Format

Part One—Purposes, General Policies and Instructions to the SVO

Section 2—Policies Defining the SVO Staff Function

\[d\] SVO Regulatory Products

\[iii\] Authority to Direct Insurers on Reporting

The SVO has responsibility and authority to assess securities that are reportable on Schedule D and Schedule BA of the NAIC Financial Statement Blank. It is, therefore, part of the role of the SVO to determine when financial instruments or securities are not eligible for reporting on Schedule D and Schedule BA. The SVO may, therefore, be required to inform an insurer filer to redirect a financial instrument or security reported to the SVO to another schedule. Similarly, the SVO may also be required to inform an insurer filer that an instrument filed with the SVO pursuant to Part Two, Section 2 a) of this Manual does not meet the definition of an Investment Security and cannot be assessed as such or that a financial transaction or security filed with the SVO meets the definition of a Regulatory Transaction eligible for assessment by the SVO only in accordance with the procedures discussed in under Part Three, Section 6 of this Manual. In all cases in which a situation described in this subparagraph is presented, final determination as to what statutory accounting and reporting applies to the instrument or security is made in consultation between NAIC statutory accounting staff and the SVO.

Part Two—Filing with the SVO

Section 2—General Reporting Framework

\[a\] Obligation to Report

Insurance companies domiciled in any state of the United States, or any of its territories or possessions, and required by the law of their domiciliary state or territory to report NAIC Designations for their Investment Securities in the NAIC Financial Statement Blank, shall report purchases of Investment Securities to the SVO or, in the case of Investment Securities exempt from filing with the SVO, for example, pursuant to Part Three, to the NAIC, as required by this Manual.

For purposes of this Part Two, Section 2 a), an Investment Security means an instrument evidencing a lending transaction between an insurance company as lender and a non-affiliated borrower, where the borrower’s sole motivation is to borrow money and the insurance company’s sole motivation is to make a profit on the loan that the state of domicile regulates by reference to the NAIC Financial Regulation Standards and Accreditation Program.
The SVO shall have no authority to issue NAIC Designations or any other NAIC analytical product to an insurance company for a Regulatory Transaction under Section 2 a) of this Part.

Part Three, Section 6 of this Manual provides that the SVO may assist a state insurance department in the assessment of the security component of a Regulatory Transaction and may issue an SVO Analytic Value to the department at the conclusion of the assessment. Part Three, Section 6 also provides instructions to insurance companies on how to report the security component of a Regulatory Transaction on investment schedules. See Part Three, Section 6 of this Manual for the definition of Regulatory Transaction and a description of the processes governing their assessment.

Part Three Credit Assessment
Section 6—Regulatory Transactions

a) Defined

Regulatory Transaction means a security or other instrument in a transaction submitted to one or more state insurance departments for review and approval under the regulatory framework of the state or states. The term Regulatory Transaction is more broadly defined as a transaction engineered to address a regulatory concern one or more insurers have or may have that should be submitted to a state insurance department for approval and that has as a component a security or other instrument which on a stand-alone version may be an Investment Security, as defined in this Manual, that is eligible for assignment of an NAIC Designation.

b) Status of Regulatory Transactions—A Regulatory Transaction is not eligible for:

—— Assignment of an NAIC Designation by the SVO;
—— The filing exemption process for publicly rated securities;
—— The private letter rating component of the filing exemption or for use of the PLGI designation symbol;
—— Self-assignment by an insurer of the administrative symbol Z under the 120 rule;
—— Self-reporting by an insurer on the general interrogatory for securities eligible for filing exemption but for which no NAIC CRP credit rating is available (i.e., 5GI) and
—— Inclusion in the SVO List of Investment Securities or any other NAIC electronic system or processes maintained for operations of the Valuation of Securities (E) Task Force.

c) Intent

This Section provides guidance to the SVO and the SSG on how to manage requests for assistance made by a state insurance department under Part Two, Section 2 b) of this Manual. Insurance companies shall not report a Regulatory Transaction as a Filing Exempt security, and the NAIC staff shall not assign an NAIC Designation to the security component of a Regulatory Transaction or to the Regulatory Transaction or add them to the Filing Exempt Securities Process of the SVO List of Investment Securities. See, the instructions on Regulatory Transactions contained in the compilation instructions in Part One, Section 3. e) and g) — l). This does not preclude the SVO from working directly with a state insurance department and issuing an opinion to the department consistent with the instructions outlined in this Manual.

d) The Security Component of a Regulatory Transaction

However, as discussed defined above, the security component of a Regulatory Transaction may be an Investment Security that is eligible for designation under filing exemption or by the SVO on a stand-alone basis,
For example,

A. An insurance company entered into a coinsurance reinsurance transaction that requires regulatory approval and as part of that transaction, received an IBM bond. The IBM bond, when owned by an insurance company as a stand-alone investment, would be considered Filing Exemption but the whole regulatory transaction would not be eligible for Filing Exemption. In this example, the IBM bond is assumed to be an Investment Security, as defined in this Manual.

B. An IBM bond that was eligible for Filing Exemption was sold/transferred from an insurance company to an affiliated insurance company that requires regulatory approval. Such an IBM bond would still be considered eligible for Filing Exemption when owned by an insurance company as a stand-alone investment. In this example, the IBM bond is assumed to be an Investment Security, as defined in this Manual. Any other parts of the transaction requiring regulatory approval, if any, would not be eligible for Filing Exemption.

Procedure – Assessment of the Investment Security Component of a Regulatory Transaction

Guidelines

The SVO or SSG is authorized to conduct an analytical assessment on behalf of any state insurance department that requests such assistance.

If an insurance company files a Regulatory Transaction with the SVO via the ATF process or under the Regulatory Treatment Analysis Service (RTAS) process, the SVO shall first contact the state insurance department of the insurance company’s state of domicile to disclose that a Regulatory Transaction has been submitted and inquire whether the state insurance department wants SVO analytical assistance.

The SVO or SSG is authorized to conduct an analytical assessment on behalf of any state insurance department that requests such assistance. If the state insurance department of the insurer’s state of domicile requests such assistance, the SVO shall engage in the requested analytical assessments of the security component of the Regulatory Transaction. In its assessment the SVO determinations would make use of include and refer to NAIC analytical benchmarks, such as those used to produce NAIC Designations, valuation or classification assessments, and such determinations may be given by the SVO or SSG to the state insurance department.

Determinations made by the SVO or SSG given to a state insurance department in connection with the assessment of the security component of a Regulatory Transaction shall be referred to as an SVO Analytic Value, (defined below) to prevent confusion in the reporting by an insurer of the Regulatory Transaction or the security component of the Regulatory Transaction to the domiciliary state insurance department and the reporting of a stand-alone Investment Security under the general procedures applicable to them.

SVO or SSG determinations given in connection with the assessment of a Regulatory Transaction may be given to the state insurance department may be and adopted by the state insurance department as part of that state’s internal determination of the regulatory issues presented by the Regulatory Transaction. However, SVO assessments of the security component of a Regulatory Transaction will not be entered into NAIC computer systems reserved for Investment Securities, as defined in Part Two, Section 2 a) of this Manual or added to the SVO List of Securities as defined in Part One, Section 3 k) of this Manual. The insurance department may give the SVO Analytical Value to the insurer and instruct the insurer to use the SVO Analytical Value to report the security component of the Regulatory Transaction to the state, as more fully discussed below.
f. Reporting Regulatory Transactions on Investment Schedules

A Regulatory Transaction is reported on an investment schedule. A Regulatory Transaction reported on Schedule D, Part I, must be reported with one of the two codes described below. The codes track the security component. Other investment schedules do not require that an NAIC Designation be reported. (For example, Schedule BA items are not required to be reported with an NAIC Designation.) The codes ONLY communicate information about the security component of the Regulatory Transaction. Each of the two codes identifies a different reporting paradigm and requires the reporting entity to report an SVO Analytical Value, defined below.

g. Definition of SVO Analytical Value

An SVO Analytical Value produced by the SVO is an expression of the credit quality of the security component of a Regulatory Transaction which is expressed with the numerical symbols 1 through 6 in the case of a Regulatory Transaction within the reporting paradigm associated with the RTS code. In the case of the security component of a Regulatory Transaction within the reporting paradigm associated with the RT code the SVO has not developed the SVO Analytical Value but in that case the Value is expressed with the numerical symbol 6.

h. Codes and Their Meaning

RTS is reported for a Regulatory Transaction for which: 1) a state insurance department requested SVO assistance in assessing the credit quality of the security component of the Regulatory Transaction; 2) the SVO provided an SVO Analytical Value for the security to the department and 3) the department thereafter directed its insurer to report the SVO Analytical Value. For the securities components of a Regulatory Transaction within the RTS reporting paradigm, the reporting entity reports the analytical value it received from the department which is the same one the SVO provided to the department. The SVO Analytical Value associated with the RTS code is expressed as a numerical symbol from 1 through 6; i.e., 4RTS. An SVO Analytical Value is ONLY assigned by the SVO if the SVO determines the Regulatory Transaction is an Investment Security if engaged in on a stand-alone basis. An SVO Analytical Value is not a preliminary or an official NAIC Designation and cannot be entered into NAIC systems maintained to support the operations of the Valuation of Securities Task Force either by the SVO or anyone else.

RT is reported for a Regulatory Transaction for which a state insurance department did not request assistance from the SVO in assessing the credit quality of the security component of the Regulatory Transaction or in which the department requested the assistance of the SVO but the SVO determined the security component of the Regulatory Transaction was not an Investment Security if engaged in on a stand-alone basis or the SVO was unable to provide an SVO Analytical Value for the security component of the Regulatory Transaction. For the security component of Regulatory Transactions within the RT reporting paradigm, the reporting entity always self-assigns and reports the SVO Analytical Value 6; i.e., 6RT.

Part One Policies of the NAIC Valuation of Securities Task Force

Authority to Direct Insurers on Reporting

40. The SVO is assigned to assess investment securities reported to state regulators on Schedule D and Schedule BA. To fulfill its function SVO must be able to communicate to an insurer that has filed a financial instrument or security that the financial instruments or security is not an investment security eligible for reporting on Schedule D and Schedule BA. SVO may be required to communicate to an insurer that it must refile a financial instrument or security to another schedule. SVO may also have to communicate to an insurer that an instrument the insurer has filed does not meet the definition of an Investment Security in this Manual and is therefore not eligible to be assessed or that the financial transaction or security is a Regulatory Transaction that can only be assessed by the SVO. The SVO, in assessing a Regulatory Transaction, will only do so in accordance with the procedures discussed in this Manual if requested by a state insurance department. When situations occur that require the SVO to communicate reporting or related statutory guidance to an insurer, SVO consults with Financial Regulatory Services Division staff to ensure the communication to the insurer is accurate.

Part One Policies of the NAIC Valuation of Securities Task Force

Filing Securities with the SVO

NOTE: See “General Filing Procedures” and “Filing Process and Required Documents” in Part Two and the various asset specific sections in Part Three for filing instructions and documentation requirements specific to the security or asset type discussed in those section.

Obligation to File Securities with the SVO

48. Insurance companies domiciled in any state of the United States, or any of its territories or possessions, that have adopted laws incorporating the standards in the NAIC Financial Regulation Standards and Accreditation Program that require the use of NAIC Designations or other analytical products for Investment Securities are required by those laws to file purchases of Investment Securities with the SVO as indicated in this Manual to obtain the NAIC Designation or other analytical product required by state law.

49. Investment Security means an instrument that documents a lending transaction between an insurance company as lender and a non-affiliated borrower, where the borrower’s sole motivation is to borrow money and the insurance company’s sole motivation is to make a profit on the loan that the state of domicile regulates by reference to the NAIC Financial Regulation Standards and Accreditation Program.

50. The SVO shall have no authority to issue NAIC Designations or any other NAIC analytical product to an insurance company for a Regulatory Transaction. This Manual provides that the SVO may assist a state insurance department in the assessment of the security component of a Regulatory Transaction and may issue an SVO Analytic Value to the department at the conclusion of the assessment. This Manual also provides instructions to insurance companies on how to report the security component of a Regulatory Transactions on investment schedules.
Part One Policies of the NAIC Valuation of Securities Task Force
Policies Applicable to Specific Asset Classes
Regulatory Transactions

Defined

111. Regulatory Transaction means a security or other instrument in a transaction submitted to one or more state insurance departments for review and approval under the regulatory framework of the state or states. The term Regulatory Transaction is more broadly defined as a transaction engineered to address a regulatory concern one or more insurers have or may have that should be submitted to a state insurance department for approval and that has as a component a security or other instrument which on a stand-alone version may be an Investment Security, as defined in this Manual, that is eligible for assignment of an NAIC Designation.[RC4]

Intent

112. This section provides guidance to the SVO and the SSG on how to manage requests for assistance made by a state insurance department made as permitted in this Manual. Insurance companies shall not report a Regulatory Transaction as a Filing Exempt security, and the NAIC staff shall not assign an NAIC Designation to the security component of a Regulatory Transaction or to the Regulatory Transaction or add them to the Filing Exempt Securities Process of the SVO List of Investment Securities. This does not preclude the SVO from working directly with a state insurance department and issuing an opinion to the department consistent with the instructions outlined in this Manual.[RC5] See Regulatory Transactions in Part Three for guidance on the status of the security component of a Regulatory Transaction.

NOTE: See “Regulatory Transactions” in Part Three and “Compilation and Publication of the SVO List of Investment Securities” in Part Two. Regulatory Transactions are excluded from all NAIC data files used to produce the SVO List of Investment Securities, including the data file that houses information about insurer-owned filing exempt securities.

Part Three SVO Procedures and Methodology for the Production of NAIC Designations

Regulatory Transactions

NOTE: See “Policies Applicable to Specific Asset Classes” in Part One for the policies governing this activity, as well as “Specific Populations of Securities Not Eligible for Filing Exemption” in “Procedure Applicable to Filing Exempt (FE) Securities and Private Letter (PL) Rating Securities” above.

Defined

9. Regulatory Transaction means a security or other instrument in a transaction submitted to one or more state insurance departments for review and approval under the regulatory framework of the state or states.

The term Regulatory Transaction is more broadly defined as a transaction engineered to address a regulatory concern one or more insurers have or may have that should be submitted to a state insurance department for approval and that has as a component a security or other instrument which on a stand-alone version may be an Investment Security, as defined in this Manual, that is eligible for assignment of an NAIC Designation.[RC6]
Status of Regulatory Transactions

10. - A Regulatory Transaction is not eligible for:

   Assignment of an NAIC Designation by the SVO;
   The filing exemption process for publicly rated securities;
   The private letter rating component of the filing exemption or for use of the PLGI designation symbol;
   Self-assignment by an insurer of the administrative symbol Z under the 120-rule;
   Self-reporting by an insurer on the general interrogatory for securities eligible for filing exemption but for which no NAIC CRP credit rating is available (i.e., 5GI) and
   Inclusion in the SVO List of Investment Securities or any other NAIC electronic system or processes maintained for operations of the Valuation of Securities (E) Task Force.
Intent

11. This Section provides guidance to the SVO and the SSG on how to manage requests for assistance made by a state insurance department under as authorized in Part Two, Section 2 b) of this Manual. Insurance companies shall not report a Regulatory Transaction as a Filing Exempt security, and the NAIC staff shall not assign an NAIC Designation to the security component of a Regulatory Transaction or to the Regulatory Transaction or add them to the Filing Exempt Securities Process of the SVO List of Investment Securities. See, the instructions on Regulatory Transactions contained in the compilation instructions in Part One, Section 3. e) and g) – l) this Manual. This does not preclude the SVO from working directly with a state insurance department and issuing an opinion to the department consistent with the instructions outlined in this Manual. [RC7]

The Security Component of a Regulatory Transaction

12. However[RC8], as discussed defined above, the security component of a broadly defined Regulatory Transaction – a transaction engineered to address a regulatory concern one or more insurers have or may have that should be submitted to a state insurance department for approval may be an Investment Security that Filing Exempt or may be eligible for designation under filing exemption or by the SVO on a stand-alone basis. For example,

A. An insurance company entered into a coinsurance reinsurance transaction that requires regulatory approval and as part of that transaction, received an IBM bond. The IBM bond, when owned by an insurance company as a stand-alone investment, would be considered eligible for Filing Exemption but the whole regulatory transaction would not be eligible for Filing Exemption. In this example, the IBM bond is assumed to be an Investment Security, as defined in this Manual.

B. An IBM bond that was eligible for Filing Exemption was sold/transferred from an insurance company to an affiliated insurance company that requires regulatory approval. Such an IBM bond would still be considered eligible for Filing Exemption when owned by an insurance company as a stand-alone investment. In this example, the IBM bond is assumed to be an Investment Security, as defined in this Manual. Any other parts of the transaction requiring regulatory approval, if any, would not be eligible for Filing Exemption.

Guidelines

Procedure – Assesment of the Security Component of a Regulatory Transaction

10. The SVO or SSG is authorized to conduct an analytical assessment on behalf of any state insurance department that requests such assistance.

13. If an insurance company files a Regulatory Transaction with the SVO via the ATF process or under the Regulatory Treatment Analysis Service (RTAS) process, the SVO shall first contact the state insurance department of the insurance company’s state of domicile to disclose that a Regulatory Transaction has been submitted and inquire whether the state insurance department wants SVO analytical assistance.

14. The SVO or SSG is authorized to conduct an analytical assessment on behalf of any state insurance department that requests such assistance. If the state insurance department of the insurer’s state of domicile requests such assistance, the SVO shall engage in the requested analytical assessments of the security component of the Regulatory Transaction. In its assessment, the SVO would make use of SVO determinations may include and refer to NAIC analytical benchmarks, such as those used to produce NAIC Designations, valuation or classification assessments, and such determinations may be given by the SVO or SSG to the state insurance department.
15 Determinations made by the SVO or SSG given to a state insurance department in connection with the assessment of the security component of a Regulatory Transaction shall be referred to as an SVO Analytic Value, (defined below) to prevent confusion in the reporting by an insurer of the Regulatory Transaction or the security component of the Regulatory Transaction to the domiciliary state insurance department and the reporting of a stand-alone Investment Security under the general procedures applicable to them.

16. SVO or SSG determinations given in connection with the assessment of a Regulatory Transaction may be given to and adopted by the state insurance department. However, SVO assessments for the security component of a Regulatory Transaction will not be entered into NAIC computer systems reserved for Investment Securities as defined in this Manual or added to the SVO List of Securities as defined in this Manual. The insurance department may give the SVO Analytical Value to the insurer and instruct the insurer to use the SVO Analytical Value to report the security component of the Regulatory Transaction to the state, as more fully discussed below.

Reporting Regulatory Transactions on Investment Schedules

17. A security component of a Regulatory Transaction is reported on an investment schedules. The security component of a Regulatory Transaction reported on Schedule D, Part I, must be reported with one of the two codes described below, unless it would otherwise qualify as an Investment Security eligible for designation under filing exemption or by the SVO on a stand-alone basis absent the broadly defined Regulatory Transaction (as discussed above). The codes track the security component. Other investment schedules do not require that an NAIC Designation be reported. (For example, Schedule BA items are not required to be reported with an NAIC Designation.) The codes apply ONLY to the security component of the Regulatory Transaction. Each of the two codes identifies a different reporting paradigm and requires the reporting entity to report an SVO Analytical Value, defined below.

Definition of SVO Analytical Value

18. An SVO Analytical Value produced by the SVO is an expression of the credit quality of the security component of a Regulatory Transaction which is expressed with the numerical symbols 1 through 6 in the case of a Regulatory Transaction within the reporting paradigm associated with the RTS code and is expressed with the numerical symbol 6 can be expressed with the grade indicated by the letters A through G for Analytical Value of 1, and three delineations each for the Analytical Value 2, 3, 4 and 5 indicated by the letters A, B and C, and one delineation for Analytical Value 6. In the case of the security component of a Regulatory Transaction within the reporting paradigm associated with the RT code the SVO has not developed the SVO Analytical Value but in that case the Value is expressed with the numerical symbol 6.

Codes and Their Meaning

19. RTS is reported for the security component of a Regulatory Transaction for which: 1) a state insurance department requested SVO assistance in assessing the credit quality of the security component of the Regulatory Transaction; 2) the SVO provided an SVO Analytical Value for the security to the department and 3) the department thereafter directed its insurer to report the SVO
Analytical Value. For the security component of a Regulatory Transaction within the RTS reporting paradigm, the reporting entity reports the analytical value it received from the department which is the same one the SVO provided to the department. The SVO Analytical Value associated with the RTS code is expressed as a numerical symbol from 1 through 6; i.e., 4RTS. The RTS SVO Analytical Value may be used in conjunction with the SVO Analytical Department Symbols and instructions defined in this manual and assigned by the SVO associated with: IF, YE and Z (but only for RTS securities issued within 120-days of the reporting period-end date); i.e. 1.G RTSYE, 4.B RTSIF, 3.A RTSZ as detailed in the Annual Statement Instructions.

An SVO Analytical Value is ONLY assigned if the SVO determines the security component of the Regulatory Transaction would not qualify as an Investment Security eligible for designation under filing exemption or by the SVO if engaged on a stand-alone basis. An SVO Analytical Value is not a preliminary or an official NAIC Designation and cannot be entered into NAIC systems maintained to support the operations of the Valuation of Securities Task Force either by the SVO or anyone else.

20. RT is reported for the security component of a Regulatory Transaction for which a state insurance department did not request assistance from the SVO in assessing the credit quality of the security component of the Regulatory Transaction or in which the department requested the assistance of the SVO but the SVO determined the security component of the Regulatory Transaction was not an Investment Security if engaged in on a stand-alone basis or the SVO was unable to provide an SVO Analytical Value for the security component of the Regulatory Transaction. For the security component of Regulatory Transactions within the RT reporting paradigm, the reporting entity always self-assigns and reports the SVO Analytical Value 6; i.e. 6RT.
MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
   Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
       Marc Perlman, Investment Counsel, NAIC Securities Valuation Office (SVO)
       Catholic Order of Foresters
       CGA Capital
       Mesirow Financial, Inc.
       CTL Capital
       Waterway Capital

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Joint Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to Add Ground Lease Financing Transactions as New Asset Class

DATE: October 17, 2019

1. **Introduction** – Earlier in 2019 the SVO became aware that certain insurance company filers were submitting credit tenant loan (CTL) transactions and transactions which are herein defined as ground lease financing (GLF) transactions through the Filing Exempt (FE) process. The SVO subsequently explained to the market that (i) all CTL structures must be submitted to the SVO for review pursuant to Part One, Paragraph 106 and Part Three, Paragraph 4 of the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P), (ii) the SVO considered GLF transactions distinct from CTL transactions and (iii) the SVO identified that it would need to study the GLF transactions before they could make a recommendation to the Valuation of Securities (E) Task Force on whether NAIC Designations could be assigned to these structures and if they should be eligible for Schedule D reporting given their credit and legal risks. The SVO has now completed that study and a discussion of the SVO’s evaluation of the GLF asset class, its proposed approach to analyzing GLF transactions, and its recommended related amendments to the P&P follow.

2. **Analytic Overview** –

   **Credit Tenant Loans** – CTLs are loans made to the owner of real property but made primarily in reliance on the credit standing of the tenant on a long-term lease of such property (generally highly rated by an NAIC CRP), structured with an assignment of the rental payments under such lease to the lender with such real property pledged as collateral in the form of a first lien. CTLs are generally structured around the terms of the lease which, in its strongest form, requires the tenant to perform all obligations related to the leased premises thereby obligating the tenant to continue to pay rent regardless of what occurs to the leased premises (e.g. casualty or condemnation). The leases are typically considered, with certain recognized variants in the P&P, to be “hell or high water” or “triple net” in nature. Therefore, the SVOs analytic focus is on the credit worthiness of the tenant (or its guarantor), and not the...
real property characteristics of the premises. As explained in the CTL section of Part Three of the P&P, the SVO recognizes four categories of CTLs as eligible for reporting on Schedule D (Bond Lease Based CTLs, Credit Lease Based CTLs, Acceptable CTL Variants (ACVs), and Multiple Property Transactions (MPTs)), each with varying degrees of landlord obligation and real estate risk exposure and varying legal and structural complexity. Pursuant to the P&P’s CTL criteria, each enumerated permitted landlord obligation or risk must be explicitly addressed with an enumerated mitigant. (CTLs are explained extensively in the P&P, Part Three, Paragraphs 71 – 91.)

Ground Lease Financings – A GLF transaction typically has two components: (i) a ground lease for a long period (e.g. 99 years) between a ground lessor who owns the land and a ground lessee who attains a leasehold for the purpose of developing the land, and (ii) the subleasing of space or operation of a business such as a hotel, warehouse, intermodal facility, etc. in an existing or to-be-constructed building to one or more tenants (space tenants) under shorter (e.g. 5-15 year) leases (space leases) or to the operator of a business such as a hotel, warehouse, intermodal facility, etc. under a franchise agreement or other arrangement.

Both the ground lessor and ground lessee will typically finance their respective estates (i.e., the fee estate of the ground lessor and the leasehold estate of the ground lessee); (i) the ground lessor, typically, with the issuance of debt-like certificates or notes, and (ii) the ground lessee, typically, by borrowing from a financial institution or traditional mortgage lender. To secure the financing, the ground lessor will grant to the lender a mortgage on the fee property such ground lessor owns, and the ground lessee will pledge to the leasehold lender its leasehold estate and its rights under the ground lease and in the improvements which it owns and the space leases if any.

Typically, in a GLF transaction neither the ground lessor nor the ground lessee is an entity either (i) rated by an NAIC CRP or (ii) whose credit worthiness can be evaluated by the SVO. Rather, they are special purpose vehicles (SPVs) intended to be bankruptcy remote.

Comparison of CTLs and GLFs – Due to the “hell or high water” or “triple net” nature of the lease in a CTL transaction or, in the instance where there are variances, their mitigation in accordance with the P&P CTL criteria, the SVO can focus its analysis on the credit worthiness of the credit tenant and not on an analysis of the underlying property. This type of lease eliminates the investor’s exposure to property risk as all payments owed to the investor ultimately come from the tenant.

In a GLF transaction it is often the case that the terms of the ground lease itself (the first leg of the transaction) is structured with the same attributes as a lease in a CTL transaction (e.g. it is “hell or high water” or “triple net”). However, because the ground lessee is an SPV rather than an operating entity, there is no NAIC CRP credit rating or SVO credit analysis to rely on. To determine whether the ground lessee will have sufficient funds to pay its ground lease obligations the SVO must look to the rent payments of the space tenants or the operation of the business being conducted on such property. The SVO, in conjunction with the NAIC Structured Securities Group (SSG) takes the position that the analysis of space leases and space tenants can be more akin to a commercial mortgage backed security (CMBS) analysis than the corporate analysis in a CTL transaction because the space leases may not meet the CTL criteria and can consist of several space tenants of differing credit profiles and each with differing space lease terms. We note that some of the NAIC CRPs which assign ratings to GLF transactions have utilized their CMBS models in their GLF ratings process, but their methodologies and criteria vary widely. The SVO understands that in most GLF transactions the certificate holder, the insurer as the investor, is in a “last loss”, or most senior, position. However, regardless of where they stand in the waterfall, unlike a traditional CTL transaction, ultimate payment on the GLF certificates is dependent not on a single credit tenant, but rather on payments by all the space tenants (which are not necessarily NAIC CRP rated or SVO analyzed entities) pursuant to space leases (which do not necessarily meet the CTL criteria).
Proposal – Recognizing that there are variances in how GLF transactions are structured the SVO proposes amending the P&P to institute a multi-pronged approach to analyzing these transactions. The proposed P&P amendments would include adding GLF transactions as a new asset class and would outline our GLF analytic process as follows:

a. The SVO would analyze the ground lease to determine if it meets the criteria for Bond Lease Based CTLs or Credit Lease Based CTLs in the P&P. We expect most ground leases to meet this test. Ground lease inconsistency with the Bond or Credit Lease Based CTL criteria would result in ineligibility for Schedule D reporting.

b. If the ground lease meets the Bond or Credit Lease Based CTL criteria and if three or fewer space tenants, each of which either (i) are rated by an NAIC CRP or (ii) whose credit worthiness can be evaluated by the SVO, when combined comprise 90% or more of the total space lease payment obligations, the SVO would analyze the space leases to determine if they meet the CTL criteria for one of the four CTL categories in the P&P. If so, the SVO could, in its sole discretion and based on its analytic judgement, analyze the transaction as akin to a CTL, based on the CTL-like nature of both the ground and space leases, the limited number of space leases and the credit profiles of the space tenants. We expect a small fraction of all GLF transactions to fall in this category.

c. If the ground lease meets the Bond or Credit Lease Based CTL criteria and there are four or more space tenants, or the SVO has determined that the transaction does not meet the criteria set forth in clause (b.) above or if there are no space tenants but one operator of a business on the leasehold such as a hotel, warehouse, intermodal facility, etc., the SVO may refer the space leases or the business operation to the SSG for possible financial modeling. If the SSG, in conjunction with its third-party modeling vendor, determines that the space leases or business operation can be modeled, the SSG would analyze the space leases or business operation, as the case may be, to determine whether they will provide sufficient cash flow to pay the ground lease rent payments and any additional costs which the ground lessee would be obligated to cover pursuant to the ground lease terms (e.g. taxes, utilities, maintenance, insurance).

d. If the SSG, in conjunction with its third-party modeling vendor, determines that it is unable to model the space leases or business operation, as the case may be, and if the transaction has been assigned an Eligible NAIC CRP Rating, public or private, the SVO may use the NAIC CRP analysis provided by the filer to assist the SVO in its own analysis. The SVO’s analysis will be entirely at the discretion of the SVO, and the SVO will be under no obligation to accept the NAIC CRP analysis, conclusions or ratings. Furthermore, upon completion of its analysis the SVO can decline to assign an NAIC Designation, in which case the security would be ineligible for Schedule D reporting.

e. Insurers that would like the SVO to review the GLF transactions prior to purchasing them may submit them through the Regulatory Treatment Analysis Service (RTAS) process. The SVO is willing to set up new RTAS processes for each of these three paths, at the request of the submitting investor: 1) SVO credit analysis, 2) SSG modeling and 3) SVO review of NAIC CRP analysis.

f. Additionally, the SVO would look for evidence that (i) the transaction is properly insured because, unlike a credit tenant in a CTL transaction, the ground lessee SPV will not have access to extra funds to cover costs such as repairs in the event of casualty, and (ii) that satisfactory Phase I and, if necessary, Phase II environmental reports have been delivered to provide comfort that there will be no unexpected environmental liabilities.

3. Recommended Amendment – The recommended changes to the P&P regarding the addition of Ground Lease Financing criteria are shown below in red, showing how it will appear in the 2019 P&P format. The SVO recommends that this amendment also be referred to the Statutory Accounting Principles (E) Working Group for affirmation that these investments are eligible for Schedule D, Part 1 reporting under the criteria proposed.
2019 P&P Manual
Part One – Policies of the NAIC Valuation of Securities (E) Task Force

POLICIES APPLICABLE TO SPECIFIC ASSET CLASSES

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GROUND LEASE FINANCING TRANSACTIONS

GLF Overview

107. A ground lease financing transaction (GLF) typically has two components: (i) a ground lease for a long period (e.g. 99 years) between a ground lessor who owns the land and a ground lessee who attains a leasehold for the purpose of developing the land, and (ii) the subleasing of space or operation of a business such as a hotel, warehouse, intermodal facility, etc. in an existing or to-be-constructed building to one or more tenants (space tenants) under shorter (e.g. 5-15 year) leases (space leases) or to the operator of a business such as a hotel, warehouse, intermodal facility, etc. under a franchise agreement or other arrangement.

108. The ground lease itself typically meets the Credit Tenant Loan (CTL) criteria for Bond Lease Based or Credit Lease Based CTLs in this Manual. Additionally, there can be one or several space tenants or business operators (which (i) may or may not be NAIC CRP rated entities or (ii) whose credit worthiness can or cannot be evaluated by the SVO) making lease payments under separate space leases (which may or may not meet the CTL criteria) or a business operation. As such, the SVO cannot rely solely on the CTL criteria for its analysis of GLF transactions and instead must rely on a combination, as necessary and available, of the CTL criteria, the CMBS criteria, the documented analysis of NAIC CRPs, and the SVOs own analytic judgement.

109. A GLF transaction reported as a CTL on transaction on Schedule D, acquired prior to January 1, 2020, and reported with an NAIC Designation produced under filing exemption, can continue to be reported on the basis of that Eligible NAIC CRP Rating until sold or disposed of.

NOTE: See “Ground Lease Financing Transactions” in Part Three for filing instructions, documentation requirements and methodology applicable to GLFs.

Part Three – SVO Procedures and Methodology for Production of NAIC Designations

PROCEDURE APPLICABLE TO FILING EXEMPT (FE) SECURITIES AND PRIVATE LETTER (PL) RATING SECURITIES

... 

FE SECURITIES

Specific Populations of Securities Not Eligible for Filing Exemption

4. The filing exemption procedure does not apply to:
Ground Lease Financing Transactions – A Ground Lease Financing (GLF) transaction typically has two components: (i) a ground lease for a long period (e.g. 99 years) between a ground lessor who owns the land and a ground lessee who attains a leasehold for the purpose of developing the land, and (ii) the subleasing of space or operation of a business such as a hotel, warehouse, intermodal facility, etc. in an existing or to-be-constructed building to one or more tenants (space tenants) under shorter (e.g. 5-15 year) leases (space leases) or to the operator of a business such as a hotel, warehouse, intermodal facility, etc. under a franchise agreement or other arrangement. GLF transactions are not eligible for filing exemption. The GLF section in this Part provides further guidance on how the SVO analyzes GLF transactions for purposes of determining Schedule D eligibility and whether the SVO can assign an NAIC Designation.

Part Three – SVO Procedures and Methodology for Production of NAIC Designations

Ground Lease Financing Transactions

NOTE: See “Policies Applicable to Specific Asset Classes” in Part One for policies governing this activity, as well as “Specific Populations of Securities Not Eligible for Filing Exemption” in “Procedure Applicable to Filing Exempt (FE) Securities and Private Letter (PL) Rating Securities” above.

Initial Filing Requirements

305. For ground lease financing (GLF) transactions, the reporting insurance company shall submit a complete GLF Evaluation Form together with the documentation described in the GLF Evaluation Form and, if available, evidence of a current Eligible NAIC CRP Rating and related NAIC CRP analysis for (i) the GLF Transaction (including, but not limited to rating methodology used, model assumptions and stress test results) and (ii) each space lessee or its guarantor or business operator in the case of a hotel, warehouse, intermodal facility, etc. or other business operation.

Subsequent Filing Requirements

306. For GLF Transactions, the reporting insurance company shall submit evidence, if available, of a current Eligible NAIC CRP Rating and related NAIC CRP analysis for (i) the GLF Transaction (including, but not limited to rating methodology used, model assumptions and stress test results) and (ii) each space lessee or its guarantor or business operator. For purposes of this section, a current Eligible NAIC CRP Rating is defined as one issued or reviewed within the past 12 calendar months. If the GLF Transaction is modeled by the NAIC’s third-party modeling vendor, the reporting insurance company will submit the data required by the vendor in the form such vendor specifies. In the event a space lessee or its guarantor or the business operator, as the case may be, is not rated by an NAIC CRP and a space lease or business operation is not modeled, the reporting insurance company shall file the Audited Financial Statements and other relevant credit information of the space lessee or its guarantor or business operator, as the case may require, consistent with all corporate bond filing requirements.

SVO Procedure
Upon receipt of a GLF Evaluation Form, the SVO analyst shall review the form and all documentation submitted with it and shall proceed with analysis in accordance with section “SVO Approach to GLF Transactions” below.

Ground Lease Financing Transaction – Definition and Overview

A ground lease financing (GLF) transaction typically has two components: (i) a ground lease for a long period (e.g. 99 years) between a ground lessor who owns the land and a ground lessee who attains a leasehold for the purpose of developing the land, and (ii) the subleasing of space or operation of a business such as a hotel, warehouse, intermodal facility, etc. in an existing or to-be-constructed building to one or more tenants (space tenants) under shorter (e.g. 5-15 year) leases (space leases) or to the operator of a business such as a hotel, warehouse, intermodal facility, etc. under a franchise agreement or other arrangement.

Both the ground lessor and ground lessee will typically finance their respective estates (i.e., the fee estate of the ground lessor and the leasehold estate of the ground lessee); (i) the ground lessor, typically, with the issuance of debt-like certificates or notes, and (ii) the ground lessee, typically, by borrowing from a financial institution or traditional mortgage lender. To secure the financing, the ground lessor will grant to the lender a mortgage on the fee property such ground lessor owns, and the ground lessee will pledge to the leasehold lender its leasehold estate and its rights under the ground lease and in the improvements which it owns and the space leases if any.

Typically, in a GLF transaction neither the ground lessor nor the ground lessee is an entity either (i) rated by an NAIC CRP or (ii) whose credit worthiness can be evaluated by the SVO. Rather, they are special purpose vehicles (SPVs) intended to be bankruptcy remote.

In a GLF transaction it is often the case that the ground lease (the first leg of the transaction) is structured with the same attributes as a lease in a CTL transaction (e.g. it is “hell or high water” or “triple net”). However, because the ground lessee is an SPV rather than a corporate entity, there is no NAIC CRP corporate credit rating or SVO corporate analysis to rely on. To determine whether the ground lessee will have sufficient funds to pay its ground lease obligations the SVO must look to the rent payments of the space tenants or the operation of the business conducted in such improvements (such as a hotel, warehouse, intermodal facility, etc.). Depending on the specifics of a GLF transaction, analysis of space leases and space tenants and business operations and business operators could be more akin to a commercial mortgage backed security (CMBS) analysis than the corporate analysis in a CTL transaction because (i) the space leases may not meet the CTL criteria and can consist of one or several space tenants of differing credit profiles and each with differing space lease terms and ultimate payment on the GLF is dependent on the space tenants making their rent payment on the space leases or (ii) in the event there is a business operation, ultimate payment on the GLF is dependent on the operation of such business to generate cashflow for ground rent and other expenses. For this reason, the SVO may refer certain GLF transaction space lease or business operations analyses to the NAIC Structured Securities Group (SSG) because of the SSG’s financial modeling capabilities and because, in accordance with this Manual, it analyzes and assigns NAIC Designations to CMBS transaction.

SVO Approach to GLF Transactions

All GLF transactions are ineligible for filing exemption and must be submitted to the SVO. The SVO will conduct GLF transaction review in the following manner:
a. The SVO will analyze the GLF transaction structure and determine whether the ground lease meets the CTL criteria for Bond Lease Based or Credit Lease Based CTLs, except for not having a credit tenant. If the SVO, in its sole discretion, determines the ground lease does not meet the Bond Lease Based or Credit Lease Based CTL criteria, except for a credit tenant, the security would be ineligible for Schedule D reporting.

b. If the ground lease meets the CTL criteria, except for a credit tenant, and if three or fewer space tenants, each of which (i) are rated by an NAIC CRP or (ii) whose credit worthiness can be evaluated by the SVO, when combined comprise ninety percent (90%) or more of the total space tenant lease obligations, the SVO will analyze the space leases to determine if they meet the CTL criteria for one of the four CTL categories in this Manual. If so, the SVO can, in its sole discretion and based on its analytical judgment, analyze the transaction as akin to a CTL, based on the CTL-like nature (e.g. “hell or high water” or “triple net” features) of both the ground and space leases, the limited number of space leases and the corporate credit profiles of the space tenants.

c. If the ground lease meets the criteria for Bond Lease Based or Credit Lease Based CTLs and there are four or more space tenants, or the SVO has determined that it cannot apply the approach in (b.) above or the transaction does not meet the criteria set forth in clause (b) above, the SVO will refer the space leases or the business operation, as the case may be, to the SSG for possible financial modeling. If the SSG, in conjunction with its third-party modeling vendor, and in its sole discretion and analytical judgment based on factors including, but not limited to, availability of data, transaction structure and other transaction specific risks, determines that the space leases or business operation can be modeled, it will analyze the space leases or business operation, as the case may be, to determine whether they will provide sufficient cash flow to pay the ground lease rent payments and any additional costs which the ground lessee is required to cover pursuant to the ground lease terms (e.g. taxes, utilities, maintenance, insurance).

d. If the SSG, in conjunction with its third-party modeling vendor, and in its sole discretion and analytical judgment, determines that it is unable to model the space leases or business operation, as the case may be, and if the transaction has been assigned a public or private Eligible NAIC CRP Rating the SVO shall proceed with an analysis of the transaction guided by the available analyses of all NAIC CRPs that provided an Eligible NAIC CRP Rating on the transaction. For the avoidance of doubt, the SVO’s analysis will be entirely at the discretion of the SVO and the SVO is not obligated to accept or follow the rating methodology of any NAIC CRP and can, in its sole discretion and based on its analytical judgement, assign an NAIC Designation which differs from the correlated Eligible NAIC CRP Rating or choose not to assign any NAIC Designation. The SVO may, in its sole discretion, upon written request from the submitting investor, disclose its rationale as to why such transaction was not given a Designation correlated to the Eligible NAIC CRP Rating.

e. Should the SVO or, if applicable, SSG determine that it cannot assign an NAIC Designation to the GLF, the GLF would be ineligible for Schedule D reporting.

GLF Specific Considerations

313. The space lease payments or business operation, as the case may be, should be sufficient to cover any recurring costs the ground lessee is obligated to pay (e.g. taxes, utilities, maintenance, insurance) pursuant to the terms of the ground lease. All such ground lessee obligations will be factored into the SSG’s financial model of the space leases or business operations, if applicable.

314. To provide comfort that there will be no environmental liabilities, the filing documents shall include a Phase I environmental report showing no environmental problems and, if the Phase I report shows a
problem or the nature and prior used of the land indicates a substantial likelihood of preexisting environmental contamination, a Phase II environmental report.

315. Typically, a ground lease will require the ground lessee to hold the following insurance to protect the ground lease payments from potential shortfall due to the termination or abatement of space lease payments or reduction or termination of business operation upon the occurrence of condemnation or casualty or other insurable condition. Any of the insurable risks below that are not insured should be otherwise mitigated and evidence of such mitigant should be included in the filing documents.

   a. Casualty insurance in an amount of coverage equal to 100% of the replacement value of the improvements with the fee lender named as the loss payee.

   b. Rent loss insurance in an amount of coverage equal to at least 12 months of ground rent with the fee lender named as loss payee.

   c. General liability insurance. The amount of coverage shall be sized appropriately, depending on the size and type of building (e.g. office, hotel, warehouse, intermodal facility, etc.).

   d. Ground Lessor would be required to purchase special risk condemnation insurance in an amount of coverage equal to the principal amount of the GLF. This policy shall be prepaid and remain in place for the entire term of the GLF secured by the fee mortgage.

Note: All insurance must be issued by a carrier with an NAIC Designation equivalent rating of 1.G or better.

Part Four – The NAIC Structured Securities Group

Ground Lease Financing Transactions

Definition

36. Ground Lease Financing (GLF) transactions are defined and explained in “Ground Lease Financing Transactions” in Part Three of this Manual.

SSG Role and Process

37. On occasion the SVO may refer a GLF transaction to the SVO for financial modeling of the GLF space leases or business operation, as applicable, in accordance with the process set forth in “Ground Lease Financing Transactions” in Part Three of this Manual. Following an SVO referral the SSG and SVO will maintain open communication related to requests for additional data, analytical questions and analytical conclusions. Any GLF transaction NAIC Designation will be assigned by the SVO.
FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

Financial Regulation Standards and Accreditation (F) Committee Dec. 7, 2019, Minutes .......................................................... 11-2
Reinsurance (E) Task Force Memorandum Regarding 2019 Revisions to Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786), Nov. 15, 2019 (Attachment Three) ............................................................................................................ 11-15
Reinsurance (E) Task Force Memorandum Regarding 2016 Revisions Model #785 and Term and Universal Life Insurance Reserve Financing Model Regulation (#787), March 20, 2017 (Attachment Four) .................................................................................................................................................. 11-29
The Financial Regulation Standards and Accreditation (F) Committee met in Austin, TX, Dec. 7, 2019. The following Committee members participated: Todd E. Kiser, Chair (UT); Jillian Froment, Vice Chair, (OH); Lori K. Wing-Heier represented by David Phifer (AK); Allen W. Kerr represented by Mel Anderson (AR); Andrew N. Mais represented by Kathy Belfi (CT); Nancy G. Atkins (KY); Gary Anderson represented by Rachel M. Davison (MA); Mike Causey (NC); Bruce R. Ramge and Justin Schrader (NE); Elizabeth Kelleher Dwyer (RI); Larry Deiter (SD); Scott A. White represented by Doug Stolte (VA); Michael S. Pieciak represented by David Provost (VT); and Jeff Rude (WY). Also participating was: Chlora Lindley-Myers (MO).

1. Adopted its Summer National Meeting Minutes

Commissioner Kiser said the Committee met Dec. 6 and Aug. 3. During its Dec. 6 meeting, the Committee met in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; and 2) vote to award continued accreditation to the insurance departments of Connecticut, Massachusetts, New York and, for the first time, the U.S. Virgin Islands.

Director Ramage made a motion, seconded by Director Dieter, to adopt the Committee’s Aug. 3 minutes (see NAIC Proceedings – Summer 2019, Financial Regulation Standards and Accreditation (F) Committee). The motion passed unanimously.

2. Adopted Revisions to the SEG/IAR for Consistency with Revisions to Part D of the Accreditation Standards

Commissioner Kiser stated that at the Summer National Meeting, the Committee adopted changes to Part D: Organizational, Redomestications and Change of Control of the Review Team Guidelines, which included updates to the standards for primary applications for new companies and Form A filings, and the addition of a new standard related to redomestications. When changes are made to the Review Team Guidelines, the related questions in the Self-Evaluation Guide (SEG) must also be updated for consistency. The Review Team Guidelines represent the requirements for accreditation. The SEG is the means through which the states report on compliance with those guidelines. These related changes to the SEG were exposed at the Summer National Meeting, and no formal comments were received.

Becky Meyer (NAIC) summarized a suggestion to remove duplicative language from (b)1 in the SEG/Interim Annual Review (IAR) for Part D. When the Review Team Guidelines were changed, the section was moved, so number two is where that information should reside. It is recommended that the highlighted portion be removed.

Ms. Belfi made a motion, seconded by Mr. Provost, to adopt the changes to the Review Team Guidelines—Procedures for Troubled Companies effective Jan. 1, 2020 (Attachment Two). The motion passed unanimously.

3. Adopted a Referral from the Financial Analysis (E) Working Group Regarding Updates to the Troubled Company Accreditation Guidelines

Commissioner Kiser stated that earlier this year, updates were made to the Troubled Insurance Company Handbook to clarify expectations regarding timely and effective communication between domiciliary and non-domiciliary state insurance departments. In situations when a company becomes troubled, communication between affected states is very important. Therefore, these concepts are incorporated into the accreditation guidelines. The referral was exposed for a 30-day public comment period and no comments were received.

Ms. Belfi made a motion, seconded by Mr. Provost, to adopt the changes to the Review Team Guidelines—Procedures for Troubled Companies effective Jan. 1, 2020 (Attachment Two). The motion massed unanimously.
4. **Adopted the 2019 Revisions to Model #785 and Model #786 as an Update to the Accreditation Standards**

Commissioner Kiser stated that on June 25, the Executive (EX) Committee and Plenary unanimously adopted revisions to the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786), which incorporate relevant provisions in the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement), which was signed on Sept. 22, 2017. Because the models are part of the accreditation standards, the impact on accreditation must be considered.

Director Lindley-Myers summarized the referral memorandum from the Reinsurance Task (E) Force with respect to the 2019 revisions to Model #785 and Model #786. Attached to this memorandum are proposed new accreditation standards with respect to reciprocal jurisdictions. The 2019 revisions to Model #785 and Model #786 were intended to incorporate the relevant provisions of the Covered Agreements signed with the European Union (EU) and United Kingdom (UK) with respect to reinsurance collateral requirements. The 2019 revisions also extend similar treatment to qualified jurisdictions and accredited NAIC jurisdictions.

At its meeting on Oct. 22, the Reinsurance (E) Task Force agreed to submit the following recommendations to the Committee: 1) the 2019 revisions to Model #785 and Model #786 for reciprocal jurisdictions should be adopted as an update to the Reinsurance Ceded accreditation standard with significant elements as outlined in the attached memorandum; and 2) the Committee should consider a waiver of procedure, as provided for in the *Accreditation Program Manual*, and expeditiously consider adoption of this standard. The Task Force recommends that the accreditation standard become effective Sept. 1, 2022, the end of the 60-month period when federal preemption determinations must be completed, with enforcement of the standard to commence on Jan. 1, 2023. After the Oct. 22 conference call, NAIC staff had conversations with representatives of the Federal Insurance Office (FIO), who advised us that the end of the 60-month period when federal preemption determinations must be completed is Sept. 1, 2022, and not Oct. 1, 2022, as originally thought.

The key aspect of a Covered Agreement under the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) is that it can preempt a state insurance measure that is inconsistent with the Covered Agreement. Another important element of federal preemption is the effective date of implementation of the Covered Agreement. The Covered Agreement with the EU was signed on Sept. 22, 2017, and it says, “42 months after the date of signature of this Agreement, the United States shall begin evaluating a potential preemption determination” with respect to any state insurance measure that is determined to be inconsistent with the Covered Agreement. The 42-month date is March 1, 2021. The Covered Agreement goes on to say, “60 months after the date of signature of this Agreement, the United States shall complete any necessary preemption determinations.” This date would be Sept. 1, 2022. So, 42 months after the date of signature the FIO shall begin its preemption determinations on inconsistent state laws, which must be completed no later than 60 months after the date of signature. Finally, the Reinsurance (E) Task Force recommends that the accreditation standard be adopted on a “substantially similar” basis. However, it should be noted that the Dodd-Frank Act requires the state insurance measure to be “consistent” with the Covered Agreement in order to avoid federal preemption, which may be interpreted as a higher standard than “substantially similar.” Therefore, it is the recommendation of the Task Force that the states adopt the 2019 revisions in close to identical form to the models in order to best avoid the possibility of federal preemption.

Director Ramge suggested that while he is in favor of exposing items for comment, it would be more expeditious to take the matter up for adoption immediately due to the states’ legislatures resuming session in January.

Dan Schelp (NAIC) stated that it was exposed at the Reinsurance (E) Task Force for a 30-day public comment period and did not receive any negative feedback. Considering the waiver of procedure requested per the *Accreditation Program Manual*, he stated that he knew of no procedural timelines that would prevent adoption without a public comment period.

Ms. Meyer stated that the decision would be presented to the Executive (EX) Committee and Plenary and require a 60% majority of members to adopt the proposal.

Director Ramage made a motion, seconded by Superintendent Dwyer, to adopt the referral, including the recommended significant elements, the waiver of procedure to expeditiously adopt the standard, and an effective date of Sept. 1, 2022 (Attachment Three). The motion massed unanimously.
5. **Adopted the Referral from the Reinsurance (E) Task Force Regarding Model #787 and the 2016 Revisions to Model #785**

Commissioner Kiser stated that the *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787), more commonly referred to as the XXX/AXXX Model Regulation, was adopted by the NAIC in 2016. This model establishes uniform, national standards governing reserve financing arrangements pertaining to term life and universal life insurance policies with secondary guarantees. Model #787 also includes provisions to ensure that funds backing these captive reinsurance transactions, which consist of primary security and other security, are held in the forms and amounts that are appropriate. Model #787 was first referred to the Committee at the 2017 Spring National Meeting for consideration for inclusion in the accreditation standards, along with the 2016 revisions to Model #785, which provided enabling language related to adoption of Model #785. Significant elements were then developed, exposed and up for adoption at the 2017 Fall National Meeting. However, the Covered Agreement had recently been signed and the Committee agreed to defer a decision on Model #787 until the effect of the Covered Agreement was known. With the adoption of the 2019 revisions to Model #785 and Model #786, it is now time to re-address this issue.

Commissioner Kiser prompted the Committee to consider if there is still strong support to make Model #787 an accreditation standard. He raised the question of whether the general acceptance of *Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation* (AG 48) has alleviated the issues that drove development of Model #787.

Andrew T. Vedder (Northwestern Mutual Life Insurance Company) commented on the joint letter from Northwestern Mutual and New York Life (Attachment Five), and he stated that he believes it is necessary to adopt Model #787; and he urges the NAIC to follow through on prior recommendations to make Model #787 an accreditation standard in parallel with the Covered Agreement revisions. He stated that companies have long advocated that Model #787 should be an accreditation requirement, which is consistent with the prior recommendation by the Reinsurance (E) Task Force.

Douglas Wheeler (New York Life Insurance Company) stated that there is no longer any reason for delay in the NAIC’s action to make Model #787 an accreditation requirement, and he urged the Committee to move forward today with adoption. Doing so will allow the NAIC to finally complete the important work of uniformly implementing its XXX/AXXX Reinsurance Framework.

Mr. Schrader stated that he did not see a reason to delay the recommendation.

Ms. Belfi agreed that there is no reason to delay, and she stated that consistency among the states is key.

Director Ramge made a motion, seconded by Ms. Belfi, to adopt Model #787 as an accreditation standard consistent with the referral from the Reinsurance (E) Task Force (Attachment Four) with an effective date of Sept. 1, 2022. The motion massed unanimously.

Having no further business, the Financial Regulation Standards and Accreditation (F) Committee adjourned.
TO: Financial Regulation Standards and Accreditation (F) Committee
FROM: NAIC Staff
DATE: July 10, 2019
RE: Company Licensing Accreditation Standards – Self-Evaluation Guide

At the Spring National Meeting, the Financial Regulation Standards and Accreditation (F) Committee exposed revisions to the Part D: Organization, Licensing and Change of Control of Domestic Insurers standards and Review Team Guidelines. The National Treatment and Coordination (E) Working Group’s recommended revisions include: 1) updating the Guidelines to reflect current practices; 2) expanding the scope to include redomestications; and 3) including Part D in the review team’s recommendation with the result that the outcome can affect a state’s accredited status. The Working Group recommended that the revisions be adopted with an effective date of Jan. 1, 2020; however, the recommended effective date for subjecting Part D to Recommendation A or B, and thus impacting a state’s accredited status, is Jan. 1, 2022.

The proposed revisions to the Part D standards and Guidelines will require the Self-Evaluation Guide (SEG) to be updated. The SEG facilitates the state’s reporting of compliance with the Guidelines; therefore, any change to the Guidelines must be accounted for in the SEG.

In addition, as a result of these revisions, the Accreditation Program Manual’s references to Part D will need to be updated. NAIC staff will ensure that these non-substantive changes will be made accordingly.

The proposed SEG revisions for Part D to ensure consistency with the Guidelines are attached.
Accreditation Program Manual
SEG/IAR Form | Part D

PART D: **ORGANIZATION, PRIMARY LICENSING, REDOMESTICATION AND CHANGE OF CONTROL OF DOMESTIC INSURERS**

a) **Sufficient Qualified Staff and Resources**

The department should have the appropriate staff and resources to effectively and timely review applications for primary licensure of new companies and redomestications and Form A filings for all domestic insurers.

1. Does the department staff have the capacity to effectively review applications for primary licensure of new companies, redomestications and Form A filings in a timely manner?

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2. Does the department have established minimum educational and experience requirements for staff positions in the company licensing area which are commensurate with the duties and responsibilities of the position?

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3. As a separate attachment, provide a current year list of staff responsible for analyzing company applications. With that list, please include the following:
   - Name,
   - Title,
   - Years employed by the department (include functional area),
   - Type of college degree, including major areas of concentration,
   - Prior regulatory or insurance experience, and
   - Indicate whether the individual is a department employee (full/part time) or a contractual employee (exclusive to the department/not exclusive to the department).

4. As a separate attachment, provide a listing of any L/H and P/C primary licensure applications and any multi-state L/H and P/C Form A filings (whether approved or denied) received since the department’s last full review. Also include any multi-state L/H and P/C primary redomestication applications received Jan 1, 2020 and after. With that list, please include the following:
   - Name of person responsible for reviewing the filing,
   - **Type of filing,**
   - Date the filing was received,
   - Date the filing was reviewed for completeness,
   - Date(s) the department contacted the company for additional or supplementary information (if applicable), and
   - Date the company was informed of licensure, approval/denial of the filing.
   - Whether the filing review was completed timely per department procedures, and
   - If the review was not completed timely, provide the reason.
Primary Licensing, Redomestications and Change of Control – continued

5. If the department has developed timing requirements that differ from the NAIC Company Licensing Best Practices Handbook, please attach a copy of the timing requirements policy, be sure to include timing expectations for initial review from date of receipt, notification to the insurer, and completion of the review.

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<th>YES</th>
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6. If there are extenuating circumstances and the required timing guidelines cannot be met for a particular application, are such circumstances clearly documented in the application file?

76. Do the department’s statutes or regulations specify timing requirements for the completion of primary licensure applications?

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<th>YES</th>
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87. If the answer to #7 above is yes, please attach a copy of the department’s authority discussing such requirement.

*If this is an interim annual review, only provide the department’s timing requirements if there has been a change from the previous submission of this information, otherwise indicate “no changes”.

9. If the answer to #7 above is no, does the department follow the timing requirements set forth in the Review Team Guidelines, which state the review should be completed within 90 calendar days of receipt (barring exceptions for when information is requested).

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<th>YES</th>
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Primary Licensing, Redomestications and Change of Control – continued

b) Scope and Performance of Procedures for Primary Applications

The department should have documented licensing procedures to provide for consistency in the review process and to ensure that appropriate procedures are being performed on all primary applications. The use of the NAIC Company Licensing Best Practices Handbook is considered acceptable.

1. Does the department have documented licensing procedures that require a review and/or analysis of the following:

   • Identification and evaluation of the business and strategic plans of the applicant, including pro forma financial projections?
   • Pro forma financial projections?
   • Biographical Affidavits?
   • Adequacy of proposed reinsurance program?
   • Adequacy of investment policy?
   • Adequacy of short-term and long-term financing agreements:
     • Initial financing of proposed operations or transaction?
     • Maintenance of adequate capital and surplus levels?

   YES | NO

2. Do department procedures require a review of the Form A and Market Action Tracking System (MATS) databases for related information about the primary applicant and other key persons?

23. In a separate attachment, provide such licensing procedures and discuss any additional processes developed to review/analyze a primary licensure application.

   *If this is an interim annual review, only provide the department’s procedures for reviewing primary applications if there has been a substantial change from the previous submission of this information, otherwise indicate “no changes”.

24. Do the department’s files contain evidence, including whether the applicant meets licensure requirements (i.e. approve or deny), and adequately demonstrate licensing procedures for primary applications were followed?

YES | NO
Primary Licensing, Redomestications and Change of Control – continued

c) **Scope and Performance of Procedures for Redomestication**

The department should have documented procedures for the review of redomestication applications to provide for consistency in the review process and to ensure that appropriate procedures are performed for all redomestications. The use of the NAIC Company Licensing Best Practices Handbook is considered acceptable.

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<th>YES</th>
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<td>1.</td>
<td>Does the department have documented procedures for the review of redomestication applications that require the following:</td>
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<td>A review and analysis of:</td>
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<td>▪ Business and strategic plans?</td>
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<td>▪ Actuarial opinion?</td>
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<td>▪ Annual and quarterly statements?</td>
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<td>▪ Risk-based capital (RBC) report?</td>
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<td>▪ Independent CPA audit report?</td>
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<td>▪ Insurance Holding Company System Annual Registration Statement and Exhibits (Form B)?</td>
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<td>An assessment of:</td>
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<td>▪ Senior management?</td>
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<td>▪ Board of directors?</td>
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<td>▪ Corporate governance?</td>
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<td>2.</td>
<td>Do department procedures require, at a minimum, a conference call with the domestic regulator to obtain, discuss and conclude on the following:</td>
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<td>▪ Most recent IPS and supervisory plan, including supporting analysis detail for significant risks?</td>
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<td>▪ Reason for redomestication?</td>
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<td>▪ Concerns identified with the insurer/group?</td>
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<td>▪ History of communication with the insurer/group?</td>
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<td>▪ History of regulatory actions?</td>
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<td>▪ Results of recent examinations (financial and market conduct), including findings and resolutions?</td>
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<td>▪ Status of and responsibilities for annual financial analysis and group analysis, if applicable?</td>
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<td>▪ Status of and responsibilities for the financial examinations?</td>
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<td>3.</td>
<td>Do department procedures require upon receipt of a primary application for redomestication that notification be sent to the lead state of the insurance holding company group and a copy of the most recent GPS be obtained, if applicable?</td>
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Primary Licensing, Redomestications and Change of Control – continued

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<td>4. In a separate attachment, provide procedures and discuss any additional processes developed to review/analyze a redomestication application.</td>
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Primary Licensing, Redomestications and Change of Control – continued

**d) Scope and Performance of Procedures for Form A Filings**

The department should have documented procedures for the review of Form A filings to provide for consistency in the review process and to ensure that appropriate procedures are being performed on all Form A filing reviews. *The use of the NAIC Company Licensing Best Practices Handbook is considered acceptable.*

1. Does the department have documented procedures for the review of Form A filings that include at least the following:

   - Business and strategic plans of the insurer?
   - Identity and background of the applicant and individuals associated with the applicant, including use of biographical affidavits to assess the quality and expertise of the following:
     - Ultimate controlling person?
     - Proposed officers and directors (as listed on the Jurat page of the most recent or upcoming financial statement)?
     - Other owners of 10% or more of voting securities?
   - The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control?
   - Fully audited financial information regarding the earnings and financial condition of the ultimate controlling person(s) for the preceding five years? (If fully audited financial information is not available, substantially similar information such as compiled financial statements or tax returns, as deemed acceptable to the commissioner, may be reviewed in lieu of fully audited financial information.)
   - Unaudited financial information regarding the earnings and financial condition of the ultimate controlling person(s) as of a date not earlier than 90 days prior to the filing of each statement of Form A?

2. In a separate attachment, provide such procedures and discuss any additional processes developed for the review of Form A filings.

   *If this is an interim annual review, only provide the department’s procedures for reviewing Form A filings if there has been a substantial change from the previous submission of this information, otherwise indicate “no changes”.*

3. Is it the department’s policy to review the Form A database to obtain information on prior filings made by an applicant and the ultimate outcome of such to inform other states of the receipt and status of Form A filings?

4. If the answer to #3 above is yes, do the department’s procedures for such utilization of the Form A database include the following:

   - Review the Form A database for any prior filings made by the Form A applicant and the ultimate outcome of such filing(s)?
Primary Licensing, Redomestications and Change of Control – continued

- Pertinent and relevant information from the Form A filing should be manually entered into the Form A database within 10 business days of receipt of the Form A?
  - YES
  - NO

- Any changes to the status of a filing or other data elements should be entered into the Form A database within 10 business days?
  - YES
  - NO

- Updating the Form A database when a filing stalls, at a minimum of once every six months to confirm the status of the filing and document the reason the filing has stalled?
  - YES
  - NO

5. If the answer to #3 above is no, please provide the department’s policy and procedures on utilizing the Form A Database or any other independently developed procedures followed to obtain information on an applicant’s filings and to inform other states of the receipt and status of Form A filings in a timely manner.

  *If this is an interim annual review, only provide the department’s policy and/or procedures if there has been a substantial change from the previous submission of this information, otherwise indicate “no changes”.

65. Do the department’s files contain evidence of conclusions regarding whether the Form A filing was approved or denied, and sufficient documentation that its procedures for Form A filings were adequately performed?
  - YES
  - NO
To: Financial Regulation Standards and Accreditation (F) Committee  
From: Financial Analysis (E) Working Group (FAWG)  
Date: April 5, 2019  
Re: Recommendation for Updated Part B.3 Procedures for Troubled Companies

On February 27, 2019, the Financial Analysis (E) Working Group (FAWG) adopted revisions to the Troubled Insurance Company Handbook, a regulator only publication. Specifically, the revisions included updated guidance for timely and effective communication between the domiciliary and non-domiciliary state departments of insurance of necessary information on troubled or potentially troubled insurance companies that may impact other jurisdictions. A cooperative communication system between states’ insurance departments promotes coordinated efforts in identifying troubled company situations and coordinating regulatory actions.

Part B.3 Procedures for Troubled Companies states that departments should generally follow and observe procedures set forth in the Troubled Insurance Company Handbook. To align the Part B.3 guidelines with the recently adopted revisions to the Handbook, the FAWG recommends the attached revisions which define more specifically which states should be included in the communication of troubled or potentially troubled insurance companies.

If you have any questions regarding his referral, please contact NAIC staff (Jane Koenigsman, jkoenigsman@naic.org).
b. Procedures for Troubled Companies

Standard: The department should generally follow and observe procedures set forth in the NAIC Troubled Insurance Company Handbook. Appropriate variations in application of procedures and regulatory requirements should be commensurate with the identified financial concerns and operational problems of the insurer.

Results-Oriented Guidelines:

1. The department should demonstrate that application of procedures and regulatory requirements are commensurate with the identified financial concerns and operational problems of the insurer. When assessing compliance with this guideline, consideration should be given to the following:
   - Whether identified concerns are adequately addressed.
   - Appropriate consideration and execution of more frequent examinations, including appropriateness of the scope of the examination.
   - Timing, quality and reasonableness of communication with other states where the insurance company is licensed, has a significant amount of written, assumed or ceded insurance business, has a significant market share, or has an impacted affiliate domiciled in that state, has pooled companies, or utilizes fronting entities, or where the domestic state is aware the company is either seeking to write business or is seeking a license.

Process-Oriented Guidelines:

1. Once the department has identified an insurance company as troubled or potentially troubled, the department should take steps, such as those set forth in the NAIC Troubled Insurance Company Handbook, to address the identified concerns. This shall apply from the point the department identifies the insurance company as troubled, or potentially troubled, to the point the company has been placed into receivership.

2. The department should examine those insurance companies that the department has identified as troubled or potentially troubled more frequently than once every five years as outlined in the NAIC Model Law on Examinations (#390) or provide rationale for not conducting more frequent examinations. Limited scope examinations are acceptable in meeting this guideline; however, the department is still required to complete a full-scope examination in compliance with statutory requirements.

3. Once the department has identified an insurance company as troubled or potentially troubled, the department should, within an appropriate time consistent with the severity of the event, make efforts to communicate proactively with other state insurance regulators where the insurance company is licensed, has a significant amount of written, assumed or ceded insurance business, has a significant market share, has an affiliate domiciled in that state, has pooled companies, or utilizes fronting entities, or where the domestic state is aware the company is either seeking to write business or is seeking a license in which affiliates of the troubled company are domiciled or those states where the troubled company has significant market share. Department files should contain written evidence of such communication(s). To a lesser extent, oral verification may provide such evidence.
MEMORANDUM

To:   Financial Regulation Standards and Accreditation (F) Committee

From:  Reinsurance (E) Task Force

Date:   November 15, 2019

Re:  2019 Revisions to Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786)

Executive Summary

On June 25, 2019, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786). These revisions were intended to incorporate the relevant provisions of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement), which was signed on Sept. 22, 2017. The Covered Agreement would eliminate reinsurance collateral and local presence requirements for European Union (EU) reinsurers that maintain a minimum amount of own funds equivalent to $250 million and a solvency capital requirement (SCR) of 100% under Solvency II. Conversely, U.S. reinsurers that maintain capital and surplus equivalent to 226 million euros with a risk-based capital (RBC) of 300% of authorized control level would not be required to maintain a local presence in order to do business in the EU or post collateral in any EU jurisdiction. On Dec. 18, 2018, a similar Covered Agreement was signed with the United Kingdom (UK). In addition, the 2019 revisions extend similar treatment to Qualified Jurisdictions and accredited NAIC jurisdictions.

At the 2019 Summer National Meeting, Director Chlora Lindley-Myers (MO), Chair of the NAIC Reinsurance (E) Task Force, made the following recommendation to the Financial Regulation Standards and Accreditation (F) Committee: 1) the Committee recognize that states may begin adoption of provisions that are substantially similar to the 2019 revisions to Model #785 and Model #786 and remain in compliance with the Reinsurance Ceded accreditation standard; 2) the accreditation standard be modified in accordance with the normal processes and procedures outlined in the Accreditation Program Manual, and that the Task Force and Financial Condition (E) Committee prepare a formal recommendation to the Financial Regulation Standards and Accreditation (F) Committee for consideration at the 2020 Spring National Meeting; and 3) in the interim, states should be encouraged to adopt the 2019 revisions in the form adopted by Plenary within the 60-month timeframe set forth in the Covered Agreement to best avoid potential federal preemption. Committee Chair Commissioner Todd E. Kiser (UT) asked if there were any objections to the approach proposed in the referral from the Reinsurance (E) Task Force, and none were noted.

At its meeting on October 22, the Reinsurance (E) Task Force agreed to submit the following new recommendations to the Financial Regulation Standards and Accreditation (F) Committee:

   1. The 2019 revisions to Model #785 and Model #786 should be adopted as a new accreditation standard by the NAIC, Reciprocal Jurisdictions, with significant elements as outlined in Attachment A.
2. The Financial Regulation Standards and Accreditation (F) Committee should consider a waiver of procedure as provided for in the Accreditation Program Manual and expeditiously consider adoption of this standard. The Task Force recommends that the accreditation standard become effective Oct. 1, 2022, the end of the 60-month period when federal preemption determinations must be completed, with enforcement of the standard to commence Jan. 1, 2023. [Note: after the Oct. 22 conference call, NAIC staff had conversations with representatives of the Federal Insurance Office (FIO), in which they advised NAIC staff that in their opinion the end of the 60-month period when federal preemption determinations must be completed is Sept. 1, 2022].

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

The current Reinsurance Ceded accreditation standard requires that state law shall contain the significant elements from Model #785 and Model #786. The models serve to provide regulators with an effective method of monitoring the reinsurance activities of U.S. companies. U.S. primary insurance companies may be given reinsurance credit on their statutory financial statements for insurance risk they transfer via reinsurance that meets the legal and accounting risk transfer requirements and other relevant laws. Both the 2011 revisions to the credit for reinsurance models, which served to reduce reinsurance collateral requirements for certified reinsurers domiciled in qualified jurisdictions, and the 2019 revisions with respect to Reciprocal Jurisdictions, address the reinsurance collateral requirements necessary for U.S. ceding companies to take credit for certain reinsurance transactions.

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

The Dodd-Frank Wall Street Reform and Consumer Protection Act provides that a state insurance measure shall be preempted to the extent that the Director of FIO “determines” that the measure is inconsistent with the covered agreement and results in less favorable treatment of a non-U.S. insurer domiciled in a foreign jurisdiction that is subject to a “covered agreement” than a U.S. insurer domiciled, licensed or otherwise admitted in that state. A “covered agreement” under Dodd-Frank is an agreement entered into between the U.S. and foreign government(s) on prudential measures with respect to the business of insurance or reinsurance that achieves a level of protection for consumers that is “substantially equivalent” to the level of protection under state law. The revisions to Model #785 and #786 are considered by the Reinsurance (E) Task Force to be consistent with the requirements of the Covered Agreements entered into with the EU and UK.

Article 9(4) of the Covered Agreements provide, as follows with respect to Implementation of the Agreement:

4. Provided that this Agreement has entered into force, on a date no later than the first day of the month, 42 months after the date of signature of this Agreement [22 September 2017], the United States shall begin evaluating a potential preemption determination under its laws and regulations with respect to any U.S. State insurance measure that the United States determines is inconsistent with this Agreement and results in less favourable treatment of an EU insurer or reinsurer domiciled, licensed, or otherwise admitted in that U.S. State. Provided that this Agreement has entered into force, on a date no later than the first day of the month 60 months after the date of signature of this Agreement [22 September 2017], the United States shall complete any necessary preemption determination under its laws and regulations with respect to any U.S. State insurance measure subject to such evaluation. For the purposes of this paragraph, the United States shall prioritise those States with the highest volume of gross ceded reinsurance for purposes of potential preemption determinations. [Emphasis added].

To summarize, FIO may begin evaluating potential preemption “determinations” 42 months after the signature of the Covered Agreement, or March 1, 2021. FIO must complete any necessary preemption determinations 60 months after signature, which they believe to be Sept. 1, 2022. In order to avoid potential federal preemption determinations by the FIO Director, each state should adopt the 2019 revisions to Model #785 and Model #786 in a timely manner.
A statement as to the number of jurisdictions that have adopted and implemented the proposal or a similar proposal and their experience to date:

The pre-2011 versions of Model #785 and Model #786 are currently part of the Reinsurance Ceded accreditation standard, and the significant elements have been adopted in substantially similar form by all NAIC-accredited jurisdictions. The 2011 revisions to these models implemented reinsurance collateral reduction for Reinsurance Ceded to Certified Reinsurers domiciled in qualified jurisdictions. At the current time, all NAIC accredited jurisdictions have adopted the 2011 revisions to Model #785, and only 5 jurisdictions have not adopted the 2011 revisions to Model #786, which became part of the accreditation standard effective January 1, 2019.

We are not currently aware of any states that have adopted the 2019 revisions to Model #785 and Model #786, although we have been advised that many states have begun their legislative processes for adoption of these revisions. We are not aware of any negative impact to any jurisdiction or its domiciliary ceding insurers that has adopted these revisions, which are similar in function and format to the Reciprocal Jurisdiction requirements of the 2019 revisions.

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

The current accreditation standard for Model #785 and Model #786 requires state adoption on a substantially similar basis. In addition, the Covered Agreements themselves and the Dodd-Frank Act require that the United States cannot impose reinsurance collateral or local presence requirements that result in less favorable treatment for EU or UK reinsurers, and further that any state insurance measures cannot be inconsistent with the Covered Agreements. Therefore, the Reinsurance (E) Task Force recommends that the attached proposed significant elements for Reciprocal Jurisdictions (Attachment A) be adopted by NAIC-accredited jurisdictions in a “substantially similar” manner, as that term is defined in the Accreditation Interlineations of the NAIC Financial Regulation Standards and Accreditation Program. Note: While the Task Force is recommending that the Committee adopt a “substantially similar” standard for accreditation purposes, it should be noted that Dodd-Frank requires the state insurance measure to be “consistent” with the Covered Agreement in order to avoid federal preemption, which may be interpreted as a higher standard. It is the recommendation of the Task Force that states adopt the 2019 revisions in close to identical form to the models in order to best avoid the possibility of federal preemption.

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

The NAIC has not performed a cost/benefit analysis with respect to the 2019 revisions to Model #785 and Model #786, nor do we believe that the specific costs for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it are reasonably quantifiable.

1 31 U.S.C. §313(f) provides the process for making a “determination” in this context:

(2) Determination.—

(A) Notice of potential inconsistency.—Before making any determination under paragraph (1), the Director shall—

(i) notify and consult with the appropriate State regarding any potential inconsistency or preemption;

(ii) notify and consult with the United States Trade Representative regarding any potential inconsistency or preemption;
(iii) cause to be published in the Federal Register notice of the issue regarding the potential inconsistency or preemption, including a description of each State insurance measure at issue and any applicable covered agreement;

(iv) provide interested parties a reasonable opportunity to submit written comments to the Office; and

(v) consider any comments received.

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(C) Notice of determination of inconsistency.—Upon making any determination under paragraph (1), the Director shall—

(i) notify the appropriate State of the determination and the extent of the inconsistency;

(ii) establish a reasonable period of time, which shall not be less than 30 days, before the determination shall become effective; and

(iii) notify the Committees on Financial Services and Ways and Means of the House of Representatives and the Committees on Banking, Housing, and Urban Affairs and Finance of the Senate.

(3) Notice of effectiveness.—Upon the conclusion of the period referred to in paragraph (2)(C)(ii), if the basis for such determination still exists, the determination shall become effective and the Director shall—

(A) cause to be published a notice in the Federal Register that the preemption has become effective, as well as the effective date; and

(B) notify the appropriate State.
10. Reinsurance Ceded

State law should contain the NAIC Credit for Reinsurance Model Law (#785), the NAIC’s Credit for Reinsurance Model Regulation (#786) and the NAIC Life and Health Reinsurance Agreements Model Regulation (#791) or substantially similar laws.

Credit for Reinsurance Model Law (#785)

a. Credit allowed for reinsurance ceded to a licensed insurer?

b. Credit allowed for reinsurance ceded to an accredited insurer who meets requirements similar to those in Section 2B and 2421 of the model law?

c. Credit allowed for reinsurance ceded to an insurer domiciled and licensed in a state which employs substantially similar standards regarding credit for reinsurance and who maintains capital and surplus of at least $20,000,000 and submits to this state’s authority to examine its books and records?

d. Credit allowed for reinsurance ceded to an insurer who maintains a trust fund, established in a form approved by the commissioner, in a qualified U.S. financial institution for the payment of the valid claims of its U.S. policyholders and ceding insurers, their assigns and successors in interest and who reports financial information annually to the commissioner to determine the sufficiency of the trust fund?

e. In instances where reinsurance is ceded to insurers maintaining a trust fund, trustees of the trust required to report to the department annually, on or before February 28, the balance of the trust and a listing of the trust’s assets as of the end of the year and a certification of the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31?

f. Credit for reinsurance allowed under c. or d. above only permitted where assuming insurer agrees in the reinsurance agreements: 1) that in the event of a failure of the assuming insurer to perform its obligations, the assuming insurer shall submit to the jurisdiction of any court of competent jurisdiction in any state of the U.S., and 2) to designate the commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process instituted by or on behalf of the ceding company?
g. Credit allowed for reinsurance ceded to an insurer not meeting the requirements of a., b., c., or d. above, or with respect to a certified reinsurer described below, in an amount not exceeding the liabilities carried by the ceding insurer and only in the amount of funds held by or on behalf of the ceding insurer in the form of cash, securities listed by the Securities Valuation Office of the NAIC, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets, clean, irrevocable, unconditional letters of credit, and other forms of security acceptable to the commissioner?

h. Ceding insurers must be subject to notification requirements with respect to reinsurance concentration risk substantially similar to those in Section 222K of Model #785.

Life and Health Reinsurance Agreements Model Regulation (#791)

i. Scope similar to Section 3?

j. No insurer, for reinsurance ceded establishes any asset or reduces any liability due to the terms of the reinsurance agreement, in substance or effect if any of the conditions in Section 4A exist?

k. Agreements entered into after the effective date of this regulation which involve the reinsurance of business issued prior to the effective date of agreements, along with subsequent amendments shall be filed by the ceding company with the commissioner within 30 days from the execution date along with attachments noted in Section 4C(1)?

l. Any increase in surplus net of federal income tax resulting from arrangements described in Section 4C(1) to be reported as described in Section 4C(2)?

m. Written agreements with provisions similar to Section 5?

n. Insurers required to reduce to zero any reserve credits or assets established with respect to existing reinsurance agreements entered into prior to the effective date of this regulation which would not be recognized under the provisions of this regulation?

Credit for Reinsurance Model Regulation (#786)

o. Credit for reinsurance allowed for reinsurance ceded by domestic insurers to assuming insurers that were licensed in the state as of the last date of the ceding insurers’ statutory financial statement?

p. Credit for reinsurance provisions for accredited reinsurer similar to Section 5?

q. Credit for reinsurance provisions for reinsurers licensed and domiciled in other states similar to Section 6?

r. Credit for reinsurance provisions for reinsurers maintaining trust funds similar to Section 7?
s. Credit for reinsurance required by law similar to Section 910?

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t. Reduction from liability for reinsurance ceded to an unauthorized assuming insurer similar to Section 4011?

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u. Provisions for trust agreements similar to Section 4412?

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v. Provisions for letters of credit similar to Section 4213?

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w. Provisions for unencumbered funds similar to Section 4314?

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x. Provisions for reinsurance contracts similar to Section 4415?

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y. The adoption of Form AR-1—Certificate of Assuming Insurer.

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Reinsurance Ceded to Certified Reinsurers

z. A state’s laws and regulations shall allow credit for reinsurance ceded to a certified reinsurer, including affiliated reinsurance transactions. Its laws and regulations shall contain provisions that are substantially similar to those applicable to certified reinsurers contained in Section 2E of Model #785 and Section 8 of Model #786.

i. The credit allowed is based upon the security held by or on behalf of the ceding insurer in accordance with the rating assigned to the certified reinsurer by the commissioner? The amount of security required in order for full credit to be allowed shall not be less than that required under Section 8A(1) of Model # 786.

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ii. The security provided by the certified reinsurer is in a form consistent with the provisions of Section 2E(5) of Model #785 and Section 8A of Model #786?

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iii. The commissioner requires the certified reinsurer to post 100% security upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer?

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iv. A state’s laws or regulations shall include provisions for granting a certified reinsurer a deferral period for posting security applicable to catastrophe recoverables, substantially similar to Section 8A(4) of Model #786. The deferral period shall not exceed one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the commissioner, and shall not apply to lines of business other than those provided in Section 8A(4) of Model #786.

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v. Credit for reinsurance ceded to a certified reinsurer shall apply only to reinsurance contracts meeting requirements substantially similar to Section 8A(5) of Model #786?
aa. In order to be a certified reinsurer, an assuming insurer must be certified by the commissioner in accordance with the process similar to Section 8B of Model #786?

i. The commissioner is required to post notice upon receipt of any application for certification substantially similar to the requirements of Section 8B(1) of Model #786?

ii. The commissioner is required to publish a list of all certified reinsurers and their ratings substantially similar to the requirements in Section 2E(4) of Model #785 and Section 8B(2) of Model #786?

iii. A certified reinsurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner?

iv. A certified reinsurer must maintain capital and surplus, or its equivalent, of no less than $250,000,000, calculated in accordance with Section 8B(4)(h) of Model #786? This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

v. A certified reinsurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner, and the maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as set forth in Section 8B(4)(a) of Model #786? These ratings must be based on interactive communication between the rating agency and the assuming insurer and not based solely on publicly available information.

vi. A certified reinsurer is rated by the commissioner on a legal entity basis, with consideration given to the group rating where appropriate (an association including incorporated and individual unincorporated underwriters that have been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating)? Factors may be considered in the evaluation process similar to those provided under Section 8B(4) and (5) of Model #786.

vii. A certified reinsurer must submit a properly executed Form CR-1 as evidence of its submission to the jurisdiction of the state, appointment of the commissioner as an agent for service of process in the state, and agreement to provide security for one hundred percent (100%) of its liabilities attributable to reinsurance ceded by ceding insurers if it resists enforcement of a final U.S. judgment? The commissioner must not certify any assuming insurer that is domiciled in a jurisdiction that the commissioner has determined does not adequately and promptly enforce final U.S. judgments or arbitration awards.
viii. A certified reinsurer must agree to meet applicable information filing requirements substantially similar to those provided under Section 8B(7) of Model #786, both with respect to an initial application for certification and on an ongoing basis?

ix. Changes in rating or revocation of certification of a certified reinsurer are applied by the commissioner in a manner substantially similar to the provisions of Section #421 of Model #785 and Section 8B(8) of Model #786?

x. A certified reinsurer must file audited financial statements, regulatory filings and actuarial opinion (as filed with the certified reinsurer’s supervisor, with a translation into English) consistent with the requirements set forth in Section 8B(4)(h) and Section 8B(7)(d) of Model #786? Upon the initial application for certification, the commissioner will consider audited financial statements for the last two (2) years filed with its non-U.S. jurisdiction supervisor?

bb. The commissioner is required to create and publish a list of qualified jurisdictions, under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer?

i. In determining whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner evaluates the reinsurance supervisory system of the non-U.S. jurisdiction, both initially and on an ongoing basis, under criteria substantially similar to those provided under Section 8C(2) of the model regulation?

ii. The commissioner shall consider the list of qualified jurisdictions published by the NAIC in determining qualified jurisdictions? If the commissioner approves a jurisdiction as qualified that does not appear on the NAIC list of qualified jurisdictions, the commissioner must provide thoroughly documented justification with respect to criteria substantially similar to that provided under Section 8C(2) of Model #786.

iii. U.S. jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program are recognized as qualified jurisdictions?

cc. A state’s laws and regulations shall allow a commissioner to defer to the certification and rating of a certified reinsurer issued by another NAIC accredited jurisdiction. Recognition of certification is made in accordance with provisions substantially similar to Section 8D of Model #786?

dd. Reinsurance contracts entered into or renewed with a certified reinsurer must include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer for reinsurance ceded to the certified reinsurer?
Reciprocal Jurisdictions

ee. A state’s laws and regulations shall allow credit for reinsurance ceded to an assuming insurer that has its head office or is domiciled in, and is licensed in, a Reciprocal Jurisdiction. Its laws and regulations shall contain provisions that are substantially similar to those contained in Section 2F of Model #785 and Section 9 of Model #786. Its laws and regulations must provide that a Reciprocal Jurisdiction is a jurisdiction that meets one of the following:

i. A non-U.S. jurisdiction that is subject to an in-force covered agreement meeting the requirements of Section 2F(1)(a)(i) of Model #785 and Section 9B(1) of Model #786.

ii. A U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Standards and Accreditation Program pursuant to Section 2F(1)(a)(ii) of Model #785 and Section 9B(2) of Model #786.

iii. A Qualified Jurisdiction that meets all of the requirements of Section 2F(1)(a)(iii) of Model #785 and Section 9B(3) of Model #786.

ff. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact reinsurance by, and has its head office or is domiciled in, a Reciprocal Jurisdiction, and which meets each of the conditions set forth in Section 2F(1)(b) – (g) of Model #785 and Section 9C of Model #786:

i. The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction of no less than $250,000,000 similar to Section 2F(1)(b) of Model #785 and Section 9C(2) of Model #786. This minimum capital and surplus requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) or own funds of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

ii. The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, as set forth in Section 2F(1)(c) of Model #785 and Section 9C(3) of Model #786.

iii. The assuming insurer must submit a properly executed Form RJ-1 consistent with Section 2F(1)(d) of Model #785 and Section 9C(4) of Model #786.
• The assuming insurer must agree to provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in this subsection, or if any regulatory action is taken against it for serious noncompliance with applicable law pursuant to Section 2F(1)(d)(i) of Model #785 and Section 9C(4)(a) of Model #786.

• The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process pursuant to Section 2F(1)(d)(ii) of Model #785 and Section 9C(4)(b) of Model #786. The commissioner may also require that such consent be provided and included in each reinsurance agreement under the commissioner’s jurisdiction.

• The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained pursuant to Section 2F(1)(d)(iii) of Model #785 and Section 9C(4)(c) of Model #786.

• Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the assuming insurer’s liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its estate, if applicable pursuant to Section 2F(1)(d)(iv) of Model #785 and Section 9C(4)(d) of Model #786.

• The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement, which involves this state’s ceding insurers, and agrees to notify the ceding insurer and the commissioner and to provide one hundred percent (100%) security to the ceding insurer consistent with the terms of the scheme, should the assuming insurer enter into such a solvent scheme of arrangement pursuant to Section 2F(1)(d)(v) of Model #785 and Section 9C(4)(e) of Model #786.

• The assuming insurer must agree in writing to meet the applicable information filing requirements pursuant to Section 9C(4)(f) of Model #786.

iv. The assuming insurer or its legal successor must provide, if requested by the commissioner, on behalf of itself and any legal predecessors, the documentation to the commissioner as outlined in Section 2F(1)(e) of Model #785 and Section 9C(5) of Model #786.
For the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer’s annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report pursuant to Section 9C(5)(a) of Model #786?

For the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer’s supervisor pursuant to Section 9C(5)(b) of Model #786?

Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States pursuant to Section 9C(5)(c) of Model #786?

Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer’s assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer pursuant to Section 9C(5)(d) of Model #786?

v. The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements consistent with Section 2F(1)(f) of Model #785 and Section 9C(6) of Model #786?

vi. The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with the minimum capital and surplus requirements and the minimum solvency or capital ratio requirements as required under Section 2F(1)(g) of Model #785 and Section 9C(7) of Model #786?

gg. The commissioner is required to timely create and publish a list of Reciprocal Jurisdictions similar to Section 2F(2) of Model #786 and Section 9D of Model #786?

i. If the commissioner approves a jurisdiction that does not appear on the NAIC list of Reciprocal Jurisdictions, the commissioner must provide thoroughly documented justification in accordance with criteria published through the NAIC Committee Process pursuant to Section 2F(2)(a) of Model #785 and Section 9D(1) of Model #786?

ii. The commissioner may remove a jurisdiction from the list of Reciprocal Jurisdictions upon a determination that the jurisdiction no longer meets one or more of the requirements of a Reciprocal Jurisdiction pursuant to Section 2F(2)(b) of Model #785 and Section 9D(2) of Model #786, except that the commissioner shall not remove from the list a Reciprocal Jurisdiction as defined under Section 9B(1) and (2) of Model #786?
hh. The commissioner shall timely create and publish a list of assuming insurers to which cessions shall be granted credit consistent with Section 2F(3) of Model #785 and Section 9E of Model #786. Such assuming insurer must submit a properly executed Form RJ-1 and additional information as the commissioner may require.

i. If an NAIC accredited jurisdiction has determined that the conditions set forth in Section 2F of Model #785 and Section 9 of Model #786 have been met, the commissioner has the discretion to defer to that jurisdiction’s determination and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit in accordance pursuant to Section 2F(3) of Model #785 and Section 9E(1) of Model #786. The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC with respect to such reinsurer.

ii. When requesting that the commissioner defer to another NAIC accredited jurisdiction’s determination, an assuming insurer must submit a properly executed Form RJ-1 and additional information as the commissioner may require pursuant to Section 9E(2) of Model #786.

iii. If the commissioner determines that an assuming insurer no longer meets one or more of the requirements set forth in Section 2F of Model #786 and Section 9 of Model #786, the commissioner may revoke or suspend the eligibility of the assuming insurer consistent with Section 2F(4) of Model #785 and Section 9F of Model #786.

i. While an assuming insurer’s eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer’s obligations under the contract are otherwise secured pursuant to Section 2F(4)(a) of Model #785 and Section 9F(1) of Model #786.

ii. If an assuming insurer’s eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer’s obligations under the contract are otherwise secured in a form acceptable to the commissioner pursuant to Section 2F(4)(b) of Model #785 and Section 9F(2) of Model #786.

iii. Before denying statement credit or imposing a requirement to post security or adopting any similar requirement that will have substantially the same regulatory impact as security, the commissioner shall follow the process set forth in Section 9G of Model #786.
ii. If subject to a legal process of rehabilitation, liquidation or
conservation, as applicable, the ceding insurer, or its representative,
may seek and, if determined appropriate by the court in which the
proceedings are pending, may obtain an order requiring that the
assuming insurer post security for all outstanding liabilities in
accordance with Section 2F(5) of Model #785 and Section 9H of
Model #786?

kk. Nothing shall limit or in any way alter the capacity of parties to a
reinsurance agreement to agree on requirements for security or other
terms in that reinsurance agreement, except as expressly prohibited by
other applicable law or regulation similar to Section 2F(6) of Model
#785?

ll. Credit may be taken only for reinsurance agreements entered into,
amended, or renewed on or after the effective date of the statute, and
only with respect to losses incurred and reserves reported on or after
the later of (i) the date on which the assuming insurer has met all
eligibility requirements, and (ii) the effective date of the new
reinsurance agreement, amendment, or renewal consistent with the
provisions of Section 2F(7) of Model #785?
MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee

FROM: John F. Finston (CA)
Chair, Reinsurance (E) Task Force

DATE: March 20, 2017

RE: 2016 Revisions to Credit for Reinsurance Model Law (#785)
Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

Executive Summary

On June 30, 2014, the Principle-Based Reserving Implementation (EX) Task Force adopted the recommendations in the report of Rector & Associates, Inc. dated June 4, 2014, regarding a proposal for the XXX/AXXX Reinsurance Framework. The Framework sought to address concerns regarding reserve financing transactions and to do so without encouraging them to move offshore. The changes would be prospective and apply only to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life with secondary guarantees business (XXX/AXXX). The NAIC Executive (EX) Committee adopted the Framework (in concept) on Aug. 17, 2014. As an interim step to implementing the Framework, the NAIC adopted Actuarial Guideline XLVIII Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830) (AG 48) on Dec. 16, 2014. It was expected that AG 48 would eventually be replaced by effective codification through the Credit for Reinsurance Model Law (#785) and creation of a new model regulation to establish requirements regarding the reinsurance of XXX/AXXX policies.

The NAIC adopted revisions to Model #785 on Jan. 8, 2016, which give insurance commissioners authority to issue regulations codifying AG 48 and the XXX/AXXX Reinsurance Framework. The Reinsurance (E) Task Force adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) at the Summer National Meeting on Aug. 27, 2016, and it was adopted by the Financial Condition (E) Committee with slight revisions via conference call on Sept. 30, 2016. Model #787 was then adopted by the Executive (EX) Committee and Plenary on Dec. 13, 2016. At that same time, the NAIC also revised AG 48 to conform with the provisions of Model #787, effective Jan. 1, 2017.

The Reinsurance (E) Task Force hereby submits the following recommendations to the Financial Regulation Standards and Accreditation (F) Committee:

1. The 2016 revisions to Model #785 and new Model #787 should be adopted as a new accreditation standard by the NAIC.

2. The F-Committee should consider a waiver in its normal timeline for adoption of an accreditation standard, and expeditiously consider adoption of this standard. The Task Force would recommend that the accreditation standard become effective January 1, 2020.
A statement and explanation of how the potential standard is directly related to solvency surveillance and why the proposal should be included in the standards:

The 2016 revisions to Model #785 provide that the commissioner may adopt regulations with respect to (1) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits; (2) universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period; (3) variable annuities with guaranteed death or living benefits; (4) long-term care insurance policies; and (5) other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance. The revisions to Model #785 also contain a “professional reinsurer exemption” for reinsurers that maintain at least $250 million in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is (1) licensed in at least 26 states; or (2) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

Model #787 does not materially change the ability of insurers to obtain credit for reinsurance ceded to “certified” reinsurers or to obtain credit for reinsurance ceded to “licensed” or “accredited” reinsurers that follow statutory accounting and risk-based capital (RBC) rules. As a practical matter, the Model #787 requirements apply to reinsurance ceded to captive insurers, SPVs, reinsurers that are not eligible to become “certified” reinsurers, or reinsurers that materially deviate from statutory accounting and/or RBC rules. In those situations, subject to certain exemptions and grandfathering provisions, the ceding insurer may receive credit for reinsurance if:

- The ceding insurer continues to establish gross reserves, in full, using applicable reserving guidance;
- Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis;
- The Actuarial Method used to establish the Required Level of Primary Security for each reinsurance treaty subject to Model #787 is based on VM-20, applied on a treaty-by-treaty basis;
- Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held are held by or on behalf of the ceding insurer as security under the reinsurance contract; and
- The reinsurance arrangement is approved by the ceding insurer’s domestic regulator.

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

The NAIC Principle-Based Reserving Implementation (EX) Task Force serves as the coordinating body for all NAIC technical groups involved with projects related to the Principle-Based Reserves (PBR) initiative for life and health policies. This Task Force was also charged with further assessing, and making recommendations regarding the solvency implications of life insurance reserve financing mechanisms addressed in the June 6, 2013, NAIC White Paper Captives and Special Purpose Vehicles, which provides in relevant part:

The Captive and Special Purpose Vehicle (SPV) Use (E) Subgroup studied the use of captives and SPVs formed by commercial insurers. The Subgroup concluded that commercial insurers cede business to captives for a variety of business purposes. The Subgroup determined that the main use of captives and SPVs by commercial insurers was related to the financing of XXX and AXXX perceived reserve redundancies. The implementation of principle-based reserving (PBR) could reduce the need for commercial insurers to create new captives and SPVs to address perceived reserve redundancies; however, existing captives and SPVs are likely to remain in existence for several years or decades, until the existing blocks of business are run-off. **Regulators need to be able to assess and monitor the risks**
that captives and SPVs may pose to the holding company system, and the current regulatory process should be enhanced to provide standardized tools and processes to be used by all regulators when reviewing such transactions. Commercial insurer-owned captives and SPVs should not be used to avoid statutory accounting. To the extent that insurer-affiliated captives and SPVs may be created in the future for unforeseen purposes, additional guidance should be developed by the NAIC to assist the states in a uniform review of transactions. [Emphasis added].

In addition, in coordination with the adoption in principle of the XXX/AXXX Reinsurance Framework, the Financial Regulation Standards and Accreditation (F) Committee was given the following charge: “As the various work products are adopted by the Principle-Based Reserving (EX) Task Force, Executive Committee, and Plenary, consider them for inclusion in the Part A and Part B Accreditation Standards.”

Finally, effective Jan. 1, 2016, the NAIC amended the Preamble for Part A: Laws and Regulations of the NAIC Policy Statement on Financial Regulation Standards to apply to the regulation of a state’s domestic insurers licensed and/or organized under its captive or special purpose vehicle statutes or any other similar statutory construct with respect to XXX/AXXX business, which is deemed to satisfy the Part A accreditation requirements if the applicable reinsurance transaction satisfies the XXX/AXXX Reinsurance Framework requirements adopted by the NAIC. Further, the revised Preamble provided, as follows: “The revisions to the Credit for Reinsurance Model Act (#785) and the new XXX/AXXX Model Regulation will need to be specifically considered for accreditation purposes once adopted by the NAIC.”

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

AG 48 became effective Jan. 1, 2015, and became part of the NAIC Accounting Practices and Procedures Manual through its inclusion in Appendix C. As such, provisions similar to the proposal have been effective in all states since that date.

As of this date, three states (Louisiana, Oklahoma and Utah) have gone beyond AG 48 and have adopted the 2016 revisions to Model #785 giving commissioners authority to issue regulations codifying AG 48 and the XXX/AXXX Reinsurance Framework, with several other states currently considering such revisions.

The new Part A Preamble became effective Jan. 1, 2016, with regard to XXX/AXXX reinsurance captives. NAIC staff worked with necessary state insurance departments to assess compliance with the new Part A Preamble related to captives that assume XXX/AXXX business, and reported its findings at the 2016 Fall National Meeting to the Financial Regulation Standards and Accreditation (F) Committee. NAIC staff reviewed all of the Dec. 31, 2015, XXX/AXXX Reinsurance Supplements that were filed with the NAIC to first ascertain whether the appropriate level of primary and other securities was being held to back the non-exempt XXX/AXXX reinsurance transactions. NAIC staff reported that all of the transactions held the required amount of securities, and therefore, all of the transactions satisfied the new Part A requirements.

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

Regulators needed to be able to assess and monitor the risks posed with respect to XXX/AXXX captive reinsurance transactions, and the regulatory process was enhanced through the adoption of the XXX/AXXX Reinsurance Framework, AG 48 and Model #787 to provide standardized tools and processes to be used by all regulators when reviewing such transactions. However, these new tools are complex and technical in nature, requiring the use of a new actuarial methodology to achieve the desired financial solvency results. Therefore, the Reinsurance (E) Task Force recommends that any new accreditation standard developed for Model #787 be
adopted by NAIC-accredited jurisdictions in a “substantially similar” manner, as that term is defined in the Accreditation Interlineations of the NAIC Financial Regulation Standards and Accreditation Program.

In addition, all of the elements of the XXX/AXXX Reinsurance Framework have been put into place, with the exception of the new accreditation standard. Therefore, F-Committee should consider a waiver in its normal timeline for adoption of an accreditation standard, and expeditiously consider adoption of this new standard effective as of January 1, 2020.

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

The NAIC has not performed a cost/benefit analysis with respect to Model #787, nor do we believe that the specific costs for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it are reasonably quantifiable. However, it should be noted that Model #787 does not require dramatic changes from how insurance companies have been financing XXX/AXXX captive reinsurance transactions since the NAIC’s adoption of AG 48. As with AG 48, Model #787 provides “standardized tools and processes to be used by all regulators when reviewing such transactions.” Prior to the adoption of AG 48, insurers would enter into various captive reinsurance transactions to “finance” different portions of the statutory reserve differently—i.e., to fund different portions of the reserve using different kinds of assets—based on what insurers believed to be a better correlation between the kind of asset used and the probability that it would be needed. Many state regulators were comfortable with these transactions in theory, but there was significant unease regarding how these transactions were being implemented, and especially as to the lack of consistency from insurer to insurer and regulator to regulator regarding key aspects as to how these transactions may have been approved. Such transactions are still permitted under Model #787, but now a clear and consistent process has been implemented to ensure that the proper amount and type of assets have been applied with respect to these transactions in order to ensure that they continue to meet strong financial solvency standards.
MEMORANDUM

TO:       Financial Regulation Standards and Accreditation (F) Committee
FROM:     Reinsurance (E) Task Force
DATE:     August 24, 2017
RE:       Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

Executive Summary

The NAIC membership adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) at the 2016 Fall National Meeting on Dec. 13, 2016. At that same time, the NAIC membership also adopted revisions to Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48) to conform with the provisions of Model #787, effective Jan. 1, 2017. Model #787 establishes uniform, national standards governing reserve financing arrangements pertaining to term life and universal life insurance policies with secondary guarantees, and ensures that funds consisting of primary security and other security are held in the forms and amounts required.

At its meeting on Aug. 7, 2017, the Reinsurance (E) Task Force agreed to submit the following recommendations to the Financial Regulation Standards and Accreditation (F) Committee:

1. Model #787 should be adopted as a new accreditation standard by the NAIC, with significant elements as outlined in Attachment A.

2. The Financial Regulation Standards and Accreditation (F) Committee should consider a waiver in its normal timeline for adoption of an accreditation standard, and expeditiously consider adoption of this standard. The Task Force recommends that the accreditation standard become effective Jan. 1, 2020. The Task Force further recommends that a state’s adoption of AG 48 will serve to satisfy this accreditation standard until such time that the state adopts the significant elements of Model #787.

3. The 2016 revisions to the Credit for Reinsurance Model Law (#785) should be considered acceptable but not required by the states.

In addition to the preceding recommendations, the Task Force is offering the following additional information in order to assist the Financial Regulation Standards and Accreditation (F) Committee in reviewing the proposed accreditation standard for Model #787.
**Substantially Similar**

The Task Force has recommended in the draft accreditation standard that the “substantially similar” standard be utilized to meet the minimum requirements of the standard. However, the Task Force did note that Drafting Notes to Section 2, Section 3 and Section 5 of Model #785 might suggest a stronger standard of review than “substantially similar.” The Drafting Notes provide, as follows: “To assist in achieving national uniformity, commissioners are asked to strongly consider adopting regulations that are **substantially similar in all material respects** to NAIC adopted model regulations in the handling and treatment of such reinsurance arrangements.” [Emphasis added]. In recognition of this, and to assist in review of the actuarial method used to determine the required level of primary security as described in Section 6 of Model #787, the Task Force recommends that the NAIC Legal Division specifically note any material changes in a state’s regulation during an accreditation review for consideration by the Financial Regulation Standards and Accreditation (F) Committee.

**State Adoption of AG 48**

The Task Force recommends that the accreditation standard become effective on an expedited basis beginning Jan. 1, 2020. However, the Task Force further recognizes that meeting the expedited date may not be feasible for some states in instances due, in whole or part, to other legislative priorities of the states. It is the recommendation of the Task Force that, in such cases, a state’s compliance with AG 48 should be considered as satisfactory to the Financial Regulation Standards and Accreditation (F) Committee as substantial compliance with Model #787. AG 48 became effective Jan. 1, 2015, and became part of the *Accounting Practices and Procedures Manual* through its inclusion in Appendix C, and has been amended to conform with Model #787 effective Jan. 1, 2017.

**2016 Revisions to Model #785**

The Task Force does not recommend that the 2016 revisions to Model #785 be included in the proposed accreditation standard. These revisions provide that the commissioner may adopt regulations with respect to: 1) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits; 2) universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period; 3) variable annuities with guaranteed death or living benefits; 4) long-term care insurance policies; and 5) other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance. The revisions to Model #785 also contain a “professional reinsurer exemption” for reinsurers that maintain at least $250 million in capital and surplus when determined in accordance with the *Accounting Practices and Procedures Manual*, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices, and is: 1) licensed in at least 26 states; or 2) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

The reasoning of the Task Force is that Model #787 only applies to term life and universal life with secondary guarantees (XXX/AXXX) captive reinsurance transactions, and that variable annuities, long-term care insurance and other life and health insurance and annuity products are not currently addressed. Therefore, it would be considered to be premature to require the states to adopt these provisions. In addition, the professional reinsurer exemption of Section 5B(4) of Model #785 is specifically referenced in the draft accreditation standard. Therefore, it is the recommendation of the Task Force that the 2016 revisions to Model #785 are optional, and should be considered as acceptable but not required by the states.
Attachment A

Proposed Accreditation Standard

Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

State statute and/or regulation should be substantially similar to uniform, national standards that govern reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees, to ensure that both the total security and the primary security are provided in forms and amounts that are in compliance with the requirements set forth in the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).

a. Provides that the Credit for Reinsurance Model Regulation (#786) and Model #787 shall both apply to reinsurance treaties that cede liabilities pertaining to Covered Policies; provided, that in the event of a direct conflict between the provisions of Model #787 and the provisions of Model #786, the provisions of Model #787 shall apply, but only to the extent of the conflict, substantially similar to Section 3 of Model #787?

b. Provides that Model #787 does not apply to reinsurance exempt by the provisions of Section 4 of Model #787, including reinsurance ceded to an assuming insurer that meets the requirements of either Section 5B(4)(a) of the Credit for Reinsurance Model Law (#785), which pertains to certain certified reinsurers, or Section 5B(4)(b) of Model #785, which pertains to reinsurers meeting certain threshold size and licensing requirements?

c. Provides definitions of “Covered Policies,” “Grandfathered Policies,” “Required Level of Primary Security,” “Actuarial Method,” “Primary Security,” “Other Security” and “Valuation Manual” that are substantially similar to such terms as defined in Section 5 of Model #787?

d. Provides for an Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this regulation that is substantially similar to the methodology as set forth in Section 6A of Model #787?

e. Provides for valuations to be used 1) in calculating the Required Level of Primary Security pursuant to the Actuarial Method; and 2) in determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, that are substantially similar to the valuations set out in Section 6B of Model #787?

f. Provides for requirements to obtain credit for reinsurance with respect to ceded liabilities pertaining to Covered Policies that are substantially similar to the requirements set out in Section 7A of Model #787?

g. Provides for requirements at inception date and on an ongoing basis substantially similar to Section 7B(1) of Model #787?

h. Provides that if the requirements to hold Primary Security and total security are not both satisfied, the ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held, unless any deficiency has been eliminated pursuant to remediation provisions substantially similar to Section 7B(2) of Model #787?

i. Includes a prohibition against avoidance provision similar to Section 9 of Model #787?
October 7, 2019

Todd E. Kiser  
Chair, NAIC Financial Regulation Standards and Accreditation (F) Committee  
Attention: Becky Meyer (bmeyer@naic.org)

Chlora Lindley-Myers  
Chair, NAIC Reinsurance (E) Task Force  
Attention: Jake Stultz (jstultz@naic.org)  
Dan Schelp (dschelp@naic.org)

Re: Credit for Reinsurance Model Accreditation Decisions

Dear Commissioner Kiser and Director Lindley-Myers:

New York Life and Northwestern Mutual are writing in response to the current exposure by the Reinsurance (E) Task Force of draft revisions to the NAIC Accreditation Program Manual intended to incorporate the 2019 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) to implement the US-EU Covered Agreement.

Our comments are not with respect to those revisions, but rather to urge that the NAIC follow through on prior recommendations and set the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) as an accreditation standard in parallel with the Covered Agreement revisions. Our companies have long advocated that Model #787 should be an accreditation requirement, which is consistent with the prior recommendation by the Reinsurance Task Force.

By way of background, the NAIC adopted Model #787 in 2016 as the permanent method to implement the NAIC’s XXX/AXXX Reinsurance Framework that it spent years developing. Model #787 establishes the credit for reinsurance that a ceding company may be allowed for a subject captive reinsurance transaction. The requirements for Primary Security and Other Security in Model #787 are substantively the same as those in Actuarial Guideline 48, the NAIC’s interim tool to implement its XXX/AXXX Reinsurance Framework. However, whereas Model #787 binds the ceding company’s allowed credit for reinsurance, AG 48 can only impose requirements on the ceding company’s appointed actuary.

On March 20, 2017, the Reinsurance Task Force recommended to the F Committee that Model #787 be made an accreditation standard on an expedited basis, so that it would become an accreditation requirement by January 1, 2020. This was consistent with the NAIC’s recognition that (1) uniformity in implementation of the XXX/AXXX Reinsurance Framework is critical to its success; and (2) AG 48 was intended from the start as only an interim solution until the ultimate credit for reinsurance mechanism could be implemented. On August 24, 2017, the Reinsurance Task Force recommended the elements of Model #787 to be included in the accreditation standard.
However, as progress was being made toward an expedited accreditation action for Model #787, the need arose to amend Models #785 and #786 to address the Covered Agreement. Not wanting states to face multiple rulemaking processes, the F Committee decided at the 2017 Fall National Meeting to defer adoption of Model #787 as an accreditation requirement until the changes to Models #785 and #786 to implement the Covered Agreement had been completed. Our companies agreed that the NAIC’s announced process made sense.

Now that the Covered Agreement changes to Models #785 and #786 have been adopted and are being considered for accreditation on an expedited basis, we strongly urge that the F Committee move forward as originally contemplated and complete the accreditation decisions on Model #787 in synch with the Model #785 and #786 changes. Doing so will make state implementation of the credit for reinsurance changes more efficient. Moreover, since the Reinsurance Task Force has already done the work to identify the accreditation elements for Model #787, moving in parallel should not delay the NAIC’s efforts on Models #785 and #786.

It is important to remember that the NAIC has already made compliance with its XXX/AXXX Reinsurance Framework an accreditation requirement. That was decided in 2015, when the NAIC revised the Part A Preamble to the 2016 Accreditation Program Manual to subject the regulation of XXX/AXXX captives to the Part A accreditation requirements, and deemed regulation according to the NAIC’s XXX/AXXX Reinsurance Framework to meet those requirements. What remains to be done is to solidify that earlier conclusion by making Model #787 itself an accreditation requirement.

While AG 48 has served as a critical interim measure to implement the XXX/AXXX Reinsurance Framework, it was never intended to be nor is it an adequate permanent substitute for Model #787. Only Model #787 embeds the Primary Security and Other Security requirements directly into the determination of reinsurance credit. AG 48, by contrast, relies upon an indirect enforcement approach: requiring a ceding company’s appointed actuary to perform an analysis and, in the event the Primary Security or Other Security requirements are not met, deliver a qualified actuarial opinion. The allowance, or not, of reinsurance credit as a matter of law under Model #787 serves as a more direct and consequential incentive for compliance and uniformity than can the actuarial opinion requirements of AG 48. While some may question the need to make Model #787 an accreditation standard in light of the existence of AG 48, we would note that the intent of the accreditation program is to ensure uniformity among accredited jurisdictions with respect to solvency regulation. That uniformity can be best achieved by making Model #787 an accreditation standard, thereby ensuring uniform consequences and enforcement with respect to this aspect of the XXX/AXXX Reinsurance Framework. Moreover, it was recognized from the beginning that utilizing an actuarial opinion requirement as a tool for enforcement of the NAIC’s XXX/AXXX Reinsurance Framework puts the actuarial opinion requirement to a novel use going beyond what is ordinarily contemplated as the purpose of the Actuarial Opinion and Memorandum Regulation.

For these reasons, the NAIC has always described AG 48 as the interim method to implement its XXX/AXXX Reinsurance Framework, and the credit for reinsurance changes set forth in
Model #787 as the permanent implementation method. This is also reflected in the fact that AG 48 itself includes sunset provisions to apply in individual states as they adopt Model #787.

There is no longer any reason for delay in the NAIC’s action to make Model #787 an accreditation requirement. We again urge that the F Committee take this up and move forward in parallel with the Covered Agreement changes to Models #785 and #786. Doing so will allow the NAIC to finally complete the important work of uniformly implementing its XXX/AXXX Reinsurance Framework.

We appreciate the opportunity to comment on this important topic. Please let us know if you need any additional information or would like to discuss our comments.

Sincerely,

Douglas A. Wheeler  
Senior Vice President, Office of Governmental Affairs  
New York Life Insurance Company

Andrew T. Vedder  
Vice President – Solvency Policy & Risk Management  
The Northwestern Mutual Life Insurance Company
The International Insurance Relations (G) Committee met in Austin, TX, Dec. 7, 2019. The following Committee members participated: Gary Anderson, Chair (MA); Andrew Stolfi, Vice Chair (OR); Andrew N. Mais (CT); Stephen C. Taylor (DC); David Altmaier (FL); Colin M. Hayashida (HI); Doug Ommen (IA); James J. Donelon (LA); Anita G. Fox represented by Judy Weaver (MI); Chlora Lindley-Myers (MO); Bruce R. Ramge represented by Justin Schrader (NE); Marlene Caride (NJ); John G. Franchini represented by Robert Doucette (NM); Jillian Froment (OH); and Jessica Altman (PA).

1. **Adopted its Nov. 6, Oct. 15, Aug. 13 and Summer National Meeting Minutes**

The Committee met Nov. 6, Oct. 15, Aug. 13 and Aug. 3 and took the following action: 1) heard an update on upcoming International Association of Insurance Supervisors (IAIS) committee meetings; 2) approved submission of NAIC comments on the IAIS draft *Issues Paper on the Use of Big Data Analytics in Insurance*; 3) heard updates on IAIS activities and the Financial Sector Assessment Program (FSAP); 4) approved submission of NAIC comments on IAIS revised supervisory material and material related to the *Holistic Framework for Systemic Risk in the Insurance Sector*; 5) adopted the report of the ComFrame Development and Analysis (G) Working Group; and 6) discussed IAIS key 2019 projects with interested parties.

Commissioner Anderson noted that the Committee also met Nov. 19, Oct. 29 and Sept. 30 in regulator-to-regulator sessions, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss key agenda items before and after the IAIS committee meetings and the International Monetary Fund (IMF) FSAP.

Commissioner Stolfi made a motion, seconded by Commissioner Caride, to adopt the Committee’s Nov. 6 (Attachment One), Oct. 15 (Attachment Two), Aug. 13 (Attachment Three) and Aug. 3 (see *NAIC Proceedings – Summer 2019, International Insurance Relations (G) Committee*) minutes. The motion passed unanimously.

2. **Adopted the Report of the ComFrame Development and Analysis (G) Working Group**

Commissioner Anderson said the ComFrame Development and Analysis (G) Working Group met prior to the Committee meeting in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss next steps on implementation of the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) and the global insurance capital standard (ICS) and monitoring period process. He said that with the adoption of ComFrame, the Working Group has fulfilled its mandate and will be disbanded at the end of 2019.

However, Commissioner Anderson said that as work related to ComFrame and the ICS is moving into a new phase, relevant charges have been added to working groups reporting to the Financial Condition (E) Committee. He noted that the Group Solvency Issues (E) Working Group’s 2020 proposed charges include: “[a]ssess the IAIS Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) and make recommendations on its implementation in a manner appropriate for the U.S.” He also noted that the Group Capital Calculation (E) Working Group’s 2020 proposed charges include: “[l]iaise, as necessary, with the International Insurance Relations (G) Committee on international group capital developments and consider input from participation of U.S. state insurance regulators in the International Association of Insurance Supervisors (IAIS) monitoring process.”

Additionally, Commissioner Anderson said, this Committee will continue to track and provide input, as appropriate, as ComFrame is implemented and the monitoring period moves forward.

Commissioner Mais made a motion, seconded by Commissioner Caride, to adopt the report of the ComFrame Development and Analysis (G) Working Group. The motion passed unanimously.

3. **Adopted its 2020 Proposed Charges**

Commissioner Anderson explained that the Committee’s 2020 proposed charges have some minor wording changes and some of the individual charges were reordered for a more logical flow. He said that as noted in the ComFrame Development and Analysis (G) Working Group report, this is the last year for the Working Group and it will be disbanded at the end of 2019.
Commissioner Anderson added that as ComFrame moves into the next phase, the necessary analysis and coordination by the states and the NAIC, as well as interaction with interested parties, will continue under the relevant groups reporting to the Financial Condition (E) Committee.

Commissioner Altmaier made a motion, seconded by Commissioner Stolfi, to adopt the Committee’s 2020 proposed charges (Attachment Four). The motion passed unanimously.

4. **Heard an Update on Key 2019 Projects of the IAIS**

Commissioner Anderson said the NAIC was very pleased to have former Commissioner Julie Mix McPeak (TN) receive the Distinguished Fellows Award from the IAIS in Abu Dhabi, United Arab Emirates, for her dedication and work at the IAIS, including serving on multiple committees and taking key leadership positions for a number of years. He congratulated Ms. McPeak on behalf of state insurance regulators and expressed appreciation for the time and leadership she provided at the international level during her time as commissioner.

Commissioner Anderson reported that at its committee meetings and annual general meeting in mid-November in Abu Dhabi, the IAIS reached key milestones on the effective cross-border supervision of insurance groups and contributing to global financial stability. He said these achievements were made possible by a shared commitment from the world’s insurance supervisors to the maintenance of fair, safe and stable insurance markets for the benefit and protection of policyholders. He said that overall, state insurance regulators are pleased with the outcomes of these meetings.

a. **ICPs and ComFrame**

Commissioner Anderson explained that in Abu Dhabi, the IAIS adopted a revised set of its Insurance Core Principles (ICPs) and ComFrame. Revisions to the ICPs has been a multi-year process, making updates to reflect input from self-assessment and peer reviews, developments in the market, and supervision, as well as to ensure consistency between the ICPs and ComFrame. He noted that ComFrame is the result of years of work, and it is intended to be a comprehensive and outcome-focused framework that provides supervisory minimum requirements tailored to the international activity and size of internationally active insurance groups (IAIGs).

Commissioner Anderson said that moving into 2020, IAIS members will begin the implementation of ComFrame. He said the NAIC’s Group Solvency Issues (E) Working Group will assess ComFrame and make recommendations on its implementation in a manner appropriate for the U.S. He said that during this initial phase of implementation, the IAIS will be providing supporting material to help members understand expectations set out by ComFrame. He commented that there have been comments submitted previously by interested parties during the development of ComFrame related to possible deviations from U.S. regulations, and he noted that there will be careful and due deliberation to ensure that the implementation of ComFrame in the U.S. is compatible with our regulatory system. He added that it will be important to have ongoing engagement with interested parties to understand any specific concerns and address them accordingly.

Commissioner Anderson said that as part of its 2020–2024 strategic plan, the IAIS plans to focus on developing supporting material for its members more broadly, which will include issues and application papers on a variety topics. He added that the IAIS will also be continuing with its implementation assessment activities through peer reviews of ICPs on a thematic basis.

Stephen Broadie (American Property Casualty Insurance Association—APCIA) commented that the APCIA appreciates the final outcomes on ComFrame, especially with regard to the overarching principles, which include recognizing that IAIGs can be organized in different manners, as long as the objectives of ComFrame are ultimately achieved. He also agreed that any regulatory changes made in the U.S. to implement ComFrame should be consistent with the U.S. regulatory framework.

b. **Holistic Framework for Systemic Risk in the Insurance Sector**

Commissioner Anderson said the IAIS adopted the holistic framework for the assessment and mitigation of systemic risk in the insurance sector. He said this new framework moves away from a solely entities-based approach and instead recognizes that systemic risk can arise both from sector-wide trends with regard to specific activities and exposures, as well as from a concentration of these activities and exposures in individual insurers. He explained that the holistic framework consists of: 1) an enhanced set of supervisory policy measures and powers of intervention; 2) an annual IAIS global monitoring exercise; and 3) a robust implementation assessment.
With regard to the global monitoring exercise, Commissioner Anderson said the IAIS will undertake an annual process to assess insurance market trends and developments and determine any potential build-up of systemic risk in the global insurance sector. He said this will include an assessment of potential systemic risk arising from sector-wide trends with regard to specific activities and exposures, which will leverage and build upon existing IAIS work, such as the Global Insurance Market Report. He said this will also assess the possible concentration of systemic risks at an individual insurer level arising from these activities and exposures using an updated version of the former global systemically important insurer (G-SII) assessment methodology.

Commissioner Anderson said the global monitoring exercise will also see a collective discussion by the IAIS on the assessment of potential systemic risk in the global insurance sector, at both a sector-wide and individual insurer level, and appropriate supervisory responses to systemic risk if it arises. He noted that the IAIS will share the outcomes of the global monitoring exercise each year with participants in the global monitoring exercise (participating insurers as well as participating IAIS members), other IAIS members, the Financial Stability Board (FSB) and the general public.

Commissioner Anderson explained that another key element of the holistic framework is the IAIS’s implementation assessment of related supervisory material. He said this approach builds on existing methodology for assessing the implementation of ICPs and ComFrame, while considering the specific nature of the holistic framework as a subset of the ICP and ComFrame material that is relevant to the assessment and mitigation of systemic risk. He said the assessments will proceed in phases, beginning with a baseline assessment in 2020 and moving towards more intensive jurisdictional assessments in 2021, which will include targeted in-depth verification of supervisory practices. He noted that the IAIS will share the outcomes of the holistic framework implementation assessments with the FSB and the general public.

Commissioner Anderson said the implementation of the holistic framework is expected to provide an enhanced basis for assessing and mitigating systemic risk in the insurance sector and therefore eliminate the need for identification of insurers as G-SIIs. He said the FSB will determine whether to discontinue G-SII identification in November 2022 based on the initial years of implementation of the holistic framework.

Commissioner Anderson noted that as implementation gets underway, state insurance regulators will be mindful of the appropriate role for the IAIS, as there have been concerns expressed about the role of the IAIS and it taking on regulatory-like powers.

c. ICS and Monitoring Period

Commissioner Anderson said the IAIS agreed on version 2.0 of the ICS for a five-year monitoring period, starting in January 2020. He said that during the monitoring period, ICS Version 2.0 will be used for confidential reporting and discussion in supervisory colleges to provide feedback to the IAIS on the ICS design and performance. He said that at the same time, the IAIS agreed on a definition of comparable outcomes and an overarching approach and timeline for the development of criteria to assess whether the aggregation method (AM) being developed by the U.S. and other interested jurisdictions, provides comparable outcomes to the ICS.

Commissioner Anderson noted that going into these meetings, there was a lot of attention domestically on the ICS, including significant time dedicated by this Committee. He said an agreement was secured that advances critical U.S. objectives as part of the IAIS debate on the next phase of the ICS project. He added that state insurance regulator support came about after the IAIS agreed to an achievable definition and approach to the assessment of comparable outcomes, providing a clear path forward for the AM. He said other objectives that were met include having timelines and governance for operationalizing the monitoring period, a commitment to consider modifications to the ICS itself, and conducting an economic impact assessment.

Commissioner Anderson said members of Team USA have been clear that this pathway ensures that the AM, as one part of a comprehensive U.S. regulatory framework, will be viewed through outcomes that it provides and not simply a quantitative lens. He said that while state insurance regulators will not be implementing the ICS, they will remain committed to an approach to group capital analysis, which can and should be viewed as comparable to the outcomes achieved by the ICS.

Commissioner Anderson noted that the IAIS posted a number of documents explaining various parts of the monitoring period. He said this includes a document that sets out the overarching principles and concepts for the annual confidential reporting of the reference ICS and, at the option of group-wide supervisors (GWS), additional reporting during the five-year monitoring period. He said there is a note that explains some of the technical decisions that were made for the reference ICS, including ICS balance sheet, market-adjusted valuation (MAV), qualifying capital resources, and margin-over-current-estimate (MOCE).
Commissioner Anderson said that as state insurance regulators have had concerns over the development phase of the ICS on some of these technical points, they will continue to see how these perform during the monitoring period and to what extent improvements and changes are merited.

Commissioner Anderson said materials have also been posted that explain the definition of comparable outcomes and the overall approach to the comparability assessment, as well as the governance and timeline planned for this work. He explained that the agreed upon definition reads, “[c]omparable outcomes to the ICS means that the Aggregation Method (AM) would produce similar, but not necessarily identical, results over time that trigger supervisory action on group capital adequacy grounds.” He said agreement on the definition also included an approach for developing high-level principles and criteria for the comparability assessment, which will be subject to further discussion over the monitoring period and will help make an informed process to develop and perform the comparability assessment of the AM, an important workstream for next year.

Commissioner Anderson said that in addition to comparability, the workplan for the monitoring period also addresses how things like the generally accepted accounting principles plus (GAAP+) valuation approach and the use of internal models will be assessed and whether they are ultimately included as part of the ICS. He also said the IAIS plans to perform an economic impact assessment, which state insurance regulators think will help inform the version of the ICS that is to be used as a prescribed capital requirement (PCR).

Commissioner Anderson noted that it will be important to develop a timeline for engagement with interested parties to help inform state insurance regulators and be best positioned to advocate at the IAIS for goals relative to comparability. The IAIS plans to issue a consultation in early July 2020 on the high-level principles to be used for the comparability assessment. These high-level principles could build upon the NAIC’s interpretative guidance issued while in Abu Dhabi, which was intended to provide context and details about the interpretation of the agreement, outlining what was included, but just as important, what was not included.

Marty Hansen (American International Group—AIG) commended the NAIC for a successful negotiation in Abu Dhabi. He noted that the way forward on the reference ICS has been substantially changed to reflect U.S. practices, including senior debt and NAIC designations for credit risk. He commented that this would also provide the necessary breathing room for the NAIC’s group capital calculation (GCC) to be developed without an artificial IAIS deadline on the AM. He said there are some concrete steps on the definition of comparable outcomes and an overarching approach to guide the development of high-level principles and criteria for assessing comparability. He suggested that a precondition for comparability will be a credible and implementable GCC, and he encouraged the NAIC to continue to maintain this positive momentum and keep moving forward.

Ian Adamczyk (Prudential) thanked the NAIC for the successful outcome achieved in Abu Dhabi with regard to the positioning of the AM and the future development of high-level principles and criteria for the comparability assessment. He noted that the additional parameters surrounding governance for the AM, economic impact analysis, and ongoing stakeholder engagement during the monitoring period are all positive outcomes.

Joe Engelhard (MetLife) noted that in 2019, the IAIS delivered the largest set of standard setting material in decades. He commented that going into the Abu Dhabi meeting, industry had three main goals for the ICS, and all three were achieved. He complimented Team USA for successfully changing the direction of the IAIS to be more positive than the previous position on the ICS. He suggested that the IAIS should consider broader public policy goals as the ICS is further refined and ensure alignment with the G20 themes of sustainable growth and the role of long-term investment. He also commented that attention should be given by IAIS members to implementing the holistic framework to ensure its credibility and effectiveness. He commended the NAIC for being ahead of the game with regard to its work on macroprudential supervision.

Robert Neill (American Council of Life Insurers—ACLI) thanked the NAIC for all the hard work that went into the final outcomes in Abu Dhabi, which met the ACLI’s stated objectives from earlier in the year. He also appreciated that the NAIC had conducted outreach to ACLI members in advance of bilateral dialogues and meetings with other jurisdictions.

Mariana Gomez-Vock (ACLI) sought clarification on the relationship between the GCC, AM and supervisory intervention. She also sought additional clarity on the transparency principles embedded within the comparability assessment approach.

Commissioner Altmaier said the AM is an aggregation-based framework being developed internationally in conjunction with other jurisdictions. He said that while the AM is influenced by work on the GCC, the AM will be more jurisdictionally agnostic, and, therefore, perhaps simpler than the GCC. He said the ultimate intention is to have the GCC serve domestically as implementation of an AM approach. He added that there are still a number of unknowns, including final design of the AM and GCC, recognition of the AM as comparable, the ultimate fate of the ICS project, and how any prescribed capital requirement
(PCR) will be implemented and evaluated in international active insurance group (IAIG) jurisdictions. He noted that there will be ongoing engagement with stakeholders as state insurance regulators get clarity on these outstanding issues.

Tracey Laws (Chubb) commented on the positive outcomes from Abu Dhabi and noted that the additional clarity shared by the IAIS about the voluntary nature of participation in ICS field testing was quite helpful. She raised the issue of the relationship between a PCR for IAIGs and non-IAIGs and the potential for creating a competitive disadvantage for IAIGs.

Tom Finnell (America's Health Insurance Plans—AHIP) reiterated earlier comments made about the good outcomes from the Abu Dhabi meetings. He sought clarification about certain elements regarding comparability and whether the IAIS will compare the GCC to the ICS or if it will compare the AM to the ICS, which would be jurisdictionally agnostic.

Commissioner Anderson replied that it would be a comparison of the AM to the ICS.

Commissioner Anderson thanked the speakers for their comments and views, and he noted that these topics are important workstreams that the NAIC will continue discussing throughout the monitoring period.

5. **Heard an Update on International Activities**

   a. **Regional Supervisory Cooperation**

   Regarding Asia, Commissioner Mais said the NAIC hosted the 11th NAIC-Financial Services Agency, Japan (JFSA) Insurance Regulatory Dialogue in Washington, DC, in October. He said the biannual dialogue brings together regulators from two of the world’s largest insurance markets, representing more than 47% of worldwide premium income. He noted that the meeting allowed regulators an opportunity to discuss regulatory issues of mutual concern, including Japan’s desire to become a reciprocal jurisdiction under the revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) and key issues at the IAIS, including the ICS and holistic framework. He said the 12th Dialogue will be hosted in Japan in the first half of 2020, where these ongoing discussions will continue.

   Regarding Europe, Commissioner Mais said the U.S.-EU Insurance Dialogue Project is continuing its work on cyberinsurance, cybersecurity, and big data with a public event expected to take place in March in Washington, DC. He thanked Commissioner Ommen and Director Froment for serving as the NAIC’s Steering Committee members for the project. He said that state insurance regulators and the NAIC continue to meet directly with counterparts at the European Insurance and Occupational Pensions Authority (EIOPA) and the European Commission on a regular basis throughout the year on matters of mutual regulatory concern, including IAIS issues such as ICS developments, developments relating to innovation and technology, and revisions to Model #785 and Model #786.

   Regarding Latin America, Commissioner Mais said state insurance regulators have been working closely with the Association of Latin American Supervisors (ASSAL) as part of the NAIC’s efforts to share best practices with other supervisors and enhance regulatory cooperation to help with the supervision of international insurance groups. He said that in October, the NAIC participated in ASSAL’s regional seminar for insurance supervisors of Latin America in San Jose, Costa Rica. He said he and Director Cameron spoke on various topics throughout the two-day meeting, including insurtech, conduct of business, and corporate governance. Commissioner Mais said that in late April, the NAIC will participate in the ASSAL’s Annual Meeting in Lima, Peru.

   Commissioner Mais said one of the NAIC’s most successful capacity building projects is the International Fellows Program, which is in its 15th year. He said that since the program started in 2004, more than 300 fellows from 35 countries have participated in this program designed to advance working relations with foreign markets, emphasizing the exchange of regulatory techniques and technology. He noted that for the fall 2019 session, the NAIC welcomed 11 international regulators from Bermuda, India, Kenya, Saudi Arabia, Taiwan, Thailand and Tunisia. He thanked the host states for this session, which included: Arkansas; California; District of Columbia; Louisiana; Missouri; New York; Oregon; Texas; and Washington. He said the NAIC is always interested in having more states host fellows, an experience that is valuable not only for fellows but also for host states.

   b. **Organisation for Economic Co-operation and Development (OECD)**

   Commissioner Mais noted that the OECD’s Insurance and Private Pensions Committee (IPPC) met earlier in the week in Paris, France, hosting a half-day roundtable on digitalization of insurance intermediation and regulatory responses. He said that during the meeting, there were updates on: 1) a revised report on the regulatory and supervisory framework of insurance intermediaries and market conduct; 2) a report on big data and artificial intelligence (AI) in the insurance sector; 3) draft revised guidance on
the structure of insurance regulation and supervision; 4) a project proposal on the interaction between public and private sectors in long-term and health care; 5) a policy framework for accessing international property catastrophe reinsurance markets; 6) a project proposal on assessing the integration of environmental, social, and governance (ESG) factors by institutional investors; and 7) a draft report on the impact of public policy and regulation on cyberinsurance coverage.

6. **Heard an Update on the FSAP**

Mr. Schrader explained that as previously reported to the Committee, the IMF is conducting its third FSAP of the U.S. financial regulatory system in 2019–20. He said the FSAP is comprised of Mission 1 and Mission 2, with much of the insurance-related work concentrated in Mission 1 and additional work happening during Mission 2 in early 2020. He noted that meetings for Mission 1 took place this fall and concluded Nov. 8 with a closing meeting hosted by the U.S. Department of the Treasury (Treasury).

Mr. Schrader said the NAIC and several states participated in a number of these meetings with IMF staff, and he added that the IMF also conducted meetings with the private sector. He said that since the last FSAP of the U.S. in 2015, state insurance regulators and the NAIC have further enhanced the U.S. state-based system, and Mission 1 included many good, in-depth discussions with the IMF on these regulatory developments. He said Mission 2 is scheduled for mid-February to early March with meetings expected at the NAIC and several states. He said the IMF is expected to publish a technical note on insurance by the summer of 2020.

Mr. Schrader added that as with previous FSAPs, it is expected that there will be areas where state insurance regulators will continue to disagree with the IMF’s approach and recommendations, as well as areas where state insurance regulators can hopefully provide constructive feedback relating to any inaccuracies or particular characterizations of the U.S. system in the document before it is published. He also thanked participating states for the time they took to meet with the IMF on the U.S. state-based system of insurance regulation and NAIC staff for their many contributions to the work so far.

7. **Discussed Other Matters**

Commissioner Anderson said the IAIS recently released its draft *Application Paper on Liquidity Risk Management* for public consultation, with a comment deadline of Jan. 20, 2020. He said this paper is intended to provide guidance on the supervisory material related to liquidity risk management in the relevant ICP and ComFrame material. He said the usual NAIC review process will take place for this paper, noting that a Committee call will be held in mid-January 2020 to approve submission of any NAIC comments.

Commissioner Anderson noted that a question-and-answer session with the IAIS secretariat would begin immediately following this Committee meeting.

Ryan Workman (NAIC) noted that the international calendars for 2019 and 2020 have been posted to the website.

Having no further business, the International Insurance Relations (G) Committee adjourned.
1. Heard an Update on Upcoming IAIS meetings

Commissioner Anderson said a number of commissioners and NAIC staff would be attending the upcoming International Association of Insurance Supervisors (IAIS) committee meetings, general meeting, and annual conference in Abu Dhabi where some important projects involving years of work by IAIS members and stakeholders would be finalized.

Commissioner Anderson noted that the holistic framework for systemic risk would be adopted. He said that following the financial crisis, the IAIS, in conjunction with the Financial Stability Board (FSB), established a methodology for analyzing and identifying global systemically important insurers (G-SIIs) and accompanying policy measures. He explained that the shortcomings of this solely entities-based approach for the insurance sector soon became evident, and the IAIS began looking at an activities-based approach, resulting in the development of the holistic framework, which takes a broader look at how systemic risk may arise in the insurance sector—whether from an individual insurer or a number of insurers undertaking a certain activity—and a broader approach to how such risks can be monitored and mitigated by supervisors. He said the holistic framework consists of: 1) new supervisory material contained within the Insurance Core Principles (ICPs) and the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame); 2) a global monitoring exercise that leverages and enhances existing IAIS work individual insurer monitoring and sector-wide monitoring; and 3) an implementation assessment component. He added that it is expected that there will be discussion in Abu Dhabi about some of the more detailed processes within the holistic framework, in particular as they relate to the global monitoring exercise; but in general, state insurance regulators are supportive of the holistic framework, and they believe it will show that a G-SII list is no longer needed for the insurance sector.

Stephen Broadie (American Property Casualty Insurance Association—APCIA) asked if revisions to the holistic framework document will be published before adoption or shortly thereafter so stakeholders are able to see the final product. Ryan Workman (NAIC) said a list of comments received from the public consultation will likely be published and a public call will be scheduled on the holistic framework after the annual conference. He also said a forthcoming document will explain how the holistic framework fits with relevant parts of ComFrame and the ICPs.

Commissioner Anderson said adoption of the revised ICP Introduction and Assessment Methodology, IAIS glossary terms, and revised versions of a number of ICPs is the result of a multi-year process to ensure that the ICPs are understandable, applicable and implementable by IAIS members. He said ComFrame has evolved over the years through a number of consultations and field-testing processes, with the end result being standards and guidance that are tailored for the supervision of internationally active insurance groups (IAIGs). He said that to avoid overlap and provide better context, ComFrame was integrated into the ICPs for presentation purposes, which resulted in a need to ensure consistency and coherency between the two. Commissioner Anderson explained that following adoption of the revised ICPs and ComFrame, IAIS members will begin the process of implementation with the expectation that the IAIS’s core supervisory material will remain stable for a number of years.

Commissioner Anderson said the global insurance capital standard (ICS) and comparability of the aggregation method (AM) have attracted significant attention over the course of 2019 and decisions in Abu Dhabi would affect the next five years over the monitoring period. He said state insurance regulators have been clear about ongoing concerns over some of the outstanding design issues of the reference ICS, which as a result make the ICS not fit for purpose for the U.S. supervisory system or the U.S. insurance market. He said state insurance regulators are in the process of developing the AM to provide comparable outcomes to the ICS.
Commissioner Anderson explained that while the ICS will eventually become part of ComFrame, what will be approved in Abu Dhabi is separate from adoption of the ComFrame material, as ICS version 2.0 will still be subject to further development during the monitoring period. Regarding ICS materials to be adopted in Abu Dhabi, he said this would include the final technical design of the reference ICS version 2.0 for the monitoring period, a definition of comparable outcomes and overarching approach to guide development of the assessment process, and a broader workplan and timeline for entire monitoring period, and a public communication on operationalizing the monitoring period.

Commissioner Anderson said that finalizing the reference ICS and coming up with a definition of comparable outcomes and accompanying overarching guidelines for the comparability assessment process has proven to be a challenge, as IAIS members have different philosophies on group capital, which influences their approach on how technical issues and issues of comparability should be viewed and determined. He noted that at an October stakeholder event hosted by the Federal Insurance Office (FIO), Team USA shared how it envisioned a definition of comparable outcomes. He said that following the event, the IAIS had calls and meetings to discuss comparability, along with the technical design issues and how the monitoring period will operate. He said that following the recent ICS Task Force meetings in London to discuss comparability, there are still some sticking points with differences of view and interpretation. He said state insurance regulators hope to have these successfully resolved in Abu Dhabi so that there is an achievable definition of comparable outcomes and a clear path forward on the AM.

Commissioner Anderson said state insurance regulators are aware that there are a number of questions as to how to proceed if an agreement on comparability is not reached in Abu Dhabi. He said that there are a variety of moving parts to this issue and different ways they could play out. He said state insurance regulators are trying to be as productive as possible with international colleagues to find a way forward; however, the NAIC and state insurance regulators will not move forward in a way that is contrary to our interests. He also said if there is not an agreement, it does not mean that the NAIC and state insurance regulators will disengage from the ICS project or the IAIS more broadly.

Michelle M. Rogers (National Association of Mutual Insurance Companies—NAMIC) asked if other IAIS members have raised concerns about the current ICS draft and whether other members might oppose approval of ICS version 2.0. Commissioner Anderson responded that there have been some concerns raised by other jurisdictions.

Ms. Rogers asked for elaboration on the sticking points on comparable outcomes. Commissioner Anderson said these are subject to internal discussions within the IAIS but reiterate that state insurance regulators will not agree to a deal that could be detrimental to the U.S. market.

Bryan Pickel (Prudential Financial) said the AM can provide comparable outcomes to the ICS, as defined by the Kuala Lumpur agreement. He said it should be contemplated what a “no” vote on the ICS might mean in a larger context, especially for larger companies that do business internationally. Commissioner Anderson responded that if the U.S. agrees to a deal, it will need to meet the NAIC’s objectives and be a good deal for the U.S. market, and state insurance regulators will be mindful of the consequences of any outcome in Abu Dhabi.

Birny Birnbaum (Center for Economic Justice—CEJ) noted that comparability could be considered in terms of outcomes of what the different models produce and comparability that triggers supervisory action. He asked for clarity about the Team USA position on what constitutes comparability. Commissioner Anderson said that Team USA has focused on outcomes for supervisory intervention, with a clear path for the AM to be deemed comparable. Mr. Birnbaum said a standard for supervisory action could be subjective, and he asked for further insight. Commissioner Anderson responded that since the ICS and AM are built differently, the two approaches will not produce the exact same numbers, thus the focus on the action that the results produce, not the result itself.

Joe Engelhard (MetLife) said he understands that the ICS market-adjusted valuation (MAV) approach will not be implemented in the U.S., but he noted that for comparability, MAV and the AM will not come up with the same ratio since they are different approaches. Instead, he said the metric should be whether the solvency ratio accurately reflects assets and liabilities. He also noted that the NAIC can likely demonstrate that risk-based capital (RBC) ratios do appropriately reflect the time needed to intervene with an insurer, and therefore the level of risk of the underlying assets and liabilities. He added that on the other hand, MAV is procyclical, potentially overstating or understating risk.

Mr. Birnbaum said that while the position of the industry regarding ICS is not unreasonable, he believed Team USA’s position would likely not change during the monitoring period. He said that Team USA is asking other IAIS members to accept the AM as functionally equivalent regardless of outcomes during the monitoring period. Commissioner Anderson disagreed with that.
characterization and said the monitoring period does matter to demonstrate comparable outcomes, noting that Team USA does not expect the IAIS to give the AM a free pass.

Mr. Broadie asked whether U.S.-based IAIGs will be required to participate in the field testing of MAV during the ICS monitoring period. Commissioner Anderson responded that based on the positions of the group-wide supervisors of U.S.-based IAIGs, the U.S. will not go forward with something contrary to its interests.

DiAnn C. Behrens (Allstate) asked for clarification regarding the intended relationship of the NAIC’s group capital calculation (GCC) under development to the AM. She asked which one will be used in the U.S. or internationally and how they relate to the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement). She also asked how these approaches compare to the ICS. Commissioner Anderson responded that these points will continue to be discussed as the work moves forward, and he noted that the Group Capital Calculation (E) Working Group and NAIC leadership will be part of these discussions as well.

Andrew T. Vedder (Northwestern Mutual) asked about Team USA’s continued efforts during the monitoring period to improve design elements of the reference ICS. He said that it is important for non-IAIG insurers to see improvements in the reference ICS. Commissioner Anderson said there would be continued engagement by Team USA regarding design elements, no matter the outcome of Abu Dhabi.

Patrick C. Reeder (American Council of Life Insurers—ACLI) asked if Team USA plans to stay engaged during the ICS monitoring period, regardless of the vote in Abu Dhabi. Commissioner Anderson said regardless of the vote, Team USA will continue working with IAIS colleagues to address deficiencies in the ICS. He noted that the NAIC approach to member engagement on topics on which there are different views serves as a good model.

Tom Leonardi (AIG) asked if it would be difficult to demonstrate comparability of the AM if not all U.S.-based IAIGs provide reference ICS data during the monitoring period. Commissioner Anderson responded that the data to be provided should be sufficient for demonstrating comparability and that there has been engagement with the relevant group-wide supervisors on regarding participation during the monitoring period.

Mr. Reeder said that after Abu Dhabi, whatever the outcome, the ACLI’s members will need to understand how to budget and allocate resources for GCC development, as well as the monitoring period. Commissioner Anderson responded that these points will be taken into account.

Commissioner Anderson noted that the Committee will meet Dec. 7 at the Fall National Meeting.

Having no further business, the International Insurance Relations (G) Committee adjourned.
The International Insurance Relations (G) Committee met via conference call Oct. 15, 2019. The following Committee members participated: Gary Anderson, Chair (MA); Andrew Stolfi, Vice Chair (OR); Andrew N. Mais represented by John Loughran (CT); David Altmaier (FL); Doug Ommen represented by Carrie Mears (IA); James J. Donelon (LA); Anita G. Fox represented by John Rehagen (MO); Bruce R. Ramge (NE); Marlene Caride (NJ); John G. Franchini (NM); Jillian Froment (OH); and Jessica Altman (PA).

1. **Approved Submission of NAIC Comments on IAIS Draft Issues Paper on the Use of Big Data Analytics in Insurance**

Commissioner Anderson said the International Association of Insurance Supervisors (IAIS) draft *Issues Paper on the Use of Big Data Analytics in Insurance*, which is currently out for public consultation, builds on a previous IAIS issues paper and focuses more specifically on issues regarding the use of personal and other data by insurers as a result of digitalization. He said the paper considers the manner in which insurers are able to collect, process and use data across various stages of the insurance product lifecycle, namely product design, marketing, sales and distribution, pricing and underwriting, and claims handling. He said the paper also makes certain observations about the potential implications for supervisors as a result of the use of big data analytics in insurance.

Commissioner Anderson said that per the usual process, the paper was reviewed internally, which resulted in the initial draft NAIC comments that were circulated in advance of the conference call. He said input for consideration by the Committee was received from the American Property Casualty Insurance Association (APCIA) (Attachment Two-A).

Ryan Workman (NAIC) provided an overview of the draft NAIC comments.

David F. Snyder (APCIA) provided support for the NAIC draft comments, and he said the APCIA would be submitting its own comments.

Birny Birnbaum (Center for Economic Justice—CEJ) said the CEJ disagrees with the APCIA comments, and it believes that the IAIS paper is not intended to provide regulatory practice or guidance; instead, it features extensive discussion on benefits and concerns related to the use of big data. He said that while the CEJ has suggestions to improve the paper, it believes that it is balanced.

Taylor Walker (American Council of Life Insurers—ACLI) agreed with the APCIA comments and noted that the ACLI will be submitting its own comments. She said the ACLI believes the issues paper should focus more on consumer benefits for big data and emphasize that concerns around big data are not new to the insurance industry. She said that while technology and techniques have evolved, commitment to the law and actuarial standards have not changed.

Commissioner Caride made a motion, seconded by Commissioner Donelon, to approve submission of the NAIC comments (Attachment Two-B). The motion passed unanimously.

Commissioner Anderson said the NAIC comments on the draft issues paper would be submitted in advance of the Oct. 16 deadline, and he urged interested parties to submit comments, as well.

2. **Heard an Update on IAIS Activities**

Commissioner Anderson reported that in November, the IAIS will have three days of committee meetings followed by its general meeting and annual conference. He said finalization of a number of long-term projects at the IAIS is expected, including revisions of several Insurance Core Principles (ICPs), the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame), the global insurance capital standard (ICS) for the monitoring period, and the Holistic Framework for Systemic Risk in the Insurance Sector. He said that while this phase of revising existing and developing new supervisory material is coming to a close, an important phase of implementation begins, and discussions in November will be laying out related plans.
Commissioner Anderson said during the week of Oct. 21, the IAIS ICS Task Force and the Executive Committee will be meeting in London, mostly to focus on reaching agreement on outstanding design issues on the ICS version 2.0 for the monitoring period and comparability of the aggregation method (AM).

Commissioner Anderson noted that the U.S. Chamber of Commerce recently released a report on the ICS and AM.

Bill Hulse (U.S. Chamber of Commerce) shared highlights of this report, noting that it aims to build an argument for why the AM is a credible approach to group capital. He gave an overview of the report’s main sections, which covers how a market-adjusted valuation approach to capital could affect product availability, competition, global competitiveness, and capital markets in the U.S., as well as the merits of the AM. He said the report also discusses market implications of adopting the reference ICS, as adoption in other jurisdictions could make the ICS the de facto international standard even with the U.S. taking the AM approach.

Commissioner Anderson said that in early October, the Federal Insurance Office (FIO) hosted a stakeholder session on the ICS during which views of Team USA were presented, including a strawman proposal for a definition of comparable outcomes. He said that in state insurance regulators’ view, the outcome should focus on group capital approaches, signaling the need for supervisory intervention. He said that based on input from that meeting, Team USA made some tweaks to help clarify the proposal submitted to the IAIS.

Commissioner Anderson noted that other IAIS members were invited to provide their thoughts on defining comparable outcomes, and he said the IAIS Secretariat will attempt to bridge the gap between the various proposals for discussion at the meetings in London. He noted the difficulty of coming up with a meaningful, high-level definition that avoids being criteria itself or suggesting that the only way to have comparable outcomes to the ICS is to adopt the ICS. He said state insurance regulators hope that the meeting reaches an agreed-upon, achievable definition of comparable outcomes and overarching guidelines that will govern the IAIS’s overall comparability assessment process for the AM.

Mariana Gomez-Vock (ACLI) said that while the ACLI supports the Team USA goal of having the AM recognized as comparable, it has some concerns with the strawman definition. She said the ACLI sent a letter outlining these concerns, and it asked if these concerns have been addressed.

Commissioner Anderson said stakeholder comments were taken into consideration in preparation for London, and he said the ACLI comments were similar to those from others at the FIO stakeholder session.

Ms. Gomez-Vock asked if the goal of the ICS Task Force meeting in London is to finalize the definition of comparable outcomes, or if a draft will come out of the meeting and feedback will be sought from stakeholders.

Commissioner Anderson said discussions will likely continue following the London meeting, though the expectation is to come away from London with an achievable definition of comparable outcomes. He said the Committee would reengage with interested parties following the meetings in London.

Tracey Laws (Chubb) asked what form such reengagement will take and whether it will be an open Committee conference call. Commissioner Anderson responded that no specific plans had been made yet.

Tom Finnell (Finnell & Co. LLC) asked if stakeholders can see the strawman definition for ICS comparability submitted by Team USA. Commissioner Anderson responded that given the status of the discussions within the IAIS, it could not be shared, but it was in line with what was discussed at the FIO stakeholder session.

Michael F. Consedine (NAIC, Chief Executive Officer) said he appreciates stakeholders’ interest in the submission, although discussions on a definition are still fluid. He noted that Team USA is unified going into the London meetings and, with a number of strawman proposals to be discussed in London, the definition is still a moving target.

Brad Smith (ACLI) asked about the Committee’s expected process for coordinating with interested parties after London or in preparation for London, and he asked about engagement of the Financial Stability Board (FSB) on the outcome at the IAIS discussions on the ICS. Commissioner Anderson said cooperation amongst Team USA will continue, and engagement with interested parties will be similar to other Committee work.
Mr. Consedine noted that FSB engagement at this stage is unlikely, though it will continue to monitor relevant developments at the IAIS as it currently does.

Ms. Gomez-Vock (ACLI) asked for clarification regarding whether the NAIC is contemplating adopting the AM with specific supervisory intervention points and whether this would be a workstream of the Committee or the Group Capital Calculation (E) Working Group.

Commissioner Anderson responded that discussion on supervisory intervention points as part of the group capital calculation (GCC) is premature at this point.

Mr. Workman said the ComFrame Development (G) Working Group will be disbanded in 2020 and that the Group Capital Calculation (E) Working Group will look at ComFrame implementation more broadly.

3. Heard an Update on the FSAP

Commissioner Anderson said the International Monetary Fund (IMF) is conducting its third Financial Sector Assessment Program (FSAP) for the U.S. in 2019 and 2020. He said that as with the last two FSAPs, the U.S. Department of the Treasury (Treasury Department) Office of Financial Markets is coordinating this FSAP for participating U.S. agencies.

Commissioner Anderson noted that the FSAP is comprised of Mission 1 and Mission 2, with much of the work for the FSAP exercise for insurance concentrated in Mission 1 and additional work happening during Mission 2 in early 2020. He said the opening meeting for Mission 1 took place earlier in the day. He explained that the NAIC and several states will be participating in a number of meetings with the IMF over the coming weeks, ending with a closing meeting on Nov. 8. He noted that several interested parties were likely also contacted about private sector meetings with the IMF.

Commissioner Anderson said the IMF is expected to publish a technical note on insurance by the summer of 2020. He noted that since the last FSAP of the U.S. in 2015, state insurance regulators and the NAIC have further enhanced the state-based system of insurance regulation, and they look forward to further in-depth discussions on these regulatory developments with the IMF in the coming weeks. He said the Committee and interested parties will continue to be informed of further developments relating to the FSAP as the process moves forward.

Stephen Broadie (APCIA) asked if the IMF would be focusing its assessment on those ICPs that are related to financial stability or have been recently revised. Commissioner Anderson replied that the IMF would be assessing the U.S. against a subsection of ICPs.

Gita Timmerman (NAIC) added that the IMF is trending to a more focused assessment rather than an assessment of all the ICPs.

Having no further business, the International Insurance Relations (G) Committee adjourned.
APCIA COMMENTS 
ON NAIC COMMENTS 
ON THE IAIS DRAFT ISSUES PAPER ON THE USE OF BIG DATA ANALYTICS

The NAIC’s work is appreciated and the NAIC’s proposed comments are straightforward and balanced. Here are several suggestions for consideration if the NAIC expands on its comments:

1. Contrary to the IAIS paper’s stated concern that more granularity in risk assessment leads to unavailability of coverage, increased granularity has often helped to promote more coverage availability. An example would be the decline in the U.S. auto residual market plan populations.

2. The IAIS paper does not need to provide more guidance or discussion on standards of “fairness” as “fairness” is determined by each jurisdiction’s laws, and existing regulatory standards are adequate to address Big Data Analytics.

3. We urge the NAIC to reject any request from interested parties that would cite to a single U.S. regulator’s action, that would elevate one U.S. regulator’s views over the majority view of others, or that would argue for acceptance of a standard of conduct that has not been enacted by the States.

4. The IAIS paper should discuss the benefit of companies engaging in an upfront dialogue with regulators when they plan to deploy a new model or use significant new data.

5. The IAIS paper should more fully demonstrate the value of Big Data Analytics in loss prevention and risk mitigation, including usage-based insurance, improved catastrophe models, and the greater ability to partner with policyholders.

6. The IAIS paper should be clearer that maintaining confidentiality and protecting intellectual property are critical to encouraging innovation and delivering its related benefits.

We appreciate this opportunity to comment. APCIA will be submitting its own comments to IAIS directly and through the Global Federation of Insurance Associations.

Sincerely,

David Snyder
Vice President, International Policy
APCIA
<table>
<thead>
<tr>
<th>Section/Paragraph</th>
<th>Comment</th>
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<tbody>
<tr>
<td>Para 5</td>
<td>As paragraph 4 states “this paper makes certain observations”, suggest the slightly awkward “the paper observers” could be deleted and the paragraph simply begin with: “For example, the increased availability…”</td>
</tr>
<tr>
<td>Para 6</td>
<td>Suggest the paragraph would read better without the “the paper” wording. Revise first sentence to “On the other hand, the complexity and opacity…” and last sentence to “Additionally, supervisors may consider whether there is a need…”</td>
</tr>
<tr>
<td>Footnote 2</td>
<td>Put quotes around the text of 19.12</td>
</tr>
<tr>
<td>Para 11</td>
<td>As benefits and risks may not arise in every use and there may be additional benefits and risks, suggest saying “…to identify potential benefits and risks for consumers…”</td>
</tr>
<tr>
<td>Para 19</td>
<td>Standard 19.12 should be quoted, not paraphrased or alternatively delete the last sentence and add a footnote to the previous sentence that directs the reader to footnote 2 which quotes 19.12</td>
</tr>
<tr>
<td>Box after para 79</td>
<td>As the last paragraph is a broader point that may be relevant beyond the UK example, suggest moving this sentence up to para 79: “…friction for the customer. However, a potential drawback…”</td>
</tr>
<tr>
<td>Footnote 38</td>
<td>Should be “22 March 2018”</td>
</tr>
<tr>
<td>Para 105</td>
<td>For better readability, suggest: “In most jurisdictions, the insurance supervisor is not responsible for privacy protection issues but rather a dedicated privacy protection authority; however, insurers and insurance supervisors…”</td>
</tr>
</tbody>
</table>
The International Insurance Relations (G) Committee met via conference call Aug. 13, 2019. The following Committee members participated: Gary Anderson, Chair (MA); Andrew Stolfi, Vice Chair (OR); Andrew N. Mais (CT); Stephen C. Taylor (DC); David Altmaier (FL); Colin M. Hayashida represented by Martha Im (HI); Doug Ommen (IA); James J. Donelon (LA); Anita G. Fox represented by Judy Weaver (MI); Chlora Lindley-Myers (MO); Bruce R. Ramge represented by Mitchell Higgins (NE); Marlene Caride (NJ); Jillian Froment (OH); and Jessica Altman (PA).

1. **Approved Submission of NAIC Comments on IAIS Revised Supervisory Material and Material Related to the Holistic Framework for Systemic Risk in the Insurance Sector**

Commissioner Anderson explained the purpose of the conference call is to discuss and approve submission of NAIC comments on draft revised International Association of Insurance Supervisors (IAIS) supervisory material and new material related to the *Holistic Framework for Systemic Risk*, which are currently out for public consultation. Commissioner Anderson said the IAIS is currently seeking feedback on supervisory material including: draft revised IAIS Glossary; draft Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) Assessment Methodology; changes in the Introduction to the Insurance Core Principles (ICPs) and ICP 7 (Corporate Governance) for consistency with ComFrame development; and draft revised ICP 22 (Anti-Money Laundering and Combatting the Financing of Terrorism). Commissioner Anderson noted the ComFrame-related material in the consultation document reflects revisions based on comments received during the 2018 public consultation on the overall ComFrame.

Commissioner Anderson said that per the usual NAIC process, the consultation material was reviewed internally, including by the: Antifraud (D) Task Force for ICP 22, ComFrame Development and Analysis (G) Working Group for the ComFrame material, and Financial Stability (EX) Task Force for the holistic framework material, which resulted in the initial draft NAIC comments that were circulated on July 25. He said the draft NAIC comments, which included two new comments, and input for consideration received from Northwestern Mutual (Attachment B) were also circulated in advance of the call.

Ryan Workman (NAIC) provided an overview of the draft NAIC comments, highlighting specific substantive comments across the material.

Commissioner Anderson noted that comments received from Northwestern Mutual focus on the holistic framework material and raise valid points. He said the NAIC plans to follow up on these comments as part of the internal IAIS review process.

Steven Simchak (American Property Casualty Insurance Association—APCIA) said substantial language was added to the holistic framework material in the consultation document that focuses on the size of insurance groups and such an emphasis on size is not constructive in moving toward an activities based approach to addressing potential systemic risk. Mr. Simchak commented the consultation document lacks clarity as to how, to whom, and under what circumstances these measures will be applied, which could be problematic during times of economic stress. He stated that in applying the principle of proportionality, it would be appropriate to be more specific about the lines of insurance and types of companies or business models for which liquidity and macroprudential effects have, or have not, been an issue. Mr. Simchak said it would be helpful for the final version of text to distinguish holistic framework material from the ICPs and ComFrame material given the different scopes of application.
David Snyder (APCIA) noted the APCIA is coordinating its comments with the Global Federal of Insurance Associations, which has similar concerns. He suggested the NAIC include in its submission a general comment on the importance of defining and using proportionality.

Robert Neill (American Council of Life Insurers—ACLI) supported the NAIC’s comment on the holistic framework material related to the Own Risk and Solvency Assessment (ORSA) being non-prescriptive and comments on stress testing. He noted that data collections conducted as part of the holistic framework should be reasonable and leverage existing data where possible.

Tom Finnell (APCIA) said the ComFrame material is unclear regarding which supervisory requirements necessitate direct versus indirect power. Mr. Workman responded that the IAIS has tried to better clarify the distinction for direct and indirect in both the ComFrame Introduction and the relevant ComFrame material.

Commissioner Mais made a motion, seconded by Commissioner Donelon, to approve submission of the NAIC comments (Attachment A). The motion passed.

Having no further business, the International Insurance Relations (G) Committee adjourned.
We have the following suggestions regarding holistic framework material.

1. **Clarify the priority of policyholder protection.** We agree that microprudential tools often support macroprudential objectives and vice versa. However, it is also possible that in a crisis an action proposed for a macroprudential purpose (to address perceived systemic risk) will conflict with microprudential objectives (policyholder protection). An extreme case could be the movement of capital from a regulated insurance entity to elsewhere in the group in order to satisfy creditors of the group. We believe that in such a circumstance, insurance regulators should act in the interests of policyholder protection. The new supervisory material is not clear on this point. Accordingly, we suggest that a sentence be added to ICP 24.4.2 to the effect that: “In the event a conflict arises between microprudential and macroprudential objectives, the insurance supervisor should prioritize policyholder protection.”

2. **Acknowledge the need for cross-sectoral perspective and analysis.** In its November 2018 consultation on the Holistic Framework for Systemic Risk in the Insurance Sector, the IAIS acknowledged the importance of taking into account a cross-sectoral view of systemic risk. This aligns with the recognition that insurers are acknowledged generally to have low potential to contribute to systemic risk. Added data collection, analysis, assessments, and supervisory responses should be done in a proportionate manner, avoiding efforts that will not have a material impact on risk to the financial system. To understand where the material impacts are, macroprudential efforts need to be considered from a cross-sectoral perspective. Yet, the proposed supervisory material does not incorporate this perspective. While it may not be realistic to expect insurance supervisors individually to be fully connected with their banking and securities counterparts, nonetheless it is important that the supervisory expectations set forth in ICP 24 be framed by a cross-sectoral perspective. Therefore, we suggest that text be added to the Introductory Guidance in ICP 24.0 to the effect that: “In order for macroprudential supervision to be performed in a proportionate manner, the supervisory framework for macroprudential supervision takes account of a cross-sectoral perspective.”

3. **Clarify language on potential liquidity risk associated with products with cash value.** The language in ICPs 16, 20, and 24 referring to the liquidity risk associated with cash value insurance products does not specifically recognize that the risk will vary widely based on attributes of the product, including attributes outside of the contract itself, such as the insurance purpose for which the product is purchased, potential loss of insurability, and tax consequences upon surrender.
   - We suggest adding language to ICP 16.9.1 acknowledging that the actual liquidity risk of the identified activities will vary greatly based upon a variety of factors, including the specific attributes of insurance products with cash value.
   - With respect to ICP 20.11.1, we observe that reporting surrender value alone, without a reasonable classification of the types of insurance policies at issue, is not likely to provide a meaningful view of liquidity risk, given the wide variation in liquidity risk across products. The NAIC recognized this with its liquidity-related changes to the Blanks, and included basic categorization by product types.
   - ICP 24.1.2 refers to “information on the surrender value of insurance products, product features that increase or decrease the propensity for early pay outs under certain circumstances (such as penalties or delays in the ability to access the cash value of a policy)”. We suggest that the parenthetical be broadened to reference “or other factors contributing to reduced propensity for surrender”.

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## IAIS revisions to the IAIS Glossary, Introduction to ICPs and ICP 7 and ComFrame Assessment Methodology - NAIC Approved Comments

**Aug. 13, 2019**

### Section/Paragraph

<table>
<thead>
<tr>
<th>Comment</th>
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<tbody>
<tr>
<td>As new material related to the holistic framework includes using stress testing as a way to assess liquidity, the current draft definition of stress testing may be read to cover only solvency rather than liquidity as well, so that there is no real definition for liquidity testing purposes. Suggest ensuring the definition is broad enough to encompass both by deleting “solvency”: “A method of solvency assessment that measures the financial impact of stressing one or more factors which could severely affect the insurer.”</td>
</tr>
<tr>
<td>For consistency, suggest changing the last sentence to read: “…observance of ComFrame Standards requirements.”</td>
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<tr>
<td>For clarity, suggest adding: “…to share results of an assessment within the supervisory college…”</td>
</tr>
<tr>
<td>For better readability, suggest adding a comma after “information”: “While legislation provides the authority to coordinate and exchange information, the supervisor…”</td>
</tr>
<tr>
<td>Standards and guidance in other ICPs and ComFrame that address conflicts of interest use wording like address, manage, mitigate, avoid, etc., in recognition that in some cases it may not be possible to have no conflicts of interest. Suggest revising the new text to be consistent with other material on conflicts of interest: “…the group should have in place appropriate measures so that there is no conflicts of interest between the different roles to be performed by such individuals are avoided or mitigated.”</td>
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## IAIS draft revised ICP 22 (Anti-Money Laundering and Combating the Financing of Terrorism) - NAIC Draft Comments

### Section/Paragraph

<table>
<thead>
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<tbody>
<tr>
<td>In changing terminology from FT to TF, we assume this is for the purpose of being consistent with FATF terminology but is not intended to change the scope of the concept itself.</td>
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<tr>
<td>Suggest doing a review to ensure commas and other punctuation are consistent (e.g., use of oxford comma in a series).</td>
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<tr>
<td>Insert missing period at the end of the first sentence.</td>
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<tr>
<td>It’s not clear whether the first sentence is intended to reflect action that has been taken at the FATF or reflect the nature of the relationship between the IAIS and the FATF. If it is the former, this wording seems appropriate. However, if it is the latter, as the IAIS is also an observer member of other international organizations, the wording used should either 1) reflect established policies for external relationships as “has endorsed” suggests that the IAIS as an organization has taken some type of (formal) action on the FATF Recommendations; or 2) use more general wording that reflects support for other standard setters work. Suggest revising the first and second sentences to read: “As the IAIS is a FATF Observer Organization and is supportive of FATF’s work, this ICP is intended to be consistent with FATF Recommendations.”</td>
</tr>
</tbody>
</table>
However, compliance with the FATF Recommendations does not necessarily imply observance of ICP 22 nor does observance of ICP 22 necessarily imply compliance with the FATF Recommendations.

### 22.0.11
Given the wording of the third bullet of Standard 22.1, suggest revising first sentence to read: “Part A describes how the RBA is applied by supervisors, insurers and intermediaries consistent with the FATF Recommendations.”

### 22.1.5
As the rest of the first sentence is singular, suggest using “its design.”
For better readability, suggest moving the second sentence to 22.1.6 (see comment on 22.1.6)
For consistency, change period after second bullet to a semi-colon.

### 22.1.6
Assuming the second sentence of 22.1.5 is moved down, suggest revising first and second sentences to read: “Product risk also encompasses service and transaction risk, which refers to the vulnerability of a product to third party use by a third party or unintended use based on the methods of transactions available. The following are examples of service and transaction attributes which may tend to increase the ML/TF risk profile:”

### 22.1.8
For consistency, suggest revising first sentence to read: “The following are examples of geographic attributes which may tend to increase the ML/TF risk profile:”

### 22.1.13
As both of these should be seen as equally important, suggest revising last sentence to read: “The supervisor should participate in such an assessment to both help inform the assessment and also to improve its understanding of the risks.”

### 22.3.1
For wording consistency with other ICPs, suggest revising sentence to read: “The supervisor should take into account of the risk of ML/TF at each stage of the supervisory process, where relevant, including the licensing stage.”

### 22.5.2
As the supervisor may need to cooperate and coordinate with other supervisors beyond relevant MAL/CFT competent authorities to effectively address policy issues, suggest broadening the second bullet to read: “policy cooperation and, where appropriate, coordination across all relevant AML/CFT competent other relevant authorities.”

### 22.5.5
As the supervisor may need to exchange of information on AML/CFT issues with other authorities than just competent authorities, suggest broadening this read: “The supervisor should consider appointing within its office a contact for AML/CFT issues and to liaise with other relevant AML/CFT competent authorities to promote an efficient exchange of information.”

### 22.6.3
To help with readability, suggest revising second sentence to read: “Such information may be relevant to the risk profile of, or the effectiveness of risk management by, an insurer or intermediary.”

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**IAIS draft supervisory material related to the Holistic Framework for Systemic Risk - NAIC Draft Comments**

<table>
<thead>
<tr>
<th>Section/Paragraph</th>
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<tbody>
<tr>
<td>General</td>
<td>While we agree that the scope of risk identification and analysis of risk interdependencies in an ORSA process should typically cover liquidity and concentration risks, U.S. state insurance regulators support a non-prescriptive ORSA process that encourages insurers to identify and assess their own material and relevant risks. This encourages insurers to develop their own methodology for determining which risk exposures require assessment and reporting through the ORSA process. We believe this provides the supervisor more opportunities to evaluate the effectiveness of an insurer’s ERM process and avoids confusion between the roles of senior management, the Board of Directors and insurance supervisors. While setting out what risks should be covered “at a minimum” may provide consistency across insurers, it is important that this does not</td>
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<tr>
<td>Paragraph</td>
<td>Notes/Recommendations</td>
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<td>lead to more prescription or turn the ORSA into a tick-the-box exercise which in turn diminishes the purpose and effectiveness of the ORSA process itself.</td>
<td></td>
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<td>CF 9.2.b.8</td>
<td>Second sentence, remove the extra “s” in “ass” (should be “as”). Given that this idea is already addressed in the second sentence, suggest deleting in the last sentence “or where its distress, disorderly failure, or its contribution to collective activities or exposures, could adversely impact financial stability” as it is superfluous.</td>
</tr>
<tr>
<td>CF 16.9a</td>
<td>CF 16.9a states: “The group-wide supervisor requires the Head of the IAIG to assess the IAIG’s resilience against severe but plausible liquidity stresses to determine whether current exposures are within the IAIG’s liquidity risk appetite.” However, most of the guidance provided under this standard focuses on stress testing. In order to help show that there are other tools available to perform the assessment, suggest adding to the guidance under CF 16.9a: “The liquidity assessment should consider results of additional tools such as various liquidity metrics, analysis of cash flow statements, cash flow projections as well as the level of readily available liquid assets.”</td>
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<tr>
<td>16.7.5</td>
<td>The new text in Standard 16.7 addresses “material relationship with macroeconomic conditions”; however, the idea of materiality is not carried through in the related guidance in 16.7.5. Suggest adding: “The underwriting policy should address the potential material impact on the insurer’s financial position from correlations between macroeconomic conditions and the insurance portfolio...”</td>
</tr>
<tr>
<td>16.9.2</td>
<td>The “more detailed liquidity risk management processes” in Standard 16.9 is in relation to Standard 16.8 which “requires the insurer’s ERM framework to address liquidity risk and to contain strategies, policies and processes to maintain adequate liquidity”. However, a reader who has not been involved in drafting this work may not easily make the association, so it may be helpful to add something more explicit to make it clear what the “more” is referring to. Suggest adding the following as a new first sentence to Guidance 16.9.2: “Some insurers require more detailed liquidity risk management processes as compared to those processes set out in Standard 16.8.”</td>
</tr>
<tr>
<td>20.11.1</td>
<td>Suggest adding some additional text on what qualitative information disclosures should include: “qualitative information on the insurer’s liquidity risk issues and concerns and management strategies, policies, and processes to address those.”</td>
</tr>
<tr>
<td>24.0.4</td>
<td>In the last sentence it is not clear what “these” refers to. Based on the previous sentence it seems “these” refers to exposures but then exposures is mentioned in the last sentence which would read in a circular manner. Suggest clarifying.</td>
</tr>
<tr>
<td>24.2.4</td>
<td>Given that the first sentence addresses “horizontal reviews to reveal the range of practices among insurers”, it would make more sense for the example to use insurers (plural): “appropriateness of insurers’ assumptions”.</td>
</tr>
<tr>
<td>24.2.10</td>
<td>The first sentence is quite long and seems to combine two ideas that could be separated: 1) monitoring liquidity of insurers in general; and 2) analyzing potential asset sales focusing on large insurers. Suggest: “The supervisor should monitor the liquidity of an insurer’s invested assets relative to its insurance liabilities based on their characteristics. Additionally, the supervisor should analyse the potential that a large insurer’s operations could require it, or a sufficiently large number of insurers, to engage in asset sales of a significant size.”</td>
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2020 Proposed Charges

INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Ryan Workman/Ethan Sonnichsen

W:\National Meetings\2019\Fall\Cmte\G\2020 Charges_draft.docx
The NAIC/Consumer Liaison Committee met in Austin, TX, Dec. 9, 2019. The following Liaison Committee members participated: Stephen C. Taylor, Chair (DC); Michael Conway, Vice Chair (CO); Lori K. Wing-Heier represented by Anna Latham (AK); Jim L. Ridling represented by Mark Fowler (AL); Andrew N. Mais represented by Kurt Swan (CT); Trinidad Navarro (DE); David Altmair represented by Mike Yaworsky (FL); John F. King (GA); Doug Ommen (IA); Dean L. Cameron represented by Randy Pipal (ID); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt (KS); James J. Donelon represented by Ron Henderson (LA); Steve Kelley and Peter Brickwedde (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Janelle Middlestead (ND); Bruce R. Ramge (NE); John G. Franchini and Paige Duhamel (NM); Barbara D. Richardson (NV); Linda A. Lacewell (NY); Jillian Froment represented by Jana Jarrett (OH); Glen Mulready (OK); Andrew Stolfi (OR); Jessica Altman (PA); Kent Sullivan and Cindy Wright (TX); Todd E. Kiser represented by Tanji Northrup (UT); Scott A. White represented by Don Beatty (VA); Tregenza A. Roach (VI); Mike Kreidler and Todd Dixon (WA); Mark Afable (WI); and James A. Dodrill represented by Ellen Potter (WV).

1. **Heard Opening Remarks**

Commissioner Taylor said, as chair of the Consumer Participation Board of Trustees, he wanted to mention that the Consumer Participation Board of Trustees, which is composed of six state insurance regulator members and six funded consumer representative members, met Dec. 8 in regulator-to-regulator session pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. He said the Board of Trustees discussed selection of 2020 consumer representatives and consumer members of the 2020 NAIC Consumer Participation Board of Trustees. In accordance with the terms in the plan of operation for the consumer participation program, selection is required by the end of the year, and notification about all appointments occurs after committee assignments early next year.

2. **Adopted its Summer National Meeting Minutes**

Commissioner Schmidt made a motion, seconded by Commissioner King, to adopt the Liaison Committee’s Aug. 5 minutes (see NAIC Proceedings – Summer 2019, NAIC/Consumer Liaison Committee). The motion passed unanimously.

3. **Observed a Presentation by NAIC Consumer Representatives of the Excellence in Consumer Advocacy Award**

Matthew Smith (Coalition Against Insurance Fraud—CAIF) and Katie Keith (Out2Enroll) presented Commissioner Conway with the Excellence in Consumer Advocacy Award.

Ms. Keith said the NAIC consumer representatives enjoy the great fortune to work Commissioner Conway and his staff on a variety of critical consumer protection issues. She said, in Colorado and at the NAIC, Commissioner Conway champions the needs of consumers, especially in promoting access to affordable, quality health insurance products. Ms. Keith said his leadership in Colorado has been critical to innovative new programs such as the Peak Health Alliance, a state-based reinsurance program that directs additional premium relief to rural communities, and to some of the nation’s most extensive consumer protections against surprise medical bills. She said his office is currently in the process of engaging stakeholders around a unique public option proposal that could be introduced in the state soon, offering additional affordable options for consumers.

Ms. Keith said beyond these broad-scale initiatives, Commissioner Conway and his staff continue to ensure that Colorado consumers, including consumers with preexisting medical conditions, have equal access to the health care they need. These policies include new drug formulary protections for patients with chronic conditions and nondiscrimination provisions for LGBTQ Coloradans.

Mr. Smith said, in addition to his leadership in Colorado, Commissioner Conway devotes a significant amount of time to promoting consumer interests at the NAIC. He said Commissioner Conway serves as chair of the Regulatory Framework (B) Task Force, which is tasked with ensuring that the major working groups of the Health Insurance and Managed Care (B) Committee continue their important work, and chair of the NAIC/American Indian and Alaska Native Liaison Committee, among other leadership positions at the NAIC.
Mr. Smith said Commissioner Conway’s office is always open to hearing input from the consumer representatives, and his staff go out of their way to help on issues at the NAIC and beyond. He said it is, therefore, a privilege and honor to present the 2019 NAIC Consumer Representative Excellence in Consumer Advocacy Award to Commissioner Conway.

Commissioner Conway said this award means so much as it is an award for his entire team in Colorado because it is the team that does the work noted by Ms. Keith. He said he often gets the credit, but without the people behind him, he could not have done any of those things. Commissioner Conway said thank you so much from the folks in Colorado. He said he would display the award proudly but said it really should say the Colorado Division of Insurance—not Michael Conway—as they are ones who get things done.

4. **Heard a Presentation on What State Insurance Regulators Can Do to Promote Retirement Security from the CEJ**

Birny Birnbaum (Center for Economic Justice—CEJ) said retirement security encompasses a broad spectrum of financial tools, including many insurance-related products and services such as life insurance, annuities and long-term care insurance (LTCI). He said the marketing and sales of these products are also areas that fall under the retirement security umbrella.

Mr. Birnbaum said state insurance departments and the NAIC could play an important role in helping American consumers prepare for financial security because insurance is a key part of a comprehensive retirement plan. He said the NAIC focuses on three major areas of retirement security: 1) education; 2) consumer protection; and 3) innovation. Mr. Birnbaum recommended that the NAIC and state insurance regulators promote retirement security in four ways. He said one was by identifying and removing retirement insecurity caused by 1) insurance rate and price increases for long-term care (LTC) products; 2) misleading sales materials and illustrations; and 3) hollowed-out property and health insurance policies resulting from major exclusions and massive deductibles.

Mr. Birnbaum said state insurance regulators no longer allow insurers to recoup costs in the form of rate increases or permit the continued use of, or approve new, LTCI products with no cap on future rate increases. He said the current framework for life insurance and annuity illustrations need rethinking, reengineering and modernization in order to serve—not defeat—consumers’ retirement planning. Mr. Birnbaum said the growth in exclusions and higher deductibles in insurance products designed to guard against natural and health catastrophic events undermines the role of these types of insurance products in recovery and retirement security.

Mr. Birnbaum said the second way was by supporting strong public social programs that deliver benefits more efficiently and effectively than the private sector. He said private insurers could deliver flood insurance more effectively and efficiently than the federal National Flood Insurance Program (NFIP). Mr. Birnbaum said public programs like Social Security and Medicare deliver retirement benefits and health care far more efficiently than the private sector. He said the decline of employer-based pensions and the rise of individual retirement accounts has caused much higher transaction costs for individuals.

Mr. Birnbaum said while the insurance industry has critical problems to offer to help with retirement security, he suggests state insurance regulators should support the strengthening of public programs when those programs deliver benefits more efficiently and effectively.

Mr. Birnbaum said the third way was to ensure that insurance products deliver good value to consumers and to not strip consumers of crucial retirement assets. He said an essential role for state insurance regulators is to ensure life insurance and annuity products deliver solid value to consumers, meaning most of the premium dollars are spent on benefits paid to the consumer. Mr. Birnbaum said insurance products that deliver only little value in the form of few premium dollars being spent on consumer benefits systematically strip consumers of scarce retirement assets. He said ensuring good value in products means that state insurance regulators need to assess the value of the products approved for sale and to communicate that value to consumers.

Mr. Birnbaum said the fourth way was to develop insurance consumer information, education and disclosures that identify the value and cost of the insurance proposition, as well as to focus on the value-added by state insurance regulators. He urged the NAIC to focus on activities for which state insurance regulators have expertise and can best leverage that expertise, such as partnering with educators and other organizations already deeply engaged in research and education related to American’s savings and financial practices.

Mr. Birnbaum said there is a need to inventory and review annuity and LTC models related to retirement security and to recommend improvements and coordination as needed. He said there is currently little or no information regarding the value of life insurance and annuity products as measured by traditional benefit (claims) ratios. However, Mr. Birnbaum said we
regularly see the loss ratios and aggregate value to consumers of most types of property/casualty (P/C) insurance and health insurance. He said developing and publishing benefit ratios and/or the cost of insurance would better enable consumers to see the value of insurance products.

Mr. Birnbaum said when consumers buy an auto or home insurance policy, they pay a premium and know the cost of the insurance protection they are receiving. However, when a consumer buys an indexed life insurance policy that provides important insurance protections, the cost of those protections is not currently available to the consumer. He suggested that the NAIC develop methods and metrics to assess the cost and benefits of life insurance, annuity and LTCI products.

Commissioner Taylor said as chair of the NAIC’s Retirement Security (A) Working Group, he found this presentation helpful. Brenda J. Cude (University of Georgia) said education is not the NAIC’s comparative advantage but that content and subject matter expertise is. Therefore, partnering with the many organizations whose expertise is education and who have already created wonderful curriculum regarding education from kindergarten through 12th grade and college through employer-based programs to create insurance and risk management courses makes sense.

Commissioner Mulready said at the beginning of the presentation, Mr. Birnbaum mentioned rate caps for LTCI. He asked what rate cap Mr. Birnbaum would recommend as proper for LTCI.

Mr. Birnbaum said he would start with no more than a 50% rate increase over the life of the product as it would give some opportunity to address some of the vagaries of LTCI over a long period of time, and it would also give some certainty to consumers. He said after 40 years of experience, insurance companies should be able to develop a product in which they can provide a rate cap on that as there are many other types of insurance products for which companies have been able to do this. Mr. Birnbaum said this is not only possible, but also it is necessary.

Commissioner Roach said he is curious about the comment Mr. Birnbaum made about flood insurance being more effectively delivered by the private sector. He said at present, it is subsidized federally, so he is curious about how states could maintain price competitiveness if it were provided privately. Mr. Birnbaum said right now, the federal government is involved in the direct provision of flood insurance. He said it is done very inefficiently through existing carriers through the write-your-own (WYO) program, and it is subject to a variety of conflicting constraints imposed by the U.S. Congress, but most importantly, it is one of the few property insurance perils that is not regulated by states and offered as part of residential or commercial property insurance, which is regulated by the states.

Mr. Birnbaum said it is his opinion that flood insurance should be given back to the states and that the NFIP, instead of being a direct provider of insurance, should be a mega-catastrophe reinsurer along the same lines as the Terrorism Risk Insurance Program, with states taking on flood insurance the way they have every other type of insurance peril, but there would be a mandatory offer of flood as part of every personal and commercial insurance.

5. **Heard a Presentation on Navigating Troubled Waters from United Policyholders**

Amy Bach (United Policyholders) said her presentation featured state insurance regulator approaches to controlling residual market growth when home insurance availability and competition shrinks dramatically. She said the once robust home insurance market has declined rapidly in recent years, necessitating intervention by state insurance regulators.

Ms. Bach said a series of catastrophes caused private companies to flee the market due to what the companies called “rating inadequacies” and “uninsurable risks” like floods, fires, etc. When asked what the NAIC can do, she said it is imperative for state insurance regulators to keep a fine balance. Ms. Bach said on one hand, it is important to maintain an option for property owners to protect their assets and comply with mandatory purchase or mortgage requirements for the economic health of individuals and communities and for preserving real estate values through buy and sell transactions. She said it is also important for preserving the benefits to consumers of competition.

Ms. Bach said it is possible for state-sponsored solutions to lead the effort by example on essential protections, quality claim handling, mitigation assistance and rewards. She said private market solutions would include non-admitted surplus lines insurance, risk pools, market assistance plans and cooperative buyer arrangements. Ms. Bach said shared market solutions would include assigned risk plans, joint underwriting associations and syndicates, as well as reinsurance facilities. She said regulatory and legislative solutions include moratoriums on non-renewals, limitations on non-renewals, enhancements to or creation of state-run insurer of last resort, and state-sponsored insurance or reinsurance programs.
Ms. Bach said due to Hurricane Andrew in 1992, Florida granted the insurance commissioner statutory emergency powers to issue emergency rules—29 in 1992 and 30 in 1993—valid for 90 days that included a rule activating the Florida Residential Property and Casualty Joint Underwriting Association (FRPCJUA) to provide property coverage to policyholders who became insolvent as a result of the hurricane and two rules setting and extending regulations relating to withdrawal of insurance companies. She said in 1993, a moratorium was imposed on the cancellation and nonrenewal of residential property coverage, and another moratorium of policies was imposed until the legislature had a chance to respond to the recommendations of a study commission on current insurance issues in special session.

Ms. Bach said the stated purpose was that, “The Legislature further finds that the massive cancellations and nonrenewals announced, proposed, or contemplated by certain insurers constitute a significant danger to the public health, safety, and welfare, especially in the context of a new hurricane season, and destabilize the insurance market.” She said recommendations from the study implemented a three-year moratorium phaseout prohibiting an insurer from cancelling or nonrenewing more than 5% of its homeowner’s policies in Florida in any 12-month period and 10% of its policies in any county.

Ms. Bach said it was immediately followed by a similar three-year phaseout moratorium requiring insurers to offer premium discounts for structural mitigation improvements and creating the Florida Hurricane Catastrophe Fund (FHCF) as a state trust fund that provides additional reinsurance for insurers writing residential insurance. She said Citizens Property Insurance Corporation (Citizens) was created in August 2002 as a nonprofit, tax-exempt, government entity as an insurer of last resort through a merger of the FRPCJUA and the Florida Windstorm Underwriting Association (FWUA).

Ms. Bach said as of June 30, 2019, Citizens has the third largest market share in terms of Total Insured Value (TIV) of personal residential property. She said since Citizens’ recent peak number of accounts in 2011, there has been a high volume of depopulation activity. Ms. Bach said Citizens attributes its strong current financial position to depopulation driven by continued interest in the private market for Citizens’ policies, a healthy private commercial market, substantial levels of Citizens’ surplus and a robust risk transfer program.

Ms. Bach said California’s current crisis is that insurers dropped more than 350,000 homeowners in high fire risk areas in 2019, noting that homeowners in ZIP codes affected by 2015 and 2017 fires saw a 10% increase in nonrenewals last year per the California Department of Insurance. She said the most recent data does not reflect or measure the full impact of non-renewals of homeowner policies linked to 2018 fires (i.e., Camp Fire, Carr Fire and Woolsey Fire).

Ms. Bach said the California Fair Access to Insurance Requirements (FAIR) Plan is the insurer of last resort and that the number of FAIR Plan policies has grown by 177% between 2015 and 2018 in the 10 counties with the most homes in high-risk or very high-risk areas. She said changes ordered to the California FAIR Plan include an option for an HO-3 Policy Equivalent no later than June 1, 2020; an increase in the option for combined coverage limit of $1.5 million to $3 million, not including the option for an additional $300,000 available for liability coverage, no later than April 1, 2020; and an option to pay for the policy in monthly installments, by credit card, or electronic fund transfer without any additional fees.

Ms. Bach suggested the states prevent insurers of last resort from getting too big.

6. **Heard a Presentation on Consumers Filing Complaints or Reporting Improper Insurer Behavior in the Automotive Repair Context from the AEPI**

Erica Eversman (Automotive Education and Policy Institute—AEPI) said department of insurance complaint systems typically accept complaints only from consumers. She said auto insurance consumers do not have the requisite knowledge or information to file an enforceable complaint; infrequently use auto insurance, unlike health insurance; do not know or understand how to frame such a complaint; and cannot explain why certain procedures or parts are necessary for safe, proper repairs.

Ms. Eversman said insurers use consumer subrogation to allege fraud or recoup money from repair facilities for alleged overpayment for “unnecessary” procedures; rental charges for perceived excessive days in repair; or overpayment for “unauthorized” parts. She said if insurers are in privity with repair facilities for subrogation, then repairers must be in privity for complaint purposes because insurer information is needed to protect consumers.

Ms. Eversman said insurers are permitted to make complaints about repairers to repair oversight entities—e.g., departments of motor vehicles (DMVs), attorneys general and secretaries of state—by claiming “qualified interest” to protect consumers. She said the reason why accepting complaints from providers is good for the system is that consumers do not file complaints because they believe state insurance departments will not do anything; they are afraid of retribution by insurers; repairers are able to
articulate specific reasons why insurers are underpaying claims; and repairers have daily interaction with insurers, which enables them to identify unfair claims payment patterns and practices by insurers.

Ms. Eversman said misinformation about complaints recently caused a New Hampshire state legislator to use the lack of any complaints in the state insurance database for insurers engaging in “improper repair” as the basis for derailing legislation for quality repairs. She said the failure is in not understanding that insurers do not repair cars and that complaint systems are not set up to address insurer involvement in unsafe repairs that result in complaints, so such complaints end up being filed under “insufficient claim payment.”

Ms. Eversman recommended state insurance regulators enable or permit motor vehicle repair professionals to submit complaints regarding insurer practices related to a specific consumer or to a specific claim; allow repair professionals to assist consumers with drafting and substantiating complaints to prevent insurers from bringing allegations of public adjuster regulations and statutes or unauthorized practice of law claims against repairers who assist consumers; and meet with vehicle repair professionals to understand their frustrations and concerns about insurers’ actions that compromise consumers’ ability to receive insurance payments for safe, proper vehicle repairs. She said insurance contracts do not include service providers as part of the contract but said maybe they should.

Commissioner Taylor said he liked Ms. Eversman’s ideas and that this is something he is going to look at when he goes back home.

Commissioner Schmidt said Kansas does take these types of complaints but that they do not do a good job of communicating that back to the body shops. She asked Ms. Eversman how state insurance regulators should go about doing that.

Ms. Eversman suggested that if states could designate a contact person within each state insurance department or, at least on the complaint form, have an attention to, that would be helpful.

Commissioner Schmidt said it could come into their general complaint division and then it could be handled by certain people from there. She agreed that the problem is a lack of data, so when legislators ask for things like this, they do not have any complaints documented. She said the Kansas Insurance Department has anecdotal information, but it does not have the type of documented evidence that would be helpful in Kansas.

7. **Heard a Presentation on Protecting Patients from Surprise Medical Bills and the Impact of Other Federal Policy Changes on Consumers from Families USA and the CBPP**

Claire McAndrew (Families USA) said the first key principle of consumer protections in surprise billing legislation is to hold consumers harmless. She said balance billing should be completely prohibited in any care situation where consumers cannot ensure they will see an in-network provider or visit an in-network facility, including in emergencies, at in-network facilities, and for air and ground emergency transit.

Ms. McAndrew said for out-of-network care that individuals incur due to no fault of their own, they should pay no more than in-network cost-sharing (including copayments, co-insurance and deductibles). She said out-of-pocket spending should count towards a consumer’s in-network out-of-pocket maximum.

Ms. McAndrew said the second key principle is to hold down health care costs for everyone. She said to ensure that insurance premiums are not unfairly increased, a reasonable payment level between insurers and out-of-network providers for surprise billing situations must be established. Ms. McAndrew said a reasonable payment level should be based on actual costs for care and should not be inflationary (e.g., should not be based on billed charges, which almost always do not accurately reflect price). She said the third key principle is to ensure comprehensive protection nationwide.

Ms. McAndrew said federal law should apply to surprise billing situations unless state law is equal or more robust in terms of consumer protections. She said federal law should determine the payment level owed by a plan to a provider in a surprise bill situation, except when a state law already established a payment level prior to passage of federal law. Ms. McAndrew said if the federal law covers surprise billing situations not covered by an established state law, the federal law should wrap around the state law to set the payment rate in those situations. She said even if states have robust surprise billing laws, federal law should apply to any situations that states cannot fully regulate, such as self-insured, federal Employee Retirement Income Security Act (ERISA)-regulated plans and air ambulance bills.
Ms. McAndrew said the current status of federal congressional action is that the U.S. Senate Committee on Health, Education, Labor and Pensions (HELP) passed legislation that protects consumers and holds down costs and that the U.S. House Committee on Energy and Commerce passed legislation that protects consumers and holds down costs. She said the House Committee on Education and Labor and the House Committee on Ways and Means have not taken any action.

Ms. McAndrew said the timeline for passage in 2019 is that Congress must pass government funding before the deadline on Dec. 20. She said leadership can include surprise billing legislation in this package, noting that it often includes miscellaneous legislation that are priorities and “must-pass” legislation that makes it hard for opposing members to vote “no.”

Ms. McAndrew said state regulatory actions still matter because protections like those proposed in Colorado HB 19-1174 are needed in all care settings, include ambulances, to provide protections even if Congress does not act, as well as to examine current payment mechanisms and their impact on costs and premiums in states that already have a law in place.

Sarah Lueck (Center on Budget and Policy Priorities—CBPP) said everyone is still waiting for decisions to come down from the federal level that will affect issues like the Texas case rule changes and proposed changes to the benefit payment parameters, but she would like to focus on other issues. One is that the CBPP is seeing the first state respond to the federal administration’s guidance on changes to Section 1332 waivers. Ms. Lueck said the CBPP is seeing proposals from the state of Georgia to do reinsurance, which many are familiar with, but to also make some unprecedented changes to its marketplace. She said the CBPP has been concerned about policies that do not meet the guardrails set under the federal Affordable Care Act (ACA).

Ms. Lueck said the CBPP wants to make sure that states with Section 1332 waivers still provide consumers with affordable, comprehensive coverage and that they are enrolled to the same extent that they would have been without the waiver in place. She said Georgia’s recent Section 1332 waiver proposal includes exiting the Healthcare.gov platform without creating its own state-based marketplace so consumers could only enroll in coverage through private web brokers and insurers, who would also be responsible for many of the other marketplace functions that the Liaison Committee is familiar with.

Ms. Lueck said, in addition, the state is proposing establishing its own subsidies in place of the ACA’s. She said, under the waiver, these subsidies could be used for plans that do not meet ACA standards, and the total amount of the subsidies would be capped and would be distributed on a first-in, first-out basis, which means that those most in need could potentially be denied benefits. Ms. Lueck said the CBPP is concerned about this proposal and how the structure of it could raise premiums for ACA-fully compliant coverage, push people into substandard plans and likely cause others to lose coverage altogether. She said it would also be a massive undertaking by any state requiring lots of legislative changes.

Ms. Lueck said the CBPP continues to be concerned about short-term health plans and rule changes that allowed those to expand so more people could be covered under them for longer periods of time. She said the CBPP is beginning to see evidence that some consumers have been harmed by such plans and hearing in news reports about consumers who are being subjected to post-claims underwriting.

Ms. Lueck said the CBPP is pleased that the NAIC is moving forward with its data calls to gather information about such coverages moving forward. She encouraged the states to continue to be vigilant in protecting consumers.

8. **Heard a Presentation on Clarifying Insurance Coverage of Living Donors from the AKF**

Deborah Darcy (American Kidney Fund—AKF) said 37 million Americans have kidney disease and that it is the 9th leading cause of death in the U.S. She said it is End Stage Renal Disease (ESRD) or kidney failure, for which the treatment options are dialysis and transplant. Ms. Darcy said Medicare spent $35.4 billion on ESRD patients in 2016 and that ESRD patients make up 1% of the total Medicare population, but they use 7% of the total Medicare budget. She said on July 10, President Trump signed an Executive Order on “Advancing American Kidney Health.”

Ms. Darcy said the order has three policy goals: 1) to reduce the risk of kidney failure; 2) to improve access to and the quality of person-centered treatment options; and 3) to increase access to kidney transplants. She said only 30% of individuals with kidney failure are living with a functioning kidney transplant; there were 94,754 individuals on the kidney transplant waiting list as of June 18, 2019; and in 2018, there were 5,645 living donors and 14,516 deceased donors.

Ms. Darcy said advancing American kidney health includes increasing access to kidney transplants by: 1) increasing the use of available organs from deceased donors by increasing organ recovery and reducing the organ discard rate; and 2) increasing the number of living donors by removing disincentives to donation and ensuring appropriate financial support. She said the insurer
of the kidney recipient is responsible for the health care costs of the donor associated with the surgery and that Medicare covers complications for the life of the donor.

Ms. Darcy said there are currently no standards regarding the amount of time a kidney recipient’s insurance must cover the donor. She said the time frame is generally 90 days, but it can be shorter or longer depending on the insurance plan. She said donors can be held responsible for complications. Ms. Darcy said living organ donors tend to be healthier than the general public. However, she said complications can occur. She said concerns about health coverage of complications outside of the contracted time can serve as a disincentive to organ donation and that the kidney community is working to address this disincentive.

Ms. Darcy asked state insurance regulators that receive a complaint from a living donor who is being charged for donor-related costs to ensure that the kidney recipient’s insurance pay for those costs. She asked that as the kidney community works with state legislatures to standardize private health insurance coverage for living donors, state insurance regulators are supportive of those who are giving the gift of life.

9. Heard a Presentation on Raising Consumer Concerns About Wellness Programs from Out2Enroll

Ms. Keith said the business of wellness programs is a booming $8 billion industry, with 84% of large employers offering wellness programs in 2019 and 14% of employers penalizing or rewarding workers for achieving a positive biometric outcome (e.g., body mass index [BMI]). She said studies show that wellness programs are ineffective, resonating with healthier employees but having little effect on medical spending or absenteeism. Ms. Keith said the first large-scale, multi-site randomized controlled trial indicated no significant effects on health outcomes, medical spending or utilization, or employment outcomes.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said wellness programs are ineffective, with randomized controlled studies finding no impact on health or employment outcomes. She said such programs are legally questionable as evidenced by the AARP successfully challenging Equal Employment Opportunity Commission (EEOC) wellness rules under the federal Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA). Ms. Yee said wellness programs discriminate against employees and dependents with disabilities and/or in poorer health. She said such programs are invasive because employees must disclose medical information and actions even during non-working (and unpaid) hours.

Ms. Keith said under the individual market wellness demonstration option, up to 10 states can participate in a wellness demonstration project in the individual market. She said participatory wellness programs are already allowed in individual markets (e.g., gym membership, gift card for smoking cessation, etc.) and would allow insurers to impose a “wellness” surcharge of up to 30% for health-contingent wellness programs (e.g., must reach a biometric outcome, such as a target BMI or blood pressure) to avoid the surcharge.

Ms. Yee said recommendations for state insurance regulators are to: 1) avoid the wellness demonstration project for the individual market; 2) monitor the use of wellness programs in the fully-insured markets; 3) consider learning more about the degree of take-up of participatory wellness programs in the individual market; and 4) collect data on the extent of use in the fully insured group market.

10. Heard a Presentation on the HFPP and How it is Protecting Americans from Insurance Fraud

Mr. Smith said the CAIF helped to create the Healthcare Fraud Prevention Partnership (HFPP). He said it was not created to investigate fraud committed by consumers. He said what it exists for is to aggregate medical fraud data throughout the nation, look at that data through a larger platform, and protect consumers from organized fraud in the medical arena that may not be identified through individual states, the federal government, other governmental agencies or private insurers.

Dan Kreitman (HFPP) said the HFPP is a voluntary, public-private partnership, with approximately 20 partners. He said in the past 12 months, the HFPP membership has grown 33%; as of today, the HFPP has 147 partners, including 13 federal agencies, 71 private plans, 13 associations, and 50 state and local partners.

Mr. Kreitman said the purpose of the HFPP is to be an unparalleled data source. He said the HFPP represents the full spectrum of health care payers and antifraud associations and enables the performance of sophisticated data analytics against a unique cross payer data set, as well as information-sharing for the benefit of all partners. Mr. Kreitman said the HFPP promotes...
collaboration and strategic partnerships. He said partners meaningfully participate, guide the partnership and have opportunities to establish strategic collaborations across diverse stakeholders.

Mr. Kreitman said the HFPP wants to help partners move from a reactive approach to taking a preventive approach to address fraud when it first appears. He said the HFPP’s most important goal is generating comprehensive approaches and strategies that materially affect each partner’s effort to combat health care fraud, waste and abuse.

Mr. Kreitman said the HFPP is the only organization through which partners can combine their data with public and private data, including the federal Centers for Medicare & Medicaid Services (CMS), in order to gain heightened antifraud insights. He said the aggregated data, across public and private sectors, provide partners with broader visibility into fraud, waste and abuse. Mr. Kreitman said partners share data, outcomes and lessons learned. He said participation in crowdsourcing on study ideas and design provides maximum impact to address emerging fraud, waste and abuse trends.

Mr. Kreitman said by contributing claims data and conducting studies through a trusted third party (TTP), each participating organization can reap the benefits of cross-sector analysis while maintaining the anonymity of their data. He said no partner—public or private—has access to the data of other partners. Mr. Kreitman said through a variety of HFPP events—including regional information sharing sessions, webinars on trending topics and working groups—partners leverage their collective experiences to play a leading role in shaping the future of the partnership and in combating health care fraud across the nation.

Mr. Kreitman said the HFPP can receive data on 112 million individuals, which is equivalent to more than one in three insured Americans. He said if all partners shared their data, at 228 million covered lives, the HFPP data set would represent more than three out of every four insured Americans. Mr. Kreitman said every additional partner that shares their data further increases the impact the HFPP cross-payer data set has in delivering outcomes for the partners. He said the principles of the partnership that underlie sharing claims for analysis start with data sharing, which is the driving force of the partnership. He said the TTP analyzes claims data contributed by participating entities for studies that offer a system-wide perspective. As a result, the information shared consists of cross-payer findings not otherwise available to partners.

Mr. Kreitman said the TTP supports the HFPP in its day-to-day operations by: 1) delivering subject matter expertise in data analytics that facilitates the design and execution of studies; 2) providing a secure environment for hosting and sharing data; 3) ensuring that non-attribution and confidentiality is maintained for data-sharing partners; and 4) communicating timely and relevant information. He said the goals for HFPP studies include: 1) delivering actionable results based on current data; 2) limiting the additional analysis required to interpret the results; 3) incorporating ideas from partner meetings into studies; and 4) increasing the level of partner participation in all study phases.

Mr. Kreitman said the purpose of data-sharing is to gather a holistic view of federal, state and private payer claims that will give HFPP fraud studies a unique view of health care. He said the studies that the HFPP runs cannot be performed in any other environment, and the data collected can only be used for HFPP studies.

Mr. Kreitman said partners must safeguard the information they receive and only distribute it as agreed-upon. He said partner data is only accessible to the TTP; partners do not have access to each other’s data. Mr. Kreitman said the purpose of studies is to provide leads to partners. He said the TTP does not do investigations and that when partners use a TTP lead, they must determine based on their own data if there is a problem with a specific provider.

Mr. Kreitman said an important strategy to overcome differences in payer policies, as well as priorities and resources, is partner engagement. Therefore, he said the TTP study life cycle built in partner participation and collaboration from beginning to end, including a pipeline where partners can share successes and challenges related to program integrity activities and where partners can suggest study topics by sharing cases or schemes.

Mr. Kreitman said it includes submissions of professional and/or institutional claims data to the TTP portal with initial submissions for the prior two years of data. He said updated claims may be submitted monthly, quarterly or semi-annually and that partners also submit reference files, such as member ID crosswalks that allow the TTP to securely assign HFPP IDs to each beneficiary during transmission, so personally identifiable information (PII) is never stored in the TTP.

Mr. Kreitman said the HFPP IDs allow tracking of billings for the same beneficiary across multiple partners. He said each study relies on specific data elements from professional claims on a preplanned production schedule and that all available data is included in each study the TTP conducts unless it is not relevant (e.g., if the study is related to physical therapy, partners from a mental health carve out will not be included).
Mr. Kreitman said partners receive a variety of outcomes from TTP studies that include their individual study findings, such as a report related to national provider identifiers (NPIs), that meet the study criteria and that partners use study results for qualified lead generation, corroborating evidence or their own analysis for allocating program integrity resources to address the issues related to the study. He said the TTP is currently conducting four types of studies to deliver a variety of value propositions across the payer spectrum.

Mr. Kreitman said the top two types of findings result from claims studies and that by applying algorithms to predefined combinations of current procedural terminology (CPT) codes and their modifiers, dates of service and other data elements, the TTP creates a unique cross-payer analysis of potential fraud, waste and abuse. He said evidence-based findings identify occurrences of suspected fraud, waste and abuse. For instance, the TTP conducts two studies that identify NPIs who have continued to bill partners after their NPI was deactivated from participation with federal programs, such as Medicare and Medicaid, with the findings revealing billing patterns across multiple payers after deactivation.

Mr. Kreitman said outlier detection findings identify claims data patterns that indicate potential fraud, waste or abuse activities. For instance, the TTP conducts studies that compare the total amount of timed procedure codes billed by one NPI across partners with the findings revealing the sum of hours billed by NPIs to all partners included in the study. He said broader analytic activities that can incorporate non-claims information are informational findings such as white papers or issue papers that are typically about emerging topics or known complex fraud schemes.

Mr. Kreitman said the HFPP uses literature review and qualitative research, although sometimes the TTP can conduct sample or test studies and that the TTP is currently studying schemes related to genetic testing. He said aggregate findings come from studies that produce a compilation of results from other studies and include additional information. For example, the TTP creates a monthly Law Enforcement Review List that identifies all the organizational and individual NPIs that were identified in the claims-based studies the TTP conducted in the prior month. In addition, he said each NPI in the list has corresponding partner IDs and contact information, so law enforcement can coordinate investigational activities appropriately.

Mr. Kreitman said because resources differ widely across participating partners, the TTP expanded its analytic products to suit a broader audience. For each study conducted, he said summary results are available for all HFPP partners, which include aggregate results of the impact on the partnership.

Mr. Kreitman said participating entities receive an individual report containing an interactive dashboard with personalized results of the analysis and study results according to risk levels and a consolidated report with combined findings for all participating entities. He said the improved visualizations use Tableau software to more easily identify suspect providers because the application graphically illustrates study objectives and suspicious billing patterns. He also said a complimentary Tableau reader application is available for partners.

Commissioner Taylor asked if there are any special obligations required for states to join the HFPP. Mr. Kreitman said there are not and that he would stay after the meeting to talk with states. A general memorandum of understanding (MoU) is signed to enter into partnership with the HFPP.

Ms. Duhamel asked what kind of fraud they are seeing from labs. Mr. Kreitman said the HFPP is seeing lab testing for drug abuse five days a week, which is unheard of in the industry because opiates and other types of drugs being abused stay in the bloodstream for several days.

Ms. Duhamel said in cases where abuse or mental illness is present, New Mexico is seeing evidence that consumers are being shuttled out of state or out of the country to receive treatment. Mr. Kreitman said the HFPP is seeing evidence of this, as well as fraudulent providers using so-called scholarships to entice patients into other states for treatment in fake treatment facilities.

Having no further business, the NAIC/Consumer Liaison Committee adjourned.
The NAIC/American Indian and Alaska Native Liaison Committee met in Austin, TX, Dec. 8, 2019. The following Liaison Committee members participated: Michael Conway, Chair (CO); Lori K. Wing-Heier, Vice Chair (AK); Trinidad Navarro (DE); Matthew Rosendale represented by Bob Biskupiak (MT); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Johnny Palsgraaf (ND); Andrew Stolfi (OR); Larry Deiter represented by Frank Marnell (SD); Mike Kreidler (WA); and Mark Afable represented by Olivia Hwang (WI). Also participating were: Brian Fordham (OR); and Todd Dixon (WA).

1. **Adopted its Summer National Meeting Minutes**

   Director Wing-Heier made a motion, seconded by Ms. Biehn, to adopt the Liaison Committee’s Aug. 4 minutes (see NAIC Proceedings – Summer 2019, NAIC/American Indian and Alaska Native Liaison Committee, Attachment One). The motion passed unanimously.

2. **Heard a Presentation on Improving How the States Work with Tribes**

   Vicki Lowe (American Indian Health Commission—AIHC) said she had worked with American Indian tribes for over two years. During that time, she has learned that the most important issue for tribes is sovereignty, which, along with Indian law, reigns over all else. She said tribes are distinct political communities. She said tribal sovereignty is exercised each time a tribe governs their own people, resources and lands. She said tribal powers include the establishment of government; the determination of membership; the policing and administration of justice; and the exclusion of people from reservation, charter business organizations, and sovereign immunity. Tribal sovereignty in practice means that tribes have the authority to govern themselves. Ms. Lowe said sovereignty ensures control over the future of the tribes and encourages the preservation of tribal culture, religions and traditional practices. She said tribes have the authority to, among other things, govern their people and their land; define their own tribal membership criteria; create tribal legislation, law enforcement and court systems; and impose taxes in certain situations. She said a lack of understanding of Indian law can have detrimental impacts to tribal governments, American Indians and Alaska Natives (AI/AN). She said one example was seen during a recent outbreak of measles when tribal leaders sought to distribute the limited vaccine themselves within their own tribes, giving the highest priority to the elderly and the very young. However, local health authorities had different priorities—giving the highest priority of the limited vaccine to those with chronic health conditions. The tribe refused to follow these priority guidelines, so the tribes received no vaccine, which resulted in many cases of measles that lead to deaths in tribal communities.

   Ms. Lowe said in order to understand the Indian Health Care Delivery system, it is necessary to go back before relationships were established between the tribes and the federal government. She said prior to such contact in the 1880s, indigenous people lived everywhere across what is now known as the U.S., with many tribes inhabiting several states. She said history is the key to understanding Indian law more than any other type of law. She said it is heavily intertwined with federal Indian policy, which shifts back and forth with the flow of popular and governmental attitudes toward American Indians. She said Indian law is the body of law dealing with the status of Indian tribes and their relationship with the federal government and the consequences/impact of that legal status/relationship for tribes and their members, states and citizens, as well as the federal government and local jurisdictions. She said understanding and respecting Indian law can bring about great improvements for tribal nations—AI/AN—and benefit the citizens of each state. She said in 2010, the Washington Department of Social and Health Services, in conflict with federal law, attempted to require tribal health programs to obtain state licensure for their facilities. She said an insurance issuer’s failure to recognize a tribal health program as a licensed or certified facility can result in loss of funds for critically underfunded tribal health programs. She also said that a Washington court’s failure to recognize a tribal health programs as a licensed or certified facility can result in AI/AN unable to receive treatment from their tribal health program medical home. She said tribal members have triple citizenship—as Tribal citizens, Federal as America citizens, and as citizens of the state in which they live.
Ms. Lowe said Executive Order 13175: “Consultation and Coordination with Indian Tribal Governments,” which was issued by U.S. President Bill Clinton on Nov. 6, 2000, requires federal departments and agencies to consult with Indian tribal governments when considering policies that would affect tribal communities, and it reiterates the federal government's previously acknowledged commitment to tribal self-government and sovereignty. She said based on this federal law, tribal governments have a government-to-government relationship with the federal government. She said tribal governments are not stakeholders, minority groups, or other community groups. She said they are consulted with as governments, which means there are certain notice requirements for federal and state policies and actions that other stakeholders do not have. She said through the Centennial Accord of 1989, Washington established a unique relationship with tribes that honors the government-to-government relationship. She said the accord is an agreement between Washington and the tribes in which each party “respects the sovereign status of the parties, enhances and improves communications between them, and facilitates the resolution of issues.” She said at the state level, Chapter 43.376 RCW requires state agencies to “make reasonable efforts to collaborate with Indian tribes in the development of policies, agreements, and program implementation that directly affect Indian tribes.” She said it requires state agencies to “develop a consultation process that is used by the agency for issues involving specific tribes.” She said RCW 43.376.050 also requires that: 1) at least once a year, the governor and other statewide elected officials must meet with leaders of Indian tribes to address issues of mutual concern; 2) the governor must maintain, for public reference, an updated list of the names and contact information for the individuals designated as tribal liaisons and the names and contact information for tribal leadership as submitted by an Indian tribe; and 3) an annual meeting between the governor and tribal leaders take place. She said it requires five state agency duties in establishing a government-to-government relationship with the tribes. State agencies must:

1. Collaborate. Make reasonable efforts to collaborate with Indian tribes in the development of policies, agreements and program implementation that directly affect Indian tribes.
2. Consultation Policy. Develop a consultation process that is used by the agency for issues involving specific Indian tribes.
3. Tribal Liaison. Designate a tribal liaison who reports directly to the head of the state agency.
4. Training. Ensure that tribal liaisons who interact with Indian tribes and the executive directors of state agencies receive training, as described in this chapter.
5. Reporting. Submit to the governor on activities of the state agency involving Indian tribes on implementation of this chapter.

Ms. Lowe said when things go south in a consultation, tribal leaders often cite one of the following as the cause:

- A misunderstanding of the difference between collaboration and consultation.
- Consultation is a formal process with specific requirements established in advance regarding:
  - The level or depth of the required consultation—it must be meaningful.
  - The result or goal of the consultation—it must be a regular, ongoing exchange of information and opinions resulting in a mutual understanding between Indian tribes as sovereign nations and the state on all policies and actions that directly affect Indian tribes.
  - Who the required parties to the consultation are.
  - The Insurance Commissioner, Chief Deputy Insurance Commissioner, or Deputy Insurance Commissioner with the appropriate decision-making authority.
  - Indian tribes represented by the Tribal President, Tribal Chair, Tribal Governor, an elected or appointed Tribal Leader, or their authorized representative(s).
  - Urban Indian Health Programs.
  - AIHC Board Chair or authorized representative who has the authority to make decisions on behalf of the AIHC. The AIHC is a not-for-profit entity that works on behalf of the Indian tribes and two urban Indian health organizations in Washington on health policy and priority AI/AN health issues that improve the Washington tribal health delivery system and the health of individual AI/AN residents. The AIHC does not represent any Indian tribe or Indian Health Service (IHS), Tribes and Tribal organizations, and urban Indian organizations (I/T/U) Provider.
  - Tribal organizations organized under the Indian Self-Determination and Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450 b (1)).
When tribal consultations must occur: prior to implementation of all Office of the Insurance Commissioner’s (OIC) policies and actions that directly affect Indian tribes except for emergency rulemaking, which means the development of policies, agreements and program implementation by the OIC that have substantial direct effects on Indian tribes or the relationship between the OIC and Indian tribes, and which may include rulemaking, interpretive and policy statements. These include, but are not limited to, rules regarding consumer access to health care providers/essential community provider provisions and health insurance issuer contract requirements.

- The collaboration requirements: only tribes can determine what has tribal implications.

Ms. Lowe said tribal leaders are very familiar with the consultation policy, so agency staff and its leaders must be as well. She said common pitfalls are: 1) the agency does not keep its tribal liaison informed at the policy level; 2) an improper determination has been made regarding tribal implications; 3) agency staff are not following the consultation procedure due to a lack of training, awareness, willingness or presence; 4) tribes are engaged or consulted too late in the process; and/or 5) tribes are improperly viewed as stakeholders and not as sovereign governments.

Director Wing-Heier asked how often consultations are typically held. Ms. Lowe said consultations are held whenever needed, if they are needed more often than the required annual consultation.

Commissioner Conway asked Ms. Lowe to elaborate a little more on what happened with the H1N1 incident. Ms. Lowe said most of what the U.S. Centers for Disease Control and Prevention (CDC) does has been unclear because the federal government does not know what effect tribal implications have on the states, and the states are used to having total jurisdiction over everything. She said the local health offices are used to being an authority all unto themselves. She said they were very strictly following the instructions they had been given due to the limited number of vaccines available, so they would not give tribes any vaccine, as the tribes refused to follow those rules.

3. **Heard a Summary on the Removal of Tribal Resources from the HHS Website**

Holly Weatherford (NAIC) said that on March 6, 2019, Senators Udall, Cortez Masto and Tester co-signed a letter addressed to Alex Azar, Secretary of the U.S. Department of Health and Human Services (HHS), expressing concerns about the removal of “federal health services information for Tribal communities from HHS-run websites.” Senator Udall also requested information about what information is still available to tribal communities and answers to the following questions:

1. Why were the above referenced resources removed from the Office of Minority Health (OMH) website? When did this occur? When do you expect them to be restored?
2. In 2015, the Administration of Native Americans (ANA) offered technical assistance to tribes to provide strategies for increasing enrollment by AI/AN in Medicaid, the Children’s Health Insurance Program (CHIP), and insurance available through the Health Insurance Marketplace. The request forms are still available on your website.
   - Is that technical assistance still available to tribes? If no longer available, why not?
   - What are you doing to ensure that Native populations and tribes know about the technical assistance that this program provides?
3. How is the HHS working to ensure that Native populations and tribes can access the resources that the federal Affordable Care Act (ACA) provides?
4. How was Healthy Tribes financed originally? Did funding come from ANA appropriations or elsewhere at the HHS? What is the function of that program today?
5. If services provided under the Healthy Tribes program are no longer available, how has the ANA repurposed those funds?

To our knowledge, there has been no response to this letter. However, OMH Press Secretary Tony Welch, in response to questions about the removal of this information from the OMH website, commented the following to Government Executive:

a. “As is standard website management practice, the Office of Minority Health [OMH] routinely reviews and updates the content on the OMH website. We also continue to make improvements to the site by reorganizing content on the site,” OMH Press Secretary Tony Welch said. He said some of the materials cited by the Web Integrity Project (WIP) have been “restructured” and made available.
b. “As with the ACA, which is administered by the Centers for Medicare and Medicaid Services,” he continued. The minority health office “regularly supports the initiatives of other federal offices, summarizing or linking to their information and resources. When OMH updates its pages, information that has left the OMH site is still available to the public.”

One of the items initially removed from the OMH website included “ACA Guidance for American Indians and Alaska Natives.” This page featured an infographic providing an overview of how to receive benefits under the ACA. While this page is no longer available, there is an article on the Administration for Children and Families website, also run by the HHS, titled “American Indians/Alaska Natives and the Affordable Care Act – General Information,” which includes a link directing users to the resource “Health coverage for American Indians & Alaska Natives” on the HealthCare.gov website.

A May 2019 article in MedPage Today states that for over a two-year period, “the Department of Health and Human Services has been removing or downplaying information about the rights, benefits, and services granted by the Affordable Care Act.” This is based on a report from the WIP, which is an arm of the Sunlight Foundation. The article goes on to say that since 2017, the HHS has removed at least 85 fact sheets, press releases, and other informational documents from its websites. In addition to minority health, the website changes have affected several issues, including climate change and women’s health.

In March 2019, the Sunlight Foundation and American Oversight jointly filed a lawsuit in the U.S. District Court for the District of Columbia to compel the HHS to release records related to the Office of Women’s Health’s removal of fact sheets and other public information on multiple issues, including lesbian and bisexual health and affordable breast cancer screenings. This lawsuit is the result of unsuccessful Freedom of Information Act (FOIA) requests, and it seeks injunctive relief to require the delivery of documents related to the HHS’s communications with the public affairs firm Hager Sharp, which runs the website for the Office of Women’s Health. The lawsuit also calls for the delivery of communications involving website user messages to the women’s health website and the agency’s handling of the website.

No lawsuit has been filed to compel similar documents from the HHS regarding federal health care information specific to tribal communities removed from the OMH website, and we are unaware if any FOIA requests have been made. Federal agencies retain much of the responsibility and discretion to determine what information is posted to their websites and what deleted content is retained as federal records.

Ms. Weatherford said for next steps, NAIC legal staff could coordinate with HHS contacts on the hill, and they would also be happy to continue to track the progression of the lawsuit with reporting feedback to the Liaison Committee.

Commissioner Conway asked if it seemed like the OMH was going to respond to those FOIA requests. Ms. Weatherford said the OMH declined to respond to the FOIA requests. Commissioner Conway asked how the OMH declined. Ms. Weatherford said the OMH relied on some exceptions to the FOIA law that this group disagreed with.

Commissioner Conway asked if the NAIC could provide resources to file FOIA requests or if the NAIC could help in pulling these resources off the HHS website in order to put the resources on the NAIC website or on the states’ websites. Ms. Weatherford said she would take this request to the NAIC Legal Division and then respond to the Liaison Committee.

4. Discussed Other Matters

Commissioner Conway said one of the Liaison Committee members, Superintendent Franchini, sent three of his staff members to participate with Lois Alexander (NAIC) at the Liaison Committee’s information booth during the 76th Annual Convention and Marketplace held by the National Congress of American Indians (NCAI) in Albuquerque, NM, Oct. 20–25, 2019. Hundreds of American Indians and Alaska Natives were assisted with their insurance concerns by these Liaison Committee representatives.

Having no further business, the NAIC/American Indian and Alaska Native Liaison Committee adjourned.
NAIC/INDUSTRY LIAISON COMMITTEE

The NAIC/Industry Liaison Committee did not meet at the Fall National Meeting.
The NAIC/State Government Liaison Committee met in Austin, TX, Dec. 7, 2019. The following Committee members participated: Eric A. Cioppa, Chair (ME); Raymond G. Farmer, Vice Chair (SC); Lori K. Wing-Heier represented by Anna Latham (AK); Jim L. Ridling represented by Mark Fowler (AL); Allen W. Kerr represented by Ryan James (AR); Michael Conway represented by Peg Brown (CO); Trinidad Navarro represented by Christina Haas (DE); Dean L. Cameron (ID); Al Redmer Jr. (MD); Mike Causey (NC); Jon Godfread (ND); John G. Franchini represented by Robert Doucette (NM); Jillian Froment represented by Meredith Alexander (OH); Glen Mulready represented by Buddy Combs (OK); Andrew Stolfi represented by Richard Blackwell (OR); Larry Deiter (SD); Hodgen Mainda (TN); Kent Sullivan represented by Luke Bellsnyder (TX); Mike Kreidler and Lonnie Johns-Brown (WA); and James A. Dodrill and Erin K. Hunter (WV). Also participating were: Chance McElhaney (IA); Anita G. Fox and Karin Gyger (MI); Chlora Lindley-Myers (MO); Barbara D. Richardson (NV); and Scott A. White (VA). The following state legislators and government officials participated: Rep. Kerry Rich (AL); Rep. Deborah Ferguson (AR); Sen. Matthew Lesser (CT); Daniel Jacob (HI); Elizabeth Matney (IA); Del. Teresa Reilly and Del. Kathleen Dumais (MD); Rep. Donna Lasinski (MI); Sen. Gary Dahms (MN); Sen. Paul Wieland (MO); Sen. Jim Burgin (NC); Sen. Shawn Vedaa (ND); Rep. Micaela Lara Cadena (NM); Terry Reynolds (NV); Sen. Jay Hottinger and Sen. Bob Peterson (OH); Rep. Brian Patrick Kennedy (RI); Rep. Robin Smith (TN); Rep. Tom Oliverson, Emily Amps, Jarrett Hill, and Jesse Sifuentes (TX); Rep. Jean O'Sullivan (VT); Rep. Nicole Macri (WA); and Sen. Cale Case (WY).

1. **Heard a Welcome from the President**

Superintendent Cioppa thanked legislators and state government officials for attending the meeting. He mentioned how the NAIC has made progress on a number of important initiatives, including recently adopting amendments to the *Credit for Reinsurance Model Law* (#785). He said these changes to the model implement the provisions of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (U.K. Covered Agreement). He said the states have until 2022 to adopt these amendments or be subject to federal preemption.

2. **Adopted its 2018 Summer National Meeting Minutes**

Director Farmer made a motion, seconded by Director Cameron, to adopt the Liaison Committee’s Aug. 4 minutes (see *NAIC Proceedings – Summer 2018, NAIC/State Government Liaison Committee*). The motion passed unanimously.

3. **Reaffirmed its Mission Statement for 2020**

The mission of the NAIC/State Government Liaison Committee is to discuss issues of common interest to state insurance regulators and state officials.

Superintendent Cioppa asked Liaison Committee members if there were any objections to reaffirming the Liaison Committee’s mission statement for 2020. Hearing none, the Liaison Committee’s mission statement was reaffirmed for 2020.

4. **Discussed Health Insurance Issues**

Director Farmer discussed health insurance developments. He said open enrollment began on Nov. 1 and ends Dec. 15. He noted that markets appear to be more stable for 2020, with some states experiencing a decrease in rates and new players in the marketplace. He said things are not looking as positive in the small group market, where rates continue to increase rapidly. He noted that state insurance regulators remain concerned about legal uncertainty, and they are closely watching several court cases. He said state insurance regulators are also tracking congressional activity on surprise billing, and he noted the creation of the U.S. Department of Transportation’s Air Ambulance and Patient Billing Advisory Committee, which Commissioner Godfread has been appointed to.
5. **Discussed LTCI**

Commissioner White discussed long-term care insurance (LTCI) and the creation of the NAIC’s Long-Term Care Insurance (EX) Task Force. He said the Task Force has two goals: 1) to develop a consistent national approach for reviewing LTCI rates that result in actuarially appropriate increases being granted by the states in a timely manner; and 2) to focus on ensuring that consumers are provided with meaningful options to reduce their benefits in situations where the premiums are no longer affordable. To achieve these objectives, the Task Force has formed six workstreams: 1) Multistate Rate Review Practices; 2) Restructuring Techniques; 3) Reduced Benefit Options and Consumer Notices; 4) Valuation of LTCI Reserves; 5) Non-Actuarial Variations; and 6) Data Call Design and Oversight.

6. **Discussed Big Data and Data Privacy**

Commissioner Godfread discussed state insurance regulatory considerations regarding big data and data privacy. He said that while big data application is allowing insurers to more accurately underwrite and price risk, these evolving technologies have made it increasingly challenging for state insurance regulators to evaluate rating plans that incorporate complex predictive models. He discussed how state insurance regulators recognize the need to be sure that no rating factors used violate existing laws, unfairly harm consumers, or result in inappropriate bias. He said state insurance regulators are working to safeguard consumer protections while fostering innovation in the insurance marketplace. He also addressed data privacy and said the NAIC has formed the Privacy Protections (D) Working Group. The Working Group’s charge is to “[r]eview state insurance privacy protections regarding the collection, use and disclosure of information gathered in connection with insurance transactions, and make recommended changes, as needed, to certain NAIC models.”

Director Fox asked if the Innovation and Technology (EX) Task Force is looking into possible consumer discrimination that may occur as insurers move away from pooling and more towards targeted/individual data collection and risk factors. Commissioner Godfread said the Task Force is studying these microtargeted risk considerations.

Rep. Kennedy said state legislators are seeing a lot of privacy legislation introduced, and he expressed concern about possible federal preemption. Commissioner Godfread said state insurance regulators share this concern, and they are working quickly to try and stay in front of the U.S. Congress (Congress).

Rep. O’Sullivan asked about blockchain technology and whether the NAIC is looking at that technology. She said Vermont recently passed blockchain legislation. Commissioner Godfread said state insurance regulators continually receive updates on blockchain technology. However, to date, they have not seen substantive developments.

Director Farmer mentioned the *Insurance Data Security Model Law* (#668).

7. **Discussed the GCC and MPI**

Superintendent Cioppa discussed the group capital calculation (GCC) and Macroprudential Initiative (MPI). He said the GCC will be a tool that state insurance regulators can use in their solvency-monitoring activities. He discussed how in 2019, the NAIC has been focused on testing the calculation and that the results will be discussed during the Fall National Meeting. State insurance regulators plan to utilize the feedback from the testing to make improvements, and the plan is to expose a revised GCC in early spring 2020. He subsequently discussed macroprudential monitoring and how it provides state insurance regulators with a better understanding of how the insurance sector is affected by various risk exposures in the broader financial markets and economy. He said state insurance regulators are focused on identifying potential enhancements in four key areas, including capitals stress testing, recovery and resolution, counterparty exposure/concentration, and liquidity risk.

8. **Discussed Other Matters**

Rep. Kennedy asked if the NAIC has looked at the insurance implications of state gender identification laws and individuals who identify as non-binary or transgender. Superintendent Cioppa replied that there is no official NAIC workstream, but some state insurance regulators have addressed this in their respective states.

Having no further business, the NAIC/State Government Liaison Committee adjourned.

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